

**SEXUAL VALUES, ATTITUDES, BEHAVIOUR AND THE
PSYCHOSOCIAL WELL-BEING OF A GROUP OF AFRICAN
ADOLESCENT MALES**

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West University (Vaal Triangle Campus)

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Dedication

This study is dedicated to the loving memory of my mother, Thokozile Kheswa, a domestic worker, who had taught me to be resilient and gentle. Though you are no more, I believe that you must be thankful for the seed that germinated in the person that I have become.

PREFACE AND DECLARATION

The article format was chosen for this study. The researcher, Jabulani Kheswa, conducted the research and wrote the manuscripts. Prof. C. van Eeden and Prof. S. Rothmann acted as promoter and co-promoter respectively. Three manuscripts have been written, and will be submitted for publication.

MANUSCRIPT ONE: Sexual values and attitudes, self-esteem and mental health and well-being of African adolescent males.

MANUSCRIPT TWO: Sexual behaviour as decision making and communication skills, coping strategies and mental health and well-being of African adolescent males.

MANUSCRIPT THREE: Guidelines for promoting healthy sexual behaviour and psychosocial well-being of African adolescent males.

I declare that **Sexual values, attitudes, behaviour and the psychosocial well-being of a group of African adolescent males**, is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.



Jabulani Kheswa (Student Number: 21189137)

Date: December 2015.



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Letter of permission

Permission is hereby granted that the following three manuscripts:

1. Sexual values and attitudes, self-esteem and mental health and well-being of African adolescent males.
2. Sexual behaviour as decision making and communication skills, coping strategies and mental health and well-being of African adolescent males.
3. Guidelines for promoting healthy sexual behaviour and psychosocial well-being of African adolescent males.

may be submitted by Jabulani Kheswa for the purpose of obtaining a PhD-degree in Psychology.

This is in accordance with academic rule A.8, and specifically rule A.8.2.b of the North-West University.

C. van Eeden.

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DECLARATION OF EDITING

I hereby declare that I was responsible for the language editing of the doctoral thesis **SEXUAL VALUES, ATTITUDES, BEHAVIOUR AND THE PSYCHOSOCIAL WELL-BEING OF A GROUP OF AFRICAN ADOLESCENT MALES** by J. G. Kheswa.

I

DR ELSABÉ DIEDERICKS

13 December 2015

SUMMARY

Title: Sexual values, attitudes, behaviour and the psychosocial well-being of a group of African adolescent males

Key terms: Communication; coping strategies; decision making; emotional, psychological and social well-being; mental health; self-esteem; sexuality values and attitudes.

In this quantitative study, the relationships of sexual values, attitudes, decision making and ease of communication, with self-esteem, coping strategies and mental health and well-being of a group ($N=552$) of African adolescent males were investigated. This study entailed a literature overview of how the constructs were theoretically conceptualised and empirically researched, as well as three manuscripts intended for later publication in accredited journals which served as the research reports. A final chapter presented the conclusions, limitations and recommendations of the study.

The concern of parents, educators, youth leaders and even government about the quality and outcomes (mostly problematic) of youth sexuality has been widely documented. In this vein, research into youth sexuality and sexual health largely focuses on self-defeating sexual practices and consequences such as risky sexual activities, unprotected sex with multiple partners, aggressive sexual relationships, and sexual encounters resulting in teenage fatherhood, STD or HIV infections, sexual offences, and more. The same trend exists as far as research of the sexual behaviour of adolescents associated with psychosocial features such as self-esteem, coping strategies and mental health and well-being is concerned, namely that mostly unhealthy psychosocial variables have been associated with problem-laden sexual aspects, for example depression or low self-esteem with risky sexual practices.

The definition of sexual health of youth by the World Health Organization, however, recognises that sexual health goes beyond avoiding negative outcomes, towards including the positive and satisfying aspects of sexuality. Sexual health is seen as a state of physical, emotional,

mental and social well-being in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, cited in Public Health Agency of Canada, 2008). Based on the latter approach to youth sexuality, this study was embedded in positive psychology, healthy developmental psychology, health psychology and constructive social psychology. A salutogenic approach - instead of a pathogenic (as indicated above) - was preferred for this investigation into sexual values and attitudes, sexual decision-making skills and ease of communication about sexual matters of African adolescent males; in relation to their self-esteem, coping strategies and psychosocial health and well-being. The fact that a paucity of research exists about the mentioned features of youth sexuality and their psychosocial well-being was a further motivation for this study.

Data for the statistical investigation of variables was gathered from learners in four secondary schools in Gauteng, South Africa. This was a convenience sample including all consenting learners in Grades 10 to 12 at the four schools. Approval for the research was obtained from parents, school principals, the Gauteng Department of Education and the North-West University Ethics Committee. The research participants, ranging from 14 to 21 years of age, completed the following validated measuring instruments: The Mathtech Sexuality Questionnaires for Adolescents: Attitude and Value and Behaviour Inventory (MSQA: AVI and BI) by Kirby (1984), the Rosenberg Self-Esteem Scale (RSES) by Rosenberg (1965), the Children's Coping Strategies Checklist (CCSC) of Ayers and Sandler (1999), and the Mental Health Continuum (MHC: LF) by Keyes (2005). Statistical analyses yielded the following, namely descriptive statistics correlational indices and reliability ρ -values; best-fitting measurement and structural models identified with structural equation modelling; mediation variables identified by means of the bootstrapping method; and three latent classes of psychosocial well-being variables identified by means of latent class analysis.

The general aim of the study was to analyse the relationships between sexual values, attitudes and aspects of behaviour, self-esteem, coping strategies and mental health and well-being of a group of African male youth. Specific aims included to identify best-fitting statistical measurement and structural models that explain the relationships between variables and the direction of the relationships; to determine whether self-esteem mediates the relationship between mental health and well-being and sexual values and attitudes; to identify possible underlying latent classes to group participants based on their levels of mental health and well-being. Findings concluded that means and standard deviations compared well with those cited in literature that had used the same scales; correlations found were significant and theoretically expected; reliability ρ -values indicated moderate to good internal consistency of the measuring instruments; statistically best-fitting measurement and structural models could be identified; self-esteem was identified as a mediating variable between mental health and well-being and sexual values and attitudes of youth; latent class analysis identified three classes, namely flourishing, moderate mental health and languishing, to which 28%, 56% and 16% of the participants belonged respectively.

Based on the empirical findings as well as relevant literature, a proposed programme for sexual education of youth was constructed. This psycho-educational programme could provide guidance to youth regarding aspects of their sexuality such as their values and attitudes, decision-making skills and communication about sexual matters. It could promote self-esteem and healthy coping strategies in sexual experiences, as well as in general and it could enhance their psychosocial well-being (flourishing).

Finally, the study was evaluated, conclusions were drawn, limitations indicated, recommendations made and the contribution of this research stated.

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CHAPTER ONE

LITERATURE OVERVIEW OF THE STUDY

In this study the sexual values, attitudes, behaviour and psychosocial well-being of a group of African adolescent males will be investigated. In the following overview, the discussion will firstly cover the background and rationale of the study. Thereafter, factors that influence adolescent males' sexuality and sexual development (practices and well-being) will be unfolded in three categories: *intrapersonal, interpersonal and societal factors*. Psychosocial well-being, as conceptualised in literature and for the purpose of this study, will be explicated. Finally, the research design, objectives and the methods used to gather and analyse data, the procedures followed and ethical considerations upheld, will be presented. In this thesis, the overview serves as the literature background of this study. The empirical research will be presented in three manuscripts intended for publication in selected scientific journals. It is therefore acceptable that some duplication of literature content may occur between the overview and the manuscripts.

1. Background and Rationale of the Study

In South Africa, an alarming portion of African adolescent males do not engage in sexually healthy practices such as involvement in monogamous relationships and the consistent use of condoms. In their search for sexual identity, African adolescent males often tend to experiment in sexual activities prematurely, without protection and with multiple sexual partners (James, Reddy, Taylor, & Jinabhai, 2004). According to Harland, Barclay, and McNamee (2006), such youth pay little attention to their emotional, mental and physical health, have little healthy sexual experience and they largely ignore the consequences of premature sexual activity such as early fatherhood, that could result in poverty, reduced job opportunities and low self-esteem (Ziyane & Ehlers, 2006). In the process, they also place themselves at risk for sexually transmitted infectious diseases (STIs) and other psychosocial problems (Guajardo, Snyder, & Jansen, 2009).

While puberty presents developing adolescent males with a range of physical, interpersonal, and social dilemmas (Nicholas, 2008), their incomplete cognitive development results in not being able to think hypothetically and may make them less able to make informed decisions about sexual activities and their sexuality (Steinberg & Scott, 2003). Being psychosocially more immature than adults, adolescent males' judgment is often impaired by peer influences, attitude towards and perception of sexual risks and incapacity for self-management. Evidence (Wilbraham, 2009) reveals that the strongest reason for most African adolescent males to engage in early sexual activities is to gain acceptance and approval from peers. In line with this is the finding of Bonomo, Coffey, Wolfe, Lynskey, Bowes, and Patton (2001) that for fear of being rejected, adolescent males often conform to peer pressure and may behave irresponsibly and aggressively. For instance, they may engage in risky sexual behaviour without using condoms and sexually coerce their partners into sexual activities without their consent, especially when under the influence of alcohol and drugs (Whitehead, 2007). The problem is exacerbated if male adolescents are involved in gang activities. They would then be more likely to disregard the social norms and rules that restrain behaviour and to lose their sense of identity as an individual person due to decreased personality strength in group settings (Hardy, 2006; Iriyama, Nakahara, Jimba, Ichikawa, & Wakai, 2007). Under the gang influence they may rape women, sexually harass homosexual "gays" and engage in multiple partners for sexual gratification to claim their masculinity (Glieds & Pine, 2002; Sawyer-Kurian, Wechsberg, & Luseno, 2009).

In many black communities in South Africa, parents (especially fathers) continue to avoid discussion of topics which involve sexuality with their adolescent males. They believe talking about sexuality would lead their adolescent males to promiscuity (Mturi, 2001). This unwillingness of many parents or caregivers to conduct balanced sex-related discussions with them leaves many African adolescent males deficient in knowledge concerning safe sex

negotiation; how to handle social pressures to engage in sexual activity; and the motivation to practice protected sex (Kigozi, 2006).

Another important factor associated with the quality of parenting that could affect adolescent sexual behaviour is poverty and divorce (Monti, Colby, & O'Leary, 2001). Senyatsi (2002) reported that divorced parents and those from poverty-stricken backgrounds are often emotionally stressed and tend to be less supportive, sensitive or even involved with their children. As a result, according to Monti et al. (2001), adolescent males could engage themselves in risky sexual behaviour in the form of prostitution with older men as a means to survive economically. Research by Mathews, Aaro, Flisher, Mukoma, Wubs, and Schaalma (2009) in Khayelitsha, Cape Town, revealed that there is little privacy among black families living in RDP houses and shacks. Adolescents are more likely to witness sexual activities as performed by adults and this could easily arouse their curiosity and trigger sexual behaviour. Under such circumstances, one could expect that the developments of poor moral standards by male adolescents are likely and that chances of making sexual advances to their siblings and others are high.

The concerning nature of sexual behaviour of adolescent African males in South Africa was indicated in a study by Jewkes, Sikweyiya, Morrell, and Dunkle (2009) of the Medical Research Council, with a group of men aged between 18-49 years in the Eastern Cape and KwaZulu-Natal ($N = 1738$). Of the participants, 27.6% indicated that they had raped women; 46.5% of these men had been between 15-19 years of age when this had happened; and 1 out of 10 had before the age of 10 years forced themselves on girls. Of the participants, 25% were HIV positive. According to Jewkes et al. (2009), the origin of such behaviour could be traced to participants' cultural convictions about masculinity; that males are in a higher hierarchy of power and status than women; and that they have the right to demand certain rights (also sexual) because they are males. From the above discussion it is evident that the

concern of parents, educators and leaders about the sexual behaviour of adolescent male youth and the impact thereof on their psychosocial well-being, is justified.

However, in contrast to the bleak picture sketched above, research has also indicated that large numbers of adolescents show healthy psychosexual developmental pathways and begin to engage in fulfilling and caring intimate relationships when they are developmentally ready to do so. Psychosocial variables that have been related to such healthy youth sexuality and sexual practices are secure parent-adolescent relationships (Koen, 2009); open communication with adults (Kigozi, 2006); supportive and constructive peer influences (Campbell & McPhail, 2002); healthy school environments and performance (National School Climate Council, 2007); sport participation (Malebo, Van Eeden, & Wissing, 2007) and religious orientation (Larson & Swyers, 2002). Intrapersonal aspects associated with healthy youth sexual development are, amongst others, identity formation (Papalia, Olds, & Feldman, 2008); self-related factors such as self-efficiency, self-esteem, self-regulation and self-determination (Aymer, 2008; Bester & Budhal, 2001; Kaplan, 2000; Ryan & Deci, 2006); absence of mental problems and presence of mental health and well-being or flourishing (Keyes, 2006); adaptive coping behaviour (Jose & Brown, 2008) and positive emotions (Fredrickson, 2009). Despite the literature mentioned above, very little research exists about the sexual values and attitudes of adolescents that underpin their sexual behaviour; also about such values, attitudes and behaviour and their relationships with features of mental health and well-being.

Therefore, in this study the sexual values, attitudes and behaviour and the relationship thereof with aspects of their psychosocial well-being will be investigated in a group of African male adolescents.

Having presented the rationale of the study, the topic of adolescence will be discussed next. It is important to note that the terms adolescent males are predominantly used in this

thesis to developmentally contextualise the researched population in line with theoretical perspectives. In other words, adolescent males are often used where mere youth or adolescents could have been used.

2. Adolescence and Sexuality in this Study

2.1 Adolescence

Adolescence is derived from the Latin word “*adolescere*” which means to grow to maturity (Bee & Boyd, 2003). Stanley G. Hall (1905), 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 (Jeftha, 2006). Adolescence is a time of biologic, psychosocial, emotional, and intellectual growth and development. Erikson (1968) identified the psychosocial development of the adolescent as resolving the critical tasks of identity versus role confusion. Thus, during this period relationships are defined, personal and social behaviours are refined, and a clearer sense of self emerges. The attitudes and beliefs developed during this period are likely to become established patterns of health behaviour, making the period of adolescence a prime opportunity for health promotion (Ablorh-Odjidja & Joseph, 2007; Dickey & Deatrck, 2000).

According to Harper, Dickson, and Welsh (2006), adolescence is the developmental period during which intimate relationships, particularly those romantic in nature, are initiated. Adolescent males are young people between the ages of 11 to 18 years of age. Their sexual anatomic structure is identified by a penis and scrotum, which grow in length and thickness as they progress in age. Also, adolescent males grow pubic hairs around genitals and their voice changes. They experience nocturnal emission (wet dreams) which signifies an ability to reproduce offspring should they engage in sexual intercourse with a female (Louw & Louw 2007). Because of the extensive physical development during puberty, adolescent males

become increasingly aware of their sexuality. They begin to manifest their sexual orientation, which refers to the dominant sexual behaviour pattern of an individual, specifically a preference for sexual activity with a person of the same gender (homosexuality) or opposite gender (heterosexuality), or indiscriminate of both genders (bi-sexuality) (Louw & Louw, 2007).

Drawing from Sigmund Freud's psychoanalytic theory, the fourth psychosexual stage (i.e. the genital stage) between the ages 12 and 15 years, is a period of sexual maturation in which psychosexual needs are directed toward sexual relationships; the most common form of sexual outlet for adolescent males is masturbation (Lefrancois, 2001). From masturbation, sexual activity progresses to kissing, to petting above the waist, to petting below the waist, and to intercourse (Kail & Cavanaugh, 2000). As changes in hormone levels affect the sexual arousal of adolescent males directly, their attitudes toward sexuality may change dramatically (Lefrancois, 2001). They develop a **sexual self-schema** – the cognitive generalisations about sexual aspects of oneself that originate in past experience, become manifested in current experience, influence the processing of sexual information, and guide sexual behaviour (Baron, Byrne, & Branscombe, 2006).

During adolescence, young males become more independent from their parents and start exploring life's possibilities (Zastrow & Kirst-Ashman, 2007). Adolescent males vary greatly from culture to culture, and are influenced by social, economic, political and cultural factors (Senanayake & Faulkner, 2003). As mentioned before, Erikson's theory of psychosocial development through stages describes adolescence as a developmental transition between childhood and adulthood. During this fifth developmental stage (identity versus confusion), adolescent males learn how to answer the question of "**Who am I**" in search of a true self (Nicholas, 2008; Swartz, de la Rey, Duncan, & Townsend, 2008), or an identity that will lead them to adulthood, because they now have to make deliberate decisions

and choices, especially about vocation, sexual orientation, and life in general (Schultz & Schultz, 2009). Adolescent males who fail to search for and form an identity will experience self-doubt; they cannot integrate the various roles they have to fulfil 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 such as the abuse of alcohol and unsafe sexual behaviours, especially when they are with their peers (Lance, 2001; Whitehead, 2007).

Adolescent males in their search for an identity tend to explore and experiment, and in doing so they are often exposed to various risks, and even indulge in taking some risks (Ayman-Nolley & Taira, 2000; Mhlahlo, 2009). Engaging in risky behaviour might seem like the normal course of experimentation during this period of development; however, experimentation with some of these risks and other risky activities such as alcohol abuse, criminal behaviour, unprotected sex and sexual violence could have some serious negative, even fatal consequences for adolescent males (Brook, Morojele, Zhang, & Brook, 2006).

When, in their quest for identity, personal competence and character strengths, adolescent males are encouraged and supported morally by educators, parents and peers, their sense of self is likely to be positive and their self-esteem sound (Park & Peterson, 2006). Competence is effective human functioning in the attainment of desired and valued goals and it is characterised by well-developed clusters of attributes, abilities and skills (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004). In adolescent males who are morally competent, their cognitive, emotional, social and behavioural characteristics propel them towards maintaining close relationships with significant others. They tend to display empathy and a relative degree of compassion as compared to adolescent males who lack in this area (Park & Peterson, 2006). Regarding sexual behaviour, they are not easily manipulated by

peers to perform risky sexual acts and to be inconsiderate of their sexual partners. They communicate with their sexual partners and refrain from alcohol abuse (von Eye, Bogat, & Rhodes, 2006). Johnston, O'Malley, and Bachman (2006) strongly attributed good behaviour of adolescent males to the motivation of parents towards morality.

2.2 Sexuality

According to Domoney (2009), sexuality reflects the integrally joyful physical part of humans' behaviour and comprises biological, social, spiritual, psychological, ethical and cultural dimensions. Sexuality encompasses growth and development and involves the whole spectrum of sexual behaviour, such as human reproduction, sexual intercourse and masturbation, pregnancy, sexual response, sexual orientation, contraception, abortion, sexual abuse and violence, HIV/AIDS and other sexually transmitted infections (STIs), among other aspects. Kaplan and Sadock (1998) considered sexuality as tied up with gender and gender identity, sexual orientation, libido, sexual behaviour and sexual fantasies, feeling attractive or cared for, intimacy and relationships.

Furthermore, sexuality cannot be separated from the very essence of personality. The Sexual Health Model that developmentally originated from sexuality education, explained that being '*sex-positive*' as an adolescent male means that one's behaviour, values and emotions should be congruent to and integrated within the person's wider personality structure and self-definition (Tsakani, Davhana- Maselesele, & Obi, 2011). Positive sexual health should be about mutual respect between partners, the development of communication and decision-making skills regarding sexual matters, a sense of belonging, self-esteem, acting intentionally and responsibly, and challenging stereotypes (e.g. the myth that sex = intercourse) (Robinson, Bockting, Rosser, Miner, & Coleman, 2002).

The focus will next be on the theories and models about sexual behaviour and psychosocial well-being which could explain aspects of adolescent males' sexual practices.

3. Theories of Sexual Behaviour

Identifying theories which explain adolescents' sexual behaviour, the direction of causality and the processes that underlie psychosexual relations are considered important in attaining a complete scientific understanding of the concept of sexual behaviour in adolescence. Therefore, in this section theories that contribute to an understanding of adolescent males' sexual behaviour and psychosexual well-being will be explored.

3.1 Implicit Theories of Relationship

According to implicit theories of relationships developed by Dweck (1996), the belief is that sexual relationships such as other interpersonal connections, have the potential to grow and relational challenges experienced may be overcome. When adolescent males believe in the destiny (i.e. compatibility) of the relationship, they may feel more satisfied and emotionally secure in prolonging their romantic relationships; whereas those who feel emptiness although they are in a relationship may end it quickly (Knee, Patrick, & Lonsbary, 2003). According to UNICEF (2007), young people who are compatible with one another in their relationships should be cautioned by adults not to enter into marriage before they are financially and psychologically matured, as that could have adverse consequences for them.

3.2 Gender Role Strain Theory

Gender role strain theory by Agnew (1985) was based on the concept that male sexual behaviours are influenced by cultural norms. By culture, Eaton and his colleagues (2003) referred to traditions, values and beliefs shared within a particular society. According to Simons-Morton (2007), such cultural ideologies may be reinforced by socialisation (adjustment to attitudes and beliefs of role models and/or peers). Sexual practices that are

based on the influence of identification with certain (mostly patriarchal) cultural norms may be:

- Males believe that risk taking is an expression of masculinity; therefore they tend to have casual sexual relationships and do not practice safe sex;
- Adolescent males indulge in alcohol use and violate the right of their partners;
- Condom use is not viewed as necessary and partners' views are ignored; and
- Gender inequality is believed and own sexual preferences are imposed (Jewkes, Levin, & Penn-Kekana, 2003).

3.3 Cognitive Behaviour Theory

Cognitive Behaviour Theory (CBT) is based on the concept that emotions and behaviours result from cognitive processes (Swartz et al., 2008), and has its modern origins in the work of Albert Ellis (1962). From the CBT viewpoint, it could be suggested that irrational beliefs, cognitive distortions and faulty reasoning could influence adolescent males to initiate sexual deviancy (Burger & Shelton, 2011; Froggatt, 2005). When such adolescents evaluate themselves illogically, they tend to develop false beliefs which persistently influence them to deny responsibility and justify their actions (Kann, 2008). They may learn sexual behaviour through inappropriate means (e.g. peer influence) and/or internalise socially deviant sexual information that could harm them or others (Froggatt, 2005). Examples of sexual behaviour based on such deviant cognitions are the following: In South Africa, violence against women and girls has reached alarming proportions and seems to result from beliefs and attitudes held by certain male groups toward females and are seldom questioned or challenged (Wood, Maforah, & Jewkes, 1998). For example, in Braamfischerville, Soweto, seven adolescent males between 13 and 19 years of age, gang-raped a 17 year-old mentally challenged girl, capturing the act on their cell-phones (Holtzhausen, 2012). According to Chen, Thompson, and Morrison-Berry (2010), one of the underlying reasons for such behaviour could be

socialisation processes. The cognitive content developed through such processes, often suppresses the male adolescent's vulnerability and negative emotions, robbing him of interpersonal awareness such as empathy.

3.4 Social Learning Theory

According to social learning theory developed by Bandura (1977), human behaviour is a result of interaction with the environment, personal factors and the behaviour itself (Weiten, 2010). Among the environmental factors that may influence the behaviour of adolescent males, Bandura identified modelling as having profound effects (Pastorino & Doyle-Portillo, 2011). Adolescent males tend to imitate what adults/parents and/or peers do; thus, through modelling such adolescents could not only learn attitudes and emotions, but inappropriate behaviour as well (Louw & Louw, 2007; Swartz et al., 2008). According to Dunkle et al. (2006), unhealthy practices such as substance use and women abuse are common in communities characterised by economic deprivation where there could be a lack of good role models to demonstrate the advantages of staying in schools, refraining from risk-taking activities, and avoiding early parenthood. For example, in a study conducted in Cape Town amongst Grade 8-11 learners, Holborn and Eddy (2011) found that 21% of adolescent males who grew up seeing verbal and physical fights between parents, were reported to use violence against their partners. Another 16% reported that they would physically punish their partners, should they anger them.

3.5 Malamuth's Confluence Model of Sexual Aggression

Malamuth's confluence model proposed that sexual aggression of adolescent males could be attributable to childhood abuse and maltreatment; and to attitudes supporting violent and hostile masculinity or sexual promiscuity (Malamuth, Sockloskie, Koss, & Tanaka, 1991). Adolescents, who experience direct victimisation or indirect vicarious exposure to

witnessing assaults, are often likely to be emotionally unstable and aggressive towards their sexual partners (Barbarin, Richter, & de Wet, 2001). Adolescent males who have experienced childhood physical, emotional and sexual abuse may feel that sexual behaviour provides relief to experienced psychological trauma. They may underestimate the dangers of engaging in premature sex and lack coping self-efficacy which can result in feelings of inadequacy, low self-esteem and self-blame (Hayhurst, 2005). Other difficulties such youth may encounter include emotional aloofness, difficulty sustaining intimate relationships, paranoid personality traits (i.e. to be suspicious of others) and the development or manifestation of ambivalent attachment (Nicholas, 2008; Weiten 2010). Adolescent males who experienced childhood abuse often have the tendency to associate themselves with deviant peers, which contributes to increased risk for experimenting with drugs and alcohol (Kostelecky, 2005; Peterson, Jansen, & Heiman, 2010). According to Louw and Louw (2007), they often become truant, skip classes at school and in many instances end up in jail for rape.

3.6 Social Exchange Theory

Social exchange theory by Homans (1958) proposed that adolescents may enter into sexual relationships where the rewards (e.g. money, gifts) outweigh the costs (e.g. physical and emotional distress) (Swartz et al., 2008). Within heterosexual romantic relationships, adolescent males may trade resources women value – such as affection, time, status or respect – with the expectation of receiving sex (Louw, Mokhosi, & Van den Berg, 2012). Adolescent males from affluent families may have increased frequency of sexual intercourse and multiple sexual partners, because they are in a position to influence their partners to exchange sexual favours in return for gifts (Santelli, Lowry, Brener, & Robin, 2000). In restoring a soured relationship, social exchange theory asserts that adolescent males' partners may be willing to engage in sex, considering what they are likely to lose should they refuse (Cote, Sobela, Dzokoto, Nzambi, Asamoah-Adu, & Labbe, 2004). In line with this argument,

Donald, Lazarus, and Lolwana (2010) found that economic needs often reduce women's ability to dictate the terms of such exchange, making them dependent on the gifts they receive from their sexual partners and exposing them further to sexual harassment and exploitation. According to Masondo (2009), in exchanging money for sex, adolescents may contract sexually transmitted infections (including HIV) since they often do not practice safe sex.

3.7 Theory of Planned Behaviour

The theory of planned behaviour, an extension of the theory of reasoned action, asserts that actual behaviour is a function of the intention to act, and it was developed by Ajzen and Fishbein (1980) in an attempt to explain a number of health behaviours, such as smoking and condom use (Crockett, Raffaelli, & Shen, 2006). When adolescent males find sex enjoyable (i.e. affective attitude) and it is approved by significant others in their social realm (e.g. peers), they are more likely to be sexually active than their counterparts who may perceive sex as unpleasant or harmful (Ajzen, 1991). Adolescent males, who are insecure, tend to exhibit an overwhelming need for approval and acceptance by their peers and thus comply with the standards and expectations of the peer group (Hayhurst, 2005). The theory of planned behaviour also supports the assumption that adolescent males who have friends with positive outlooks on life and a stable sense of self, even if they engage in sexual activities, are more likely to practice safe sex as compared to adolescent males with weak self-perceptions (Carmack, 2007).

3.8 Problem Behaviour Theory

Problem Behaviour Theory (PBT) assumes that youth with a history of socialisation difficulties may be rebellious, initiate rule-breaking behaviours, and become sexually active at an early age (Boles, Biglan, & Smolkowski, 2006). Their behaviour results from two opposing sets of factors, namely risk or protective factors, which determine proneness toward

either deviant or normative conduct. These sets of variables are present in three individual systems, namely the personality system (e.g. values, self-perception), the behaviour system (e.g. problem behaviour, delinquency) and the perceived environment system (e.g. peer and parental influence). Thus, the dominance of either positive (protective) or negative (risk) factors will predict whether the adolescent male will engage in normative or deviant behaviours (Fortenberry, Costa, Jessor, & Donovan, 1997). According to Wei, Hipwell, Pardini, Beyers, and Loeber (2005), adolescent males' problematic behaviour may also be caused by social disorders (e.g. violence, crime) prevailing in their communities and which may in turn, plunge them into states of hopelessness and powerlessness. Evidence (Kalichman, Simbayi, Kaufman, Cain, Cherry, Jooste, & Mathiti, 2005; Nduna, Jewkes, Dunkle, Jama, & Colman, 2010) revealed that adolescent males who grow up in deprived townships or rural areas where there are few recreational facilities and opportunities for advancement are reported to be engaged in anti-social activities, including sexual promiscuity.

Comparatively, protective factors within the family, school and community may enable youth to seek opportunities to engage in prosocial activities (e.g. sport, community groups, input into school activities and rules) and acknowledge the importance of internalising healthy beliefs and clear standards set by parents and educators (Hemphill, Toumbourou, Herrenkohl, McMorris, & Catalano, 2006). Also, quality parent-adolescent interaction and engagement in religious activities can help adolescents become resilient, as they are perceived to be inversely proportional to risk factors related to problem behaviour (Zweig, Phillips, & Lindberg, 2001). For example, in a study conducted among adolescents in KwaZulu-Natal by Kaufman, Clark, Manzini, and May (2004), boys who belonged to organised sport and church groups reported to be focused, autonomous and making informed decisions regarding sexual matters, as compared to those who did not belong to such groups.

3.9 Risky-shift Theory

Risky-shift theory postulates that adolescent males tend to make decisions regarding behaviour differently when in groups than they would if they were alone. When in a group, adolescent males are inclined to make riskier decisions because they believe that the risk is shared by the group members; therefore they are exposed to more risk behaviour than as individuals (Ghanotakis, Bruins, Peacock, Redpath, & Swartz, 2007; Hart, 2001). It is important to acknowledge that the reasons for risk taking could be numerous and they may involve fear of inadequacy, developmental and group dynamics such as peer pressure (Kaplan & Sadock, 2002). Pickett et al. (2004) contended that engaging in one form of risk behaviour under the influence of peers or group members often results in an increased likelihood of engaging in other forms of risk behaviour. The example of gang rape of a girl in Braamfischerville, Soweto, mentioned before, also applies to this theoretical explanation of a reduced sense of awareness due to the groupthink phenomenon and the de-individuation involved (Janis, 1982, in Kassin, Fein, & Markus, 2014).

Having explicated the relevance of theories and models in explaining adolescent sexual practices, the discussion will continue to focus on risk-taking behaviour and factors which have been found to contribute to adolescent males' sexual activities.

3.10 Risk-taking Behaviour in Adolescent Sexuality

According to Louw and Louw (2007), risk-taking behaviour is behaviour that is either physically or emotionally dangerous or contributes to developmental problems for the young people involved. As adolescent males develop their own identity, opinions and values, they tend to experiment which often entails taking some risks (Jeftha, 2006). Thus, risk-taking behaviour does not exist in isolation and the majority of adolescent males when they reach

puberty may engage in some experimental activities, ranging from alcohol, drug and tobacco use, weapon carrying, tattooing and body piercing, sexual game playing and even shoplifting and pickpocketing (Roberts & Ryan, 2002). According to Crockett et al. (2006), sensation or excitement-seeking is a related construct which is often associated with various activities for the sake of the fun or adventure they provide, or the perception of sensation/excitement experienced in such actions. Danger lurking in such sensation/ excitement-seeking behaviour, especially when performed in group context, is that possible negative consequences of behaviour are not foreseen or even ignored. Furthermore, cognitive reasoning could be impaired due to the “high” sensation/excitement levels experienced (Topolski, Patrick, Edwards, Huebner, Cornell, & Mount, 2001).

According to Brook et al. (2006), risk-taking behaviour is attributable to a combination of factors which are ecological. According to the model (see Figure 1) proposed by these authors, family poverty is both directly and indirectly associated with risky sexual behaviour. The main mediators of the association between family poverty and risky sexual behaviour are proposed to be a loss of or distant parent-child relationship, witnessing violence and deviant peers. Brook et al. have found that (a) family economic hardships and their associated stress reduce opportunities for positive parent-child relations; and (b) adolescents from lower socioeconomic status backgrounds are more likely than affluent counterparts to have deviant peers. Butters (2002) also found that parental absence stemming from break-ups, divorce or death, places adolescent males in a position of increased risk for seeking escape of emotional distress in substance use. Research by Donnerstein and Smith (2001) indicates that in many households where parental control and influence are relatively low owing to family violence and/or divorce, adolescent males are more likely to become exposed to risky sexual behaviour. Figure 1 below depicts family poverty, deviant peers and a low quality parent-

child relationship as contributory factors for adolescent males to engage in risky sexual behaviour and to develop vulnerable personality and behavioural attitudes.

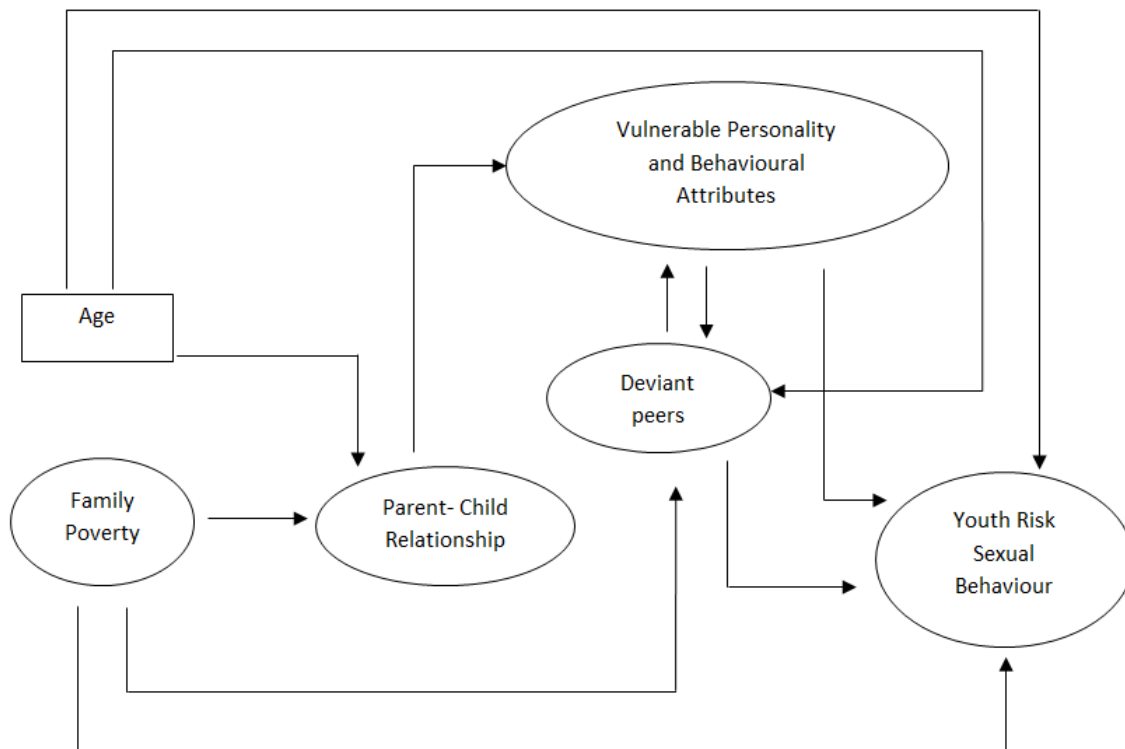


Figure 1. Hypothesized pathways to risky sexual behaviour: (Adapted from Brook, Morojele, Zhang, & Brook, 2006).

Other factors associated with risk taking of adolescent males are biological or hormonal in nature. For example, in Irwin and Milstein's (1986) Causal Model of Adolescent Risk-Taking Behaviour, early timing of puberty maturation for both boys and girls was indicated as a predictor of several risky behaviours, including unprotected sexual activity. In line with this is the fact that the adolescent brain has not yet been completely developed. Parritz and Troy (2011) stated that frontal lobe maturation which involves complex cognitive processes such as self-regulation, impulsivity control, decision-making abilities and strategies and complex emotional, motivational and regulatory cognitions only develop in late adolescence and early adulthood. Therefore, the adolescent males' risk-taking behaviour is often as a

result of immature neurological functioning that seriously detracts from good judgement and the ability to comprehend the consequences of risks taken (Parritz & Troy, 2011).

Risk taking in adolescent males must thus be understood in the context of adolescent identity formation and neuro-psychological development, the parent-adolescent relationship, powerful peer influences, and the sampling of adult behaviours linked to freedom of adult responsibilities (Parritz & Troy, 2011). Protective factors buffering the adolescent against risky behaviour would stem from personal variables, family variables and social factors, which will be explored in the sections to follow.

In the following section of this literature overview, the intra- and interpersonal factors that play a role in the sexuality and sexual behaviour of adolescent males are discussed.

4. Intra- and Interpersonal Factors in Adolescent Sexuality

4.1 Intrapersonal Aspects

Intrapersonal variables that may influence the unfolding sexuality and sexual behaviour of adolescent males are personality, self-esteem, self-regulation and control, self-efficacy, motivational factors, cognition, and values and attitudes. These may all serve as protective or risk factors.

Personality

Lefrancois (2001) defined personality as the set of characteristics that people typically manifest in their interactions with others, including all the abilities, predispositions, habits and other qualities that make them unique. According to Chersich, Rees, Scorgie, and Martin (2009), adolescent males with impulsive personality traits may engage in unsafe sexual practices and other risky behaviour, even when not influenced by alcohol. In the same vein, Adams and Govender (2008) found that adolescent males with hyper masculine personality characteristics are likely to have a history of sexual aggression, use alcohol, be impulsive,

seek danger and excitement, and to have reported emotional outbursts that can lead to inflicting and sustaining physical aggression. According to Parritz and Troy (2011), a tendency toward social deviance and one toward excitement-seeking are two personality profiles linked by research to all forms of risky behaviour, including sexual promiscuity and abusive behaviour in males. For the purpose of this discussion, only maladaptive personality factors were explained, since these are also most often researched. It is too often assumed that positive personality factors would be associated with healthy youth sexuality, but research into such linkages is recommended.

A Sense of Self

A sense of self is made up of the awareness or concerns of an individual relating to his competence as a person functioning in the world and relating to others (Carr, 2011; Leary & Gaudagno, 2011). In this discussion aspects of self, such as self-esteem, self-efficacy, self-regulation and self-assertion will be described.

Self-esteem: Rosenberg (1989) described self-esteem as the totality of the individual's thoughts and feelings with reference to himself as an object, while it also incorporates a notion of self-worth, involving confidence, respect and satisfaction with oneself. According to Ryckman (2008), self-esteem consists of cognitive, emotional and behavioural components. The cognitive component involves individuals' thoughts about themselves and the incongruity between what they currently are and what they strive to become; the emotional component entails feelings an individual has when considering the incongruence, while behaviours such as assertiveness or decisiveness are evidence of the behavioural component of self-esteem.

Self-esteem in adolescent males is related to various outcomes. High self-esteem is related to academic success, an internal locus of control, feeling that one is in control of one's life and positive interpersonal relationships (Kaplan, 2001; Neff, 2011; Twenge & Campbell,

2009). Research by Bester and Budhal (2001) in South Africa found that adolescent males with consistently high esteem were more resistant to peer pressure; had higher average grades; and reported less tolerance for deviant behaviour and risky sexual behaviour. On the other hand, adolescent males with low self-esteem often experience depression (Lefrancois, 2001; Oattes & Offman, 2010) and behavioural problems owing to peer pressure and seeking peer approval (Kaplan, 2001). Male adolescents who are low in ego or impulse control are reported to use drugs more often than their higher ego-resilience counterparts (Crockett et al., 2006; Peacock & Theron, 2007). The lack of self-belief, self-worth and their ability to control certain situations will often prevent young males from insisting on the use of protection during sexual intercourse, for fear of being accused and embarrassed by their sexual partners (Chetri, 2014; Quina, Morokoff, Harlow, & Zurbriggen, 2004). Houck, Nugent, Lescano, Peters, and Brown (2009) noted that adolescent males who have difficulty managing or expressing affect may become overwhelmed by the task of negotiating safe sex with their partners, responding with avoidance, dissociation or impulsivity owing to their low self-assertion and low self-esteem. High self-esteem has also been identified as minimising the negative effects of environmental risks. Consistent with a resilience perspective, researchers found that adolescent males with positive self-concept living in adverse circumstances, do not misuse alcohol and practice unsafe sex, owing to their goals, hopes and aspirations for the future, as compared to their counterparts with low self-esteem. They are reported to be less depressed and achieve good grades academically (Damon, 2009; Outlaw, Naar-King, Janisse, & Parsons, 2010; Piko & Fitzpatrick, 2003).

Papalia, Olds, and Feldman (2009) posited that if parents failed to prepare their adolescent males during Erikson's fifth stage of psychosocial development, in which adolescent males sought the development of a coherent sense of self and an identity (conception of the self, made up of goals, values and beliefs to which a person is solidly committed), the psychosocial well-being of their adolescent males would be compromised.

For instance, a study by Kheswa (2006) found high levels of anti-social behaviour of a group of African adolescent males in one Soweto secondary school. The majority of these participants reported negative behaviour when under the influence of alcohol and drugs, and to have a low self-esteem because their parents' parenting style lacked open communication and guidance. Hoffman (2004) and Huure, Junkhari, and Aro (2006) found that youth participation in risky activities may be a coping mechanism for them against depression and a negative sense of self, caused by neglect from or anger against their parents (also see Koen, 2009).

Self-efficacy: A central mechanism of personal agency and self-regulation is self-efficacy, a concept in Albert Bandura's theory that refers to one's belief that one can successfully perform behaviours that will produce desired effects (Engler, 2009). According to Engler, self-efficacy is a major component of social cognitive theory. It plays a central role in governing people's thoughts, motivations, and actions; influences factors such as the acquisition of knowledge, choice of activities and level of motivation, and has the generative capacity that activates and coordinates other cognitive, social and emotional sub-skills (Engler, 2009).

A quantitative research study by Coffman, Smith, Flisher, and Caldwell (2011) conducted in Mitchell's Plain, Cape Town, South Africa, among 2 429 adolescents, found that sexual self-efficacy predicts condom use. Participants reported that participation in the Health Wise Risk-reduction Life Skills curriculum equipped them with self-awareness, skills development, knowledge, analysis and synthesis, and community integration. As a result of advances in their social cognition (e.g., empathy), the adolescent males' prosocial behaviour and internalisation of prosocial values increased (Carlo & Randall, 2002).

Reddy, Meyer-Weitz, van den Borne, and Kok (2006) also found in a South African study that adolescent males with high self-efficacy were inclined to use condoms when

engaging in sexual activities. Aymer (2008) established that adolescent males with high self-efficacy could express themselves sexually through petting and did not pressurise their partners to have sex by violating their rights, as they were sensitive to their emotional needs. Widman, Welsh, McNulty, and Little (2006) found that sexual communication is an important component of intimate relationships for youth with self-efficacy, since they bring sexual and emotional adequacies into a relationship. Feelings of closeness, connectedness and intimacy characterise such relationships and underpin the decision to stay involved in a relationship, maintaining a potential long-term relationship (Overbreek, Ha, Scholte, de Kemp, & Engels, 2007), that is characterised by respect for their partners (Feldman & Rosenthal, 2000).

Self-regulation and self-assertion: As adolescent males develop, they become more capable of regulating their own behaviours; they are able to inhibit impulsive tendencies, to delay gratification and to consider the impact of their behaviour on others (Kail & Cavanaugh, 2000). They present themselves to others as being competent or having positive and desirable attributes, conforming to societal and cultural norms (Baron et al., 2006; Roffey, 2011). According to Kaplan (2000), self-regulation in adolescent males is related to many significant outcomes, including positive interpersonal relationships, academic success, internal locus of control, less susceptibility to peer pressure and substance use. A closely related concept is self-assertion and, according to Gerber (2002), self-assertion implies putting one's own opinions forward without hurting other people's feelings and/or self-worth. The development of self-assertion depends on social status and how independent the adolescent male is.

Values and Attitudes

Attitude has been defined by Engler (2009) as “a positive or negative feeling toward an object, person or situation” (p. 79). The author stated that attitudes result from a complex interaction of beliefs, feelings and values. On the other hand, values could be defined as

principles that parents or adults in a particular culture instil in adolescent males, such as responsibility, respect, caring, honesty and justice (Lefrancois, 2001).

Attitudes towards sexual behaviour have altered in many countries and cultures. Worldwide communication, including the internet, have had a bearing on social norms, transporting sexual images and information from liberal to more conservative societies, especially those in which advances in information technology have been rapid (Wellings, Collumbien, Slaymaker, Singh, Hodges, Patel, & Bajos, 2006). Values and attitudes obtained from the peer group and social media may influence adolescent males to engage in distorted and inaccurate sexual behaviour (Le Roux, 2010), especially if parents' moral or religious grounds are not followed (Jaccard, Dittus, & Gordon, 2000).

Values and attitudes are mostly studied in the fields of social psychology, philosophy and less so developmental psychology. An exploration of literature for this study indicated a dearth of research on these topics in the developmental context of adolescence. The nine theories explaining adolescent sexual behaviour, briefly mentioned before, could assist in inferring features of value and attitude development and the manifestation thereof in sexual behaviour, especially the decisions made about sexual actions and/or risks taken. In this thesis, values and attitudes will be more broadly discussed in the first manuscript in chapter two, which describes the empirical research done pertaining to the role of sexual values and attitudes in the well-being of adolescent males.

Cognition

One of the most profound areas of adolescent development is in the area of cognitive processing. Piaget described the reasoning that characterises adolescence as formal operational thought (the fourth and final stage of cognitive development) (Kaplan, 2000). Cognition refers to the way in which adolescent males would process, store, remember and use social information to interpret their world (Baron et al., 2006) and, according to

Bandura's social cognitive theory, adolescent males become either socially reinforced or punished as they actively try to understand what goes into their social context (Kail & Cavanaugh, 2000). The higher their stage of moral reasoning, the less likely they are to engage in risky sexual behaviour (Kaplan, 2000).

Furthermore, adolescent males may begin to venture away from parents' values and beliefs towards an establishment of their own beliefs and values, and in so doing they may adopt beliefs and values that could engage them in either self-enhancing or self-defeating behaviours (Lohman & Billings, 2008). Because adolescent males are often egocentric (self-centred), they tend to fail to discriminate risky behaviours from safer ones and to understand the possible negative consequences of such behaviours (Kaplan, 2000). They may begin to explore at a relatively young age and engage in sexual activity by judging the rewards of sex (e.g., emotional and physical closeness) and ignoring the costs (guilt and fear of HIV and other sexually transmitted infections) (Kail & Cavanaugh, 2000). Their personal fable - a belief that what they are experiencing and thinking is original, new and special - may mislead them into believing that they have heightened physical and mental powers, are invincible - "*It won't happen to them*"- and invulnerable to the consequence of risky sexual behaviour (Kaplan, 2000). For example, they may misinterpret their intense sexual drive as a sign of masculinity and begin to sexually coerce young women or their sexual partners to meet their sexual needs (Kail & Cavanaugh, 2000), especially when they are pressurised by peers (Baron et al., 2006).

In the above exposition, some intrapersonal factors that underpin the nature and quality of adolescent male sexual behaviour were briefly discussed. Interpersonal influences on sexuality and sexual behaviour of male youth will be discussed in the following part.

4.2 Interpersonal Factors

Interpersonal variables that have been identified in literature to have either protective or risk-laden influences on adolescent male sexuality and sexual behaviour are family-, peer-, culture- and society-related factors. These include, amongst others, the parent-adolescent relationship, family dysfunction, paternal absence, single parenthood, family violence, influence of siblings, maltreatment and sexual abuse, dating relationships, dating violence and communication between sexual partners, culture and male fertility, school and sex education, poverty, substance abuse and religiosity.

4.2.1 Family-related Factors

Parent-adolescent relationship: A healthy parent-adolescent relationship has features of reciprocal caring and commitment, open and honest communication, clear and congruent expectations and emotional security and expressiveness (Becvar & Becvar, 2006; Carr, 2011). However, in some African families in South Africa, parent-adolescent relationships lack these relational features (Koen, 2009). Hence, parenting styles are to be reckoned with when trying to understand the sexual behaviour of adolescent males. The most widely used typology of parenting behaviours is that developed by Baumrind, as referred to by Berg-Cross (2000). The most prominent three parenting styles are *permissive parenting*, *authoritarian parenting* and *authoritative parenting* (Louw & Louw, 2007), and these will be discussed in terms of their influence on adolescent males' sexual behaviour.

Authoritative parenting style: Engler (2009) defined authoritative parents as parents who provide warmth, unconditional love and firm guidance to their adolescent males. Authoritative parents create a conducive atmosphere in which their adolescent sons are encouraged to interact with them and share their problems, while this in turn enable adolescents to be prosocial in their interaction with significant others (Lyons, Giordano, Manning, & Longmore, 2011; Nolen-Hoeksema, 2008). Several studies show that a

supervising and supportive style of parenting results in adolescents developing behaviours that can protect against unhealthy sexual activities (Hakelind, 2007; Gur, 2011; Wight, Williamson & Henderson, 2006). A study Patrick, Palen, Caldwell, Gleeson, Smith, and Wegner (2010) of Africans living in urban public housing, found that parental guidance with a supervision style is associated with lower likelihood of early sexual debut as well as reduced sexual experimentation at later stages. Kaufman et al. (2004) found that among young males, the perception of being supervised is linked to appropriate decision making in relation to sexual behaviour, as well as lower chances of engaging in early sexual activity. According to Dittus and Jaccard (2000), male adolescents whose parents are closely supervising their social activities had fewer sexual partners than those adolescents whose parents did not supervise their behaviours.

Babalola, Tambashe, and Vondrasek (2005) noted that when parents provide close guidance and a supportive environment for their male adolescents, these adolescents in turn learn to cope with sexual development challenges and are able to make sound decisions with regard to sexuality issues, demonstrating low risk sexual behaviour. However, Wilson and Donenberg (2004) mentioned that there should be a balance between parental control and the adolescent males' freedom to choose, so that the adolescents may be able to experience supported independence without a sense of imposed control. Therefore, Sturgeon (2008) suggested that styles of parenting that promote autonomy and responsibility in adolescents, could be a factor equal to or stronger than behavioural controlling in predicting sexual risk-taking behaviour among male adolescents. In this regard, Kostecky (2005) found that adolescent males, who perceived their parents as being supportive, tend to strive for social competence and autonomy; thus promoting their psychosocial growth instead of exploring risky sexual behaviour. Lyons et al. (2011) and Patterson (2008) reported that when parents or caregivers are authoritative in their parenting skills, the possibility arises that siblings are likely to display prosocial behaviour. Such siblings can influence adolescent males to avoid

the development of less desirable behaviour, such as early sexual debut and teenage fatherhood.

Permissive parenting style: Permissive parents are parents who are low in both warmth and control and provide little emotional support to their adolescent males. Such parents make few behavioural demands on their sons and most of the time they have a tendency of neglecting and rejecting them (Engler, 2009; Sylvester, 2010). The “*hands-off*” attitude of such parents may lead their adolescent males into risky behaviour or other conduct problems owing to a lack of parental support, supervision and discipline (Lefrancois, 2001; Frick, Barry, & Kamphaus, 2010; Shisana & Simbayi, 2002). According to Ward (2006), a lack of autonomy found in permissive family settings may stifle the process of social and psychological maturation necessary for the male adolescent to make responsible choices about his sexual behaviour, compared to male adolescents who are allowed psychological autonomy in which they develop psychological maturity and moral internalisation.

Kaplan (2000) also found that adolescent males from households with permissive parents may arrive home late and it is often difficult to trace their whereabouts and know who their friends are; thus delinquency, gang behaviour (e.g. rape, substance use) and juvenile crime may occur amongst them. It is worth noting that such adolescent males often lack norms and values which should have been acquired and internalised during early stages of their social development (Mwamwenda, 2004; Weiten, 2010), and as a result they are susceptible to antisocial peer influence (Aymer, 2008; Pahl, Brook, Morojele, & Brook, 2010).

Authoritarian parenting style: Authoritarian parents are parents who are high on demands but low on warmth and emotional support, expecting obedience from their children (Engler, 2009; Sigelman & Rider, 2009). Such parents identify clear standards of conduct for their children, often based on religious, cultural or political beliefs (Lefrancois, 2001). Parents who

practice the authoritarian style restrict the autonomy of their adolescent males and decide what appropriate behaviour is for them. Such adolescent males may tend to become uncooperative, suffer from depression, have low self-esteem, low initiative and difficulties in making decisions (Bhana, 2013).

When excessive parental control occurs along with coldness and punitiveness, adolescent males may rebel against parents' standards in an attempt to become independent (Kaplan, 2000), because they are neither given responsibility for personal decisions nor involved in discussion of the family's standards (Lefrancois, 2001). Eventually, these adolescent males may end up leaving home (Donald et al., 2010; Lefrancois, 2001), drop out of school prematurely and face economic hardships (Mwamwenda, 2004; Swartz, Deutsch, Makoe, Michel, Harding, Garzouzie, & Van der Heijden, 2012). Research by Reddy, James, Sewpaul, Koopman, Funani, and Sifunda (2010) found that when adolescent males have left homes prematurely or do not stay with parents, they may become easily influenced by peers to engage in substance use, antisocial behaviour and unsafe sexual behaviour. Kostelecky (2005), and Sriranganathan, Jaworsky, Larkin, Flicker, Campbell, and Flynn (2012), reported that when authoritarian parents deprive their adolescent males of nurturance, feelings of worthlessness could develop in them and, as a form of coping with feelings of emotional emptiness, they may resort to multiple sexual partners. In addition to this, Kelly and Parker (2000) noted that such adolescent males may turn to premature and even excessive sexual behaviour, while Bettinger (2004) found that adolescent males who perceive high levels of restrictive parenting control are more likely to resort to high risk sexual behaviours.

Furthermore, drawing from Erik Erikson's theory of social development, adolescent males who grow up in family settings characterised by emotional detachment tend to display pessimistic attitudes towards life, also referred to as identity diffusion (Pastorino & Doyle-Portillo, 2011). They tend to be uncaring in social relationships and prone to impulsive

behaviour and they may have little self-confidence and engage in difficult relationships with others (Nolen-Hoeksema, 2008). Consequently, such youth often do not feel comfortable interacting with parents, educators and other significant adults about matters concerning sexual behaviour (Kheswa, 2006; Louw & Louw, 2007).

Parental role in sex education: When parents engage their adolescent males in discussions about sexual matters, research by Aspy, Vesely, Oman, Rodine, Marshall, and McLeroy (2007) found that such adolescents remain inactive longer or use condoms if sexually active. Nolen-Hoeksema (2008) stated that when adolescent males have been provided with sex education by their parents, they become less prone to risky practices and engage in healthy sexual behaviour with fewer sexual partners. In addition, such adolescents are more likely to display relational self-confidence and respect and empathy towards their sexual partners (Schouten, van den Putte, Pasmans, & Meeuwesen, 2007; Whitehead, 2007).

Wilbraham (2009) pointed out that parental communication about sexual matters is assumed to naturalise sexuality as the central axis of identity construction for adolescents, sensitising them against sexual risks by educating them about rights, choices and responsibilities. Research by Bester (2009), and Fares and Raju (2007) found the family to be central to the psychosexual well-being of adolescent males. In healthy families the parents and caregivers provide role models for interpersonal relationships; they teach about the roles of males in both family and wider contexts. Good parent-adolescent male communication about sexuality and sexual health can increase knowledge and may help adolescent males to be more responsible decision makers. In other words, the prediction from such upbringing (i.e. involved and educative parents) would be that adolescent males are more likely to form quality friendships with significant others.

Some family-related factors that may pose risk to and/or detrimentally influence sexuality development and behaviour in adolescent males are discussed below.

Family dysfunction: In dysfunctional families the relationships are strained and family functioning is often characterised by tension and communication, marred with conflict and misunderstanding (Koen, 2009). Such disrupted families or those characterised by eroding or strained relationships may be less able to provide social bonding to their adolescent males (Butters, 2002). Butters also found that adolescent males from such families often become prone to peer manipulation due to family problems; their sense of self-worth is more likely to be negatively impacted upon and their academic performance declines at school.

Perceived dysfunctional parenting patterns during late childhood and early adolescence, such as harsh parental practices, laxness of monitoring and parental conflict are significant contributors in predicting dating violence during adolescence (Lavoie, Hebert, Tremblay, Vitaro, Vezina, & McDuff, 2002). Higgins and McCabe (2003) found adolescent males who witness family violence, substance use by parents, and experience neglect to be more likely to form insecure attachment with and be ambivalent towards their sexual partners. Additionally, they may show aggression towards such sexual partners, threatening and coercing them. The reason for this behaviour may stem from what Lee, Jackson, Pattison, and Ward (2002) described as impulsivity, an inability to maintain emotional control of the self, due to often chaotic emotional patterns in the family.

Brook, Brook, Pahl, and Montoya (2002), stated that when adolescent males are raised in dysfunctional families characterised by poor communication, unclear guidelines and lack of warmth between parents, chances of de-individuation are higher compared to adolescent males raised in families that are functional. In dysfunctional families, Higgins and McCabe (2003) found that parents/caregivers often misuse alcohol and that adolescents from such homes tend to mask their emotional scars (feelings of anger, shame and inadequacy) by resorting to substance abuse themselves. They affiliate with peers who are anti-social and violent and are prone to risky sexual behaviour.

Many researchers have reported that parental drug use results in chaotic family processes, limited attention being devoted to important family matters (Brook, Yuming, Balka, Brook, Lubliner, & Rosenberg, 2007; Dube, Felitti, Dong, Chapman, Giles, & Anda, 2003), with various types of childhood maltreatment occurring (Chapple, Hope, & Whiteford, 2005). The impact of parental drug use/abuse has been shown to have long-lasting effects on adolescent males' lives, lasting well into adulthood (Perkins, Elifson, & Sterk, 2010). In families in which there are two drug-abusing parents, the chances are high that adolescent males may suffer psychologically and may manifest a low sense of self-esteem and self-efficacy (Hoffman & Cerbone, 2002).

Family violence: Sociologists were the first social scientists to grapple with family violence. Some of the typically stress-producing elements of family life are due to parental power imbalances and these factors often result in violent behaviour in families (Feiring, Deblinger, Hosh-Espada, & Haworth, 2002). When adolescent males have been exposed to family violence, they are at risk of developing depression, attachment difficulties and being more aggressive themselves (Barbarin et al., 2001). Because their relationship with parents is often hostile and they feel neglected, such adolescent males could become troublesome at school, bullying others and associating with peers who are antisocial (Pithey & Morojele, 2002). Lefrancois (2001) stated that adolescents from violent families manifest low self-esteem and behavioural problems and they are more likely to engage in risky sexual behaviour. A longitudinal study by O'Leary and Slep (2003) found that adolescent males who violate their girlfriends have reported to have witnessed their mothers being ill-treated by their fathers; thus placing them at risk for future relationship violence.

Under the next subtopic, divorce, single parenthood and stepfamilies will be explored as factors influencing the sexual behaviour of adolescent males.

Divorce, single parenthood and stepfamilies: Marital discord and breakdown often lie at the core of family dysfunction, violence and disorganisation. Divorce is the separation and dissolving process that mostly follow marital breakdown. Divorce is not just an event, but rather a process that unfolds over many years and impacts the intellectual, social and emotional development of adolescents involved (Kaplan, 2000), especially if it is characterised by further conflict between parents and disputes over custody rights (Lefrancois, 2001).

Although developmental psychologists differ on the extent, nature and intensity of adverse influence that divorce has on youth, they agree that the impact on the well-being of adolescents is significant. According to Louw and Louw (2014), approximately 25% of youth from divorced homes have psychological difficulties (depression, anxiety and negative self-concepts), behavioural problems (anti-social behaviour, substance abuse and aggression), scholastic underachievement, and interpersonal problems. To cope with the psychological distress and emotional emptiness experienced after divorce, many adolescent males may leave school and become involved with risky peer groups (Pastorino & Doyle-Portillo, 2011), who may introduce them to risk-laden and self-defeating behaviour. However, the resilience of youth cannot be underestimated and the 75% who do not develop serious emotional or behavioural difficulties, cope relatively well and continue on their developmental paths (Louw & Louw, 2014).

Lefrancois (2001) defined single parents as parents who raise children on their own as a result of separation or divorce; more one-parent households are headed by mothers rather than fathers. According to Holborn and Eddy (2011), 44% of all urban parents were single in South Africa during 2007; 52% were African urban parents; 30% were of coloured parents; 7% of Indian parents; and 24% of white parents. Kail and Cavanaugh (2000) found that single parents face considerable obstacles. Amongst others, they are usually much less well-

off financially than their married counterparts, especially if they are semi-employed due to lack of proper academic qualifications. Kaplan (2000) stated that single mothers who are employed may work overtime to improve their financial prospects in order to meet the educational needs of their children; however, supervision of their children then becomes compromised. Kail and Cavanaugh (2000) were of the opinion that emotionally these single mothers' sleep patterns, eating patterns, work, and social relations are badly affected and they may report feelings of frustration, failure and ambivalence toward the parent-adolescent relationship. As single parents struggle to supervise their adolescent males, because most of the time they are at work and upon arrival at home they are tired (Sigelman & Rider, 2009), such adolescents may be exposed to early sexual activity, resulting in having multiple sexual partners and practising unsafe sex (Miller, Benson, & Galbraith, 2001; Louw & Louw, 2007).

Following a divorce, parents may remarry and adolescents are expected to adjust to a new set of rules established in stepfamilies (Kaplan, 2000). Kaplan also noted that stepparent-adolescent relationships may be detached, conflicted and less warm than relationships with biological parents. Adolescents may resent their new stepparent's attempts to discipline them and feel that the entrance of the new parent threatens their relationship with their biological parents. Lefrancois (2001) found that adolescent males living with stepparents may experience feelings of abandonment and perceive their biological parents as displaying less affection and attention towards them. Sexual fantasies and inclinations between stepsiblings as well as between adolescent males and their stepmothers may develop (Lefrancois, 2001). However, when positive relationships exist between stepparents and stepchildren, the children often show higher self-esteem, display social competence among their peers, exhibit cognitive development (e.g. obtain good grades at school) (Kaplan, 2000) and emotional maturity (e.g. self-regulation) (Baron et al., 2006; Engler, 2009).

In addition to divorce, single parenthood, step-parent relationships and the effects of being raised without a father figure as an adolescent male will be discussed next.

Paternal absence: In cases where mothers in a divorce settlement are given custody to take care of children, noncustodial fathers often find it difficult to develop and maintain good relationships with their children (Kail & Cavanaugh, 2000). According to Louw and Louw (2014), almost 70% of youth from divorced homes report poor father-child relationships. The more disengaged fathers are in the lives of their adolescent males; the greater the impact will be on these emotionally neglected youth. They are likely to experience stress and numerous psychosocial difficulties (Lefrancois, 2001). Because the contact with one parent is reduced, adolescent males' sense of security may be threatened and often even less adequate parenting by the single parent may result (Kaplan, 2000). Topolski et al. (2001) found that such youth may resort to using substances, report feelings of depression, emotional distress, suicidal thoughts, dislike of school, low levels of academic achievement and pressure to be sexually active.

That a father's absence can have a negative impact on the psychosexual development of adolescent males, is a well-known fact in developmental psychology (Parritz & Troy, 2011). A socio-cultural dimension seems evident in trends of absent fathers; Holborn and Eddy (2011) found African children in South Africa under 15 years of age had the lowest proportion of fathers present, namely 30%, compared to 53% for coloured children, 85% for Indians, and 83% for whites. The proportion of African children under the age of 15 years with absent living fathers increased between 1996 and 2009 from 45% to 52% (Holborn & Eddy, 2011). Adolescent males growing up in family-settings without a father as discussed before, were found to be experiencing difficulty initiating and maintaining intimate relations with adolescent females (Størksen, Røysamb, Moum, & Tambs, 2005). According to Jewkes et al. (2009), however, paternal absence is significantly associated with rape. In their research

conducted among men aged 20–24 years of age in three districts of KwaZulu-Natal and the Eastern Cape in South Africa, these researchers found that young men raped women because they perceived their parents as being unkind. Additionally, these participants also revealed that they started engaging in sexual activities since a young age, because they felt deprived of warmth and support by their parents, especially fathers.

Due to less social and financial support, substance use and aggressive behaviours are common features in adolescent males raised in families where there is no father figure (Kaplan, 2000). For example, such adolescent males may be associated with poor educational outcomes, anti-social behaviour and delinquency, and disrupted employment in later life (Holborn & Eddy, 2011). Furthermore, Holborn and Eddy found that adolescent males are not only emotionally disadvantaged by the absence of a father, but they are also disadvantaged when they belong to a household without access to a social position, labour, and financial support as provided by men.

In addition to the family influences indicated above, it is crucial to know how adolescent males are being influenced by peers regarding their sexuality and sexual behaviour. This will be discussed next.

4.2.2 Peers

The role of peers in the adolescent's life is central and peers may even take on the role of parent substitutes for various reasons (Parritz & Troy, 2011). Peers provide adolescents with information about sexuality, dating, romantic relationships and substance use (Swartz et al., 2011). Steinberg and Scott (2003) argued that risky behaviour is closely linked to psychosocial immaturity during adolescent years and that adolescent males are less able to resist peer and other coercive influences from their friends, due to the incomplete development of their character and identity. This susceptibility to peer influence increases from childhood into adolescence and peaks at approximately fourteen years of age.

Peer pressure for adolescent males often has to do with proving masculinity; therefore drinking alcohol and having many sexual encounters and partners could win a young man some status and admiration amongst his peers. The use of alcohol by peers has been found to be a strong risk factor for adolescents towards abusing alcohol; peers may influence one another in several ways, either actively by offering alcohol or passively through social modelling (Flansburg & Pettijohn, 2011). It has also been found that adolescents who report having deviant peers tend to display more conduct problems; however, the fact that they associate with deviant peers indicates that these adolescents are already more likely to engage in risky behaviour due to other pre-existing problems in their lives (Barnes, Brynard, & de Wet, 2012).

For some adolescent males in South Africa, peer-affiliation demands conformity. Therefore, to be accepted and have their sense of belonging approved in the peer group, they often engage in required activities such as substance abuse and non-condom use during sex (Batten, Follette, & Aban, 2002; Gear, 2010; MacPhail & Campbell, 2001; Ricardo & Barker, 2008). According to Rathi and Rastogi (2007), adolescent males who need to conform to peer pressure are more likely to choose riskier partners, to have multiple partners and even to engage in prostitution. A research study by Kalichman and Simbayi (2003) found that male adolescents under peer influence take risks which may lead to HIV-acquisition and transmission, because they have multiple sexual partners and engage in sexual activities with strangers or acquaintances. In addition, Louw and Louw (2007) cited research about a group of African adolescent males in the Eastern Cape, South Africa, who became sexually active to prove their masculine normality (i.e. virility) among their peers. Of these, more than 75% revealed that they practised unsafe sex despite being aware of HIV/AIDS transmission.

Crockett et al. (2006) further emphasised that peers might serve as a sexual risk factor, because male adolescents may become deviant from societal norms, engaging in unprotected

sex and bullying of their sexual partners, due to peer influences. This is more so for adolescent males whose self-regulation is externally controlled (Myers & Parry, 2002). When adolescent males realise that their peers do not approve of them or their behaviour, they may feel powerless and suffer from depression, which could strengthen their use of drugs and/or alcohol, as well as their involvement in risk sexual behaviour (Hayhurst, 2005).

Conversely, supportive and prosocial peers are reported to be crucial for adolescent males' emotional, scholastic and health development in the transition to adulthood (Viner, Ozer, Denny, Marmot, Resnick, Fatusi, & Currie, 2012), while literature indicated that peer modelling and awareness of peer norms can be protective and buffer violence, substance use and sexual risk (Moolla & Lazarus, 2014). For example, Brown (2008) found that peers with healthy future mindedness enhanced their friends' self-esteem, encouraged them to engage at school and think creatively, while upholding good sexual values. In this regard, one understands the finding of Schofield, Bierman, Heinrichs, Nix, and Conduct Problems Prevention Research Group (2008) that in the healthy peer-relating process, adolescent males may become academically engaged, connecting with educators. This may reduce the risk for early sexual debut and substance use, since they often spend time participating in extracurricular activities such as soccer, cricket and drama. Engler (2009) pointed out that when adolescent males continue to engage themselves in constructive activities as opposed to self-destructing ones; they establish values that help shape their lives, experience satisfaction with school and educational expectations, and viewing life as meaningful.

Consistent with social control theory which suggests that adolescents who feel emotionally connected to peers, educators and parents are more likely to delay sexual activity and acquire decision-making skills (Schofield et al., 2008), Wellings et al. (2006) found that positively assertive peers encourage the adoption of safe sex or alternative practices among

their sexually active friends, rather than having them engage with multiple sexual partners and being exposed to the possibility of contracting STIs or HIV/AIDS.

4.2.3 Maltreatment and Sexual Abuse

Maltreatment as depicted in Table 2 below is an encompassing term that includes physical abuse, sexual abuse, psychological or emotional abuse, neglect or deprivation of necessities (Pretorius, 2009). Grounded in attachment theory, rejection sensitivity theory posits that early experience of rejection by caregivers – such as maltreatment, parental neglect and exposure to family violence – results in a heightened anticipatory anxiety and expectation of further rejection by significant others in future interpersonal relationships (Harper, Dickson, & Welsh, 2006). Adolescent males who have been subjected to neglect and abuse are considered high-risk for anti-social behaviour, also of a sexual nature (Papalia et al., 2009).

Table 2

Types of Maltreatment (Adapted from Harper, Dickson, & Welsh, 2006)

| Abuse | Description |
|----------------|---|
| Physical | Infliction of physical injury or physical brutality as a result of punching, kicking, biting, burning, shaking, punishing or otherwise harming an adolescent, carried out by a person responsible for the adolescent's welfare. |
| Sexual | Fondling an adolescent's genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials. |
| Emotional | Acts or omissions by caregivers that have caused, or could cause, serious behavioural, cognitive, or emotional problems. |
| Neglect | |
| Physical | Refusal of, or delay in seeking healthcare; abandonment; expulsion from the home or refusal to allow a runaway to return; and inadequate supervision. |
| Educational | Allowance of chronic truancy, failure to enrol a child of mandatory school age in school, and failure to attend to a special education need. |
| Emotional | Marked inattention to the adolescent's needs for affection; refusal or failure to provide necessary psychological care; spousal abuse in the adolescent's presence; and permitting drug or alcohol use by an adolescent. |

The environment from which most maltreated youth emerge consists of drunkenness, disorderly conduct, violence, fighting, and parents who directly or indirectly project messages that deviant behaviours are tolerable (Ungar, 2001; Wingo, Wrenn, Pelletier, Gutman, Bradley, & Ressler, 2010). Additionally, many adolescent males removed from abusive homes and placed in foster care are diagnosed with multiple mental health problems that are independently associated with increased risky sexual behaviour (Yendork & Somhlaba, 2014). Maltreatment increases the risk of substance abuse and risky sexual behaviour during adolescence (Bensley, van Eenwyk, & Simmons, 2000; Moran, Vuchinich, & Hall, 2004), through generated effects that may include a distorted sexual self-concept, confusion and misconceptions around sexual norms and knowledge, preoccupation with sex, phobic reactions to sexual intimacy and sexual compulsivity (Ng-Mak, Salzinger, Feldman, & Stuevol, 2010; Spiegel, 2003). Maltreatment can contribute to long-term posttraumatic stress disorder (PTSD), depression, personality problems and delinquency (Donald et al., 2014; Nolen-Hoeksema, 2008; Thompson, Bender, & Kim, 2011).

Adolescent male sexual abuse is reported each year in South Africa (Muntingh & Satardien, 2011) and there is an on-going debate as to whether there has been a real increase in adolescent male sexual abuse, because not all such incidents are reported (Townsend & Dawes, 2004). Drawing from the cognitive behavioural perspective, adolescent males who have been sexually abused may experience hopelessness, helplessness and guilt, and have negative self-evaluation (Louw & Louw, 2007). They tend to have maladaptive beliefs/schemas related to mistrust, vulnerability, incompetence and insecure attachment (Bee & Boyd, 2003).

According to Patel, Andrews, Pierre, and Kamat (2001), adolescent males who had experienced forced sex are more likely to engage in dysfunctional consenting sexual intercourse, both vaginal and anal and their mental and physical health were found to be

significantly low. Harrison, Cleland, Gouws, and Frohlich (2005) in their analysis of sexual behaviour established that 3.5% of 314 young men (15–24 years of age) in rural KwaZulu-Natal Province, South Africa, reported to have been sexually abused at an early age. These authors also found that this group of adolescent males had multiple sexual partners and had sexual relations with older women. According to Mash and Wolfe (2010), having experienced an unwanted sexual activity at an early age could result in displaying passivity, anxiety, fear, anger, difficulties in concentration and withdrawal from usual activities. These youth often display a pattern described as insecure-disorganised attachment, characterised by a mixture of approach and avoidance, helplessness, and a general disorientation. Furthermore, their likelihood of engaging in risky sexual behaviours throughout life is higher. In line with these findings, Lohman and Billings (2008) found that adolescent males who have been sexually abused are at an increased risk for lower levels of academic achievement and increased levels of school problems and substance abuse.

A crucial developmental task of adolescence relating to both identity and social development is acquiring the skills to and engaging in a social environment in which psychosexual relationships can be formed and maintained. The dating experience is an activity aimed at fulfilling the stated task and aspects thereof will be discussed below.

4.2.4 Dating Relationship, Dating Violence and Communication Between Sexual Partners

Feiring (2000) defined a dating relationship as a dyadic interaction that focuses on participation in mutually rewarding activities that may increase the likelihood of future interaction, emotional intimacy, and/ or sexual intimacy. Jewkes et al. (2009) suggest that dating relationships start in early adolescence between 13 and 14 years of age and sexual experience could take place shortly after that. Boys engage earlier than girls and often with older women.

More literature described the negative or risk-laden aspects of the dating experience than the healthy features thereof. Relationship or dating violence refers to any attempt to control or dominate a partner physically, sexually, or psychologically, causing some level of harm (O' Leary & Slep, 2003). Violence that occurs in the context of an intimate dating relationship has been labelled as partner violence, courtship violence, dating violence and battering (Aspy et al., 2007). Feminist theory views dating violence as being gender specific, often with adolescent males as perpetrators and adolescent females as victims (O' Leary & Slep, 2003).

Dating violence is fairly prevalent among adolescents due to aspects such as low self-esteem, lack of impulse control, poor self-regulation and performance pressure (Jama-Shai, Jewkes, Nduna, & Dunkle, 2012). Of importance is that dating violence has been associated with negative physical and mental health outcomes for adolescents and with high-risk behaviours such as unsafe sex (Manganello, 2008). For instance, adolescent males may use violence as the primary aggressor to exert control over their sexual partners. They force themselves upon their girlfriend to be kissed, touched and to have unprotected penetrative sex (Tatcher & Clark, 2008; Widman et al., 2006). For fear of violence, adolescent females avoid saying "no". Supporting this, Hagne and Malos (2005) in their research among adolescent females in South Africa, found that partner violence prevented adolescent females from negotiating safe sex because their sexual partners (adolescent males) would insult them and insist on having them pregnant. In another study, Feiring et al. (2002) found that poor anger management is one of the main reasons cited for adolescent males' use of aggression in romantic relationships.

Adolescent males who are jealous and insecure in their romantic relationships tend to display anger and negative attitudes towards their partners when they have male friends. They may also become antisocial, carry weapons and may lack good communication skills

(Pellegrini, 2001). Such adolescent males perpetrate violence and may increase women's feelings of powerlessness; thus limiting their ability to negotiate safe sex practices and increasing the risk of STI acquisition (Buelna & Ulloa, 2009). Pellegrini (2001) found that a causal factor of adolescent boys being aggressive towards their partners is ascribed to conformation with peers, because by doing so they want to portray a certain image of masculinity (Lavoie et al., 2002). Furthermore, Holborn and Eddy (2011) found that in a study of Grade 8–11 pupils in Cape Town, 21% of respondents reported perpetrating violence against their partner, and 16% said they would use violence against their partners in future if angered. Research showed that partner violence is correlated with low socio-economic status of parents, substance use, and unhealthy role modelling or imitation of parents or adult role models (Greif, Dodoo, & Jayarama, 2011; Hayhurst, 2005; Pithey & Morojele, 2002; Swartz et al., 2012).

Sexual communication is an important component of intimate relationships. Open discussions of topics such as sexual preferences, sexual fantasies and sexual behaviour between sexual partners are associated with good sexual experiences, consideration and satisfaction (Widman et al., 2006). However, sexual miscommunication appears to plague adolescent sexual relationships due to ignorance, embarrassment, self-concept issues, lack of communication and assertiveness skills and many more. According to Jewkes et al. (2009) and MacPhail (1998), when romantic relationships are characterised by poor communication and discussion of sex-related matters, partners tend to terminate condom use and expose themselves to greater risk of both HIV and STD infection. Adolescent dating behaviour and even communication in sexual encounters are strongly influenced by socio-cultural influences and the messages conveyed from influences.

In most South African black townships, traditional norms and cultural practices regarding sexual activity are still being followed and adolescent males' sexual behaviour is often defined by those customs, as will be described below.

4.2.5 Culture and Male Fertility

Cultural and social beliefs affect adolescent males' attitudes toward sex, which in turn affect their sexual behaviour (Bhugra & de Silva, 1993; Gault, 2012). From a sociological perspective, adolescent males have been encouraged to be active rather than passive in expressing their sexuality, in order to develop ways of being in control and to structure situations to meet their own needs (Macionis, 1995). The importance of sexuality in defining Zulu masculinity in particular, is embodied in the concept of "**isoka**", a term that denotes an adolescent male who is socially successful and popular with girls, although its colloquial usage has strong sexual connotations (Vilakazi, 1962). In South Africa where gender imbalances reign, adolescent males see nothing wrong in getting involved with multiple sexual partners (MacPhail & Campbell, 2001). They may learn from role models that real men are always ready for sex and that if they impregnated their partners, they would feel like real men (Haffner, 1998; Kim, 2009; Langa, 2010) and improve their manhood (Gevers, Jewkes, Mathews, & Flisher, 2012; Glieds & Pine, 2002; Soudien 2011). In communities where cultural sexual practices are still in use - especially in South Africa - male adolescence is characterised by non-surgical circumcision (removal of foreskin) by "**ingcibi**" a traditional surgeon, as a rite to manhood (Papu & Verster, 2009; Peltzer, Nqeketo, Petros, & Kanta, 2008). In many societies, adolescent males may be expected to be knowledgeable about sex and be sexually experienced before marriage (Senanayake & Faulkner, 2003), and this puts pressure on them to seek traditional herbs generally known as **imbiza** to enhance their sexual powers (Ndinda, Uzodike, Chimbwete, & Mgeyana, 2011). Based on these beliefs, many adolescent males prefer *skin-on-skin* sex to prove their fertility (Gupta, 2002). They perceive

condoms as preventing sexual pleasure and believe that condoms may break while having sex or disappear into a woman, causing injury or death (Eaton et al., 2003).

Traditional sex role stereotypes were and in many respects still are for the man to be the “hunter” and initiator of sexual activity, the one with a more powerful figure in an intimate relationship (Cekiso & Meyiwa, 2014; Jeftha, 2006). According to Frosh, Phoenix, and Pattman (2003), masculinity is not naturally occurring. Instead, it is constructed in social interactions and achieved through the use of the cultural resources available to particular boys and men. Literature suggests that there are different kinds of masculinities available to boys and men, but generally finds that there is a “dominant” form of masculinity that influences their understanding of how they have to act in order to be “acceptably” male. According to Connell (1995), this dominant mode is associated with heterosexuality, toughness, power and authority, competitiveness, subordination of gay men and often referred to as hegemonic masculinity (Frosh et al., 2003).

Social exchange theorists, for example, conceptualised power as the extent to which one person’s resistance can be overcome by another person. They posited that the person with the greater amount of power in the relationship will be dominant when it comes to decision making, including decision making in the domain of sexual behaviours. The Theory of Gender and Power (Connell, 1987) contend that men (including adolescent males) tend to be more powerful than women in many traditional societies; thereby leaving women in heterosexual couples with less decision-making power than their male counterparts. This lack of parity often results in sexual coercion, decreased condom use and greater involvement in unsafe sex, because many men consider it unnecessary, undesirable and less pleasurable to use condoms with women (Elifson, Klein, & Sterk, 2010). According to Eaton et al. (2003), in such relationships the threats of violence or rejection prevent girls and women from insisting on condom use.

Involving African adolescent males in the promotion of their psychosexual well-being such as in psychosexual education, it is important to consider that traditional gender norms put them at risk of contracting HIV/AIDS and other sexually transmitted infections. James et al. (2004) in a study in KwaZulu-Natal among African adolescent males found that the levels of STI transmission were high and behaviour change was low. Sabcoha and Ber (2004) stated that the cultural blame is shifted to women and girls for STIs transmission. The combination of permissive cultural attitudes, sexual experimentation and lack of accurate information from parents, pose a threat to the sexual health of adolescent males and expose them to risky sexual behaviours and the consequences thereof (Bee & Boyd, 2003).

Having discussed intrapersonal and interpersonal variables which shape the sexual behaviour of adolescent males, the societal factors will be explored in the next section.

4.2.6 Societal Factors

A study of literature has identified the following variables as societal factors that may influence adolescent males' sexual behaviour: school and sex education, poverty and living conditions, boredom and unemployment, substance use, HIV/AIDS, mass media and religiosity.

School and sex education: A school is a place where adolescents learn to interact formally with educators and other learners, develop age-appropriate skills and interests, control social behaviour, acquire society's ethics and morals, and share their challenges and feelings (Smith & Harrison, 2013; Wang & Holcombe, 2010). When the school provides the protective factors of academic achievement and academic expectations for learners, adolescent males in particular become interested in school matters and less interested in sexual activities (Lohman & Billings, 2008; Skinner, Furrer, Marchand, & Kinderman, 2008) and the adolescent male's sense of competency, worthiness, and belonging is usually enhanced when positive

comments come from educators and family members about school-related achievements (Radebe, 2001).

Research examining sex education has established that sex education programmes are associated with delay in first intercourse, and increased condom use and other contraception at first and subsequent intercourse (Hosie, 2002; Kirby, 2007; Kirby & Laris, 2009). When adolescent males are positively influenced by parents, siblings, peers, community and schools about their sexual behaviour from an early age, they grow up with the confidence and self-esteem to be able to make informed choices about their sexual well-being (Goldman & Coleman, 2013; Iyer, & Aggleton, 2013; Kirby, 2002; Senanayake & Faulkner, 2003). Not only do adolescent males receiving sex education abstain more, but those who are sexually active increase their self-efficacy and intent to adopt safe sex behaviours (Wellings et al., 2006). Similar to these findings, Doyle et al. (2010) found that among Tanzanian adolescent males, the adolescent sexual health intervention programme had delayed reported sexual debut, reduced the reported number of sexual partners in the past twelve months, and increased reported condom use. Thus, to prevent young males from risky sexual behaviour, sex education is considered vital (Bay-Cheng, 2003).

In South Africa, the Children's Act No. 38 of 2005 states that no person may refuse to sell condoms to a child twelve years or older, or refuse to provide such a child with condoms on request where such condoms are distributed free of charge (Han & Bennish, 2009). However, good sex education should make it clear that provision of condoms is not an endorsement of premature and often unhealthy sexual activity (Myer, Mathews, Little, & Karim, 2001).

Poverty and living conditions: A substantial association between low socio-economic status (SES) and risky sexual behaviour of adolescent males exist (Capaldi, Stoolmiller, Clark, & Owen, 2002; Lutya, 2012). Adolescent males who live in poverty are reported to be more

vulnerable to risky sexual behaviour than their more wealthy counterparts, owing to their relative lack of knowledge about risky sexual behaviour, lack of access to condoms and lack of empowerment with respect to the negotiation of safe sex behaviours, including condom use (Brook et al., 2006; Luty, 2012). Adolescent males' sexual behaviour becomes risky especially when their social environments are characterised by poverty, high crime rates and high residential turnover (Miller, 2002). In a study conducted in South Africa among street children, Richter and Swart-Kruger (1995), found that most respondents agreed that selling sex to both men and women is the best way to get money on the streets.

Vulnerable, usually poverty stricken adolescent males are confronted with a daily challenge to obtain meals, clothing, and secure shelter and maintain their health. According to the report by UNICEF (2007), approximately 60% of South African adolescents are living in poverty and at least 3 million go hungry every day. In the context of the HIV/AIDS epidemic, many breadwinners (in already impoverished communities) are rendered infected or ill and thus incapable of supplying food and clothing to household members, compelling countless adolescent males to struggle to obtain regular meals, impacting negatively on their health, growth, ability to learn, as well as capacity to take care of themselves, their siblings and ill parents. While limited availability of clothing and shelter naturally has a detrimental effect on adolescent males' health and impacts negatively on their already strained sense of self-worth due to the HIV/AIDS stigma towards their family, the absence of school uniforms means that adolescent males often do not attend school (Ebersohn & Maree, 2006) and this impacts negatively on their cognitive and psychosocial well-being (Cluver & Gardner, 2006; Nduna & Jewkes, 2012).

Living in affluent communities is reported to be linked to the adolescents' emotional, social and psychological well-being as compared to overcrowded or cramped environments (Hoffman, 2004), as well-off parents may be in the position to control adolescent behaviour

and provide models of successful adults (Weatherburn & Lind, 2001). In South Africa, Brook et al. (2006) found that adolescents from informal settlements and/or overcrowded communities tend to display behavioural problems at school, stay out at night without telling parents and are associated with criminal acts. Such adolescent males are prone to experimentation with drugs and alcohol, conform to deviant peers and are likely to engage early in sexual activities as compared to their counterparts from families who monitor their sons' behaviour (Hoffman, 2002).

According to Gwandure (2009), another disadvantage of living in cramped homes is that when parents sleep in the same room with their adolescents, the possibility of sexual stimulation and even incest increases. Petersen, Bhagwanjee, Bhana, and Mzimela (2004) found that such adolescent males may be forced to sleep with their visiting uncles, who may sexually molest them, which in turn leaves young people psychologically traumatised.

Boredom and unemployment: Unemployment is a state of job loss or joblessness in which an individual does not receive remuneration on a regular basis (e.g. per week or month), and it may lead to negative psychological outcomes because of lacking the nine benefits associated with employment, namely opportunity for control, opportunity for skill use, externally-generated goals, variety, environmental clarity, availability of money, physical security, opportunity for interpersonal contact, and valued social position (McKee- Ryan, Song, Wanberg, & Kinicki, 2005; Statistics South Africa, 2012). According to Hallman (2004), unemployment creates a gap between aspirations and reality for jobless adolescent males with no qualifications, as their disadvantaged status impacts negatively on their mental well-being. In South Africa the rate of youth unemployment is alarmingly high, as in 2008 it was at 44.5% and in 2009 at 48.1% (Holborn & Eddy, 2011). Unemployment statistics begin to reflect the reality of the disadvantaged age group (15–24 years old) in South Africa, a fairly large proportion of adolescent males who experience de-individuation (e.g. engage in risk of

drug use and other socially unacceptable behaviour) and pessimism (Statistics South Africa, 2012). In addition, boredom as a consequence of such a state of affairs is perceived to have detrimental effects on the psychosocial well-being of adolescents, which may contribute to the development of distress, depression and hopelessness (Hayhurst, 2005). Boredom as an environmental stressor may disempower the youth's capacity to cope with adversities, as well as induce both psychological and physiological emotional dysregulation (Murali & Chen, 2005). In turn such youth, especially those raised in single-parent households with no financial stability, living with their grandparents and often affected by HIV/Aids (Holborn & Eddy, 2011), may find themselves experiencing low self-esteem and loss of self-confidence when their peers progress in life and contribute meaningfully in society (Social Exclusion Unit, 2004).

The host of unfulfilled psychosocial needs in young males created by the situation of unemployment would likely render them at risk for premature sexual involvements in order to escape from the bleakness of the situation. In this regard, one understands the finding of Horton (2002) that adolescent males often use sexual activities as coping strategies. The self-defeating outcomes of such efforts to escape from or cope with unemployment and related adversities would be unhealthy sexual practices, casual and unfulfilling relationships, unplanned fatherhood, HIV positive status, substance abuse, crime and overall psychological emptiness.

Substance abuse: In the preceding parts of this overview, the influence of substance use/misuse in adolescent males (often initiated by peers), as a precursor of mostly dysfunctional sexual behaviour, has been given much prominence. However, substance use/misuse as a trigger for risk-taking behaviour of a sexual nature has been reported so extensively by researchers that it warrants further discussion. Of particular relevance is the fact that Njoroge, Olsson, Pertet, and Ahlberg (2010) relate substance use of adolescents to a

major developmental task, namely of differentiating from the family in search of their own identity and linking up with their peer group. Furthermore, data from an epidemiological survey research about the patterns of substance use by adolescents showed that age trends indicate that substance use has become a developmental tendency, which seem to increase linearly from puberty to late adolescence (Young, Corley, Stallings, Rhee, Crowley, & Hewitt, 2002; Kheswa, 2006). Mpofu, Bility, Onya, and Lombard (2005) found that a large proportion of adolescent males engaged in sexual activities when under the influence of alcohol and dagga in Mankweng District, Limpopo Province, in South Africa. Topolski et al. (2001) found that attitudes towards sexual behaviour while under the influence of a substance are often defiant and that they may initiate dating girls and then force them to have sex (Ferreira, 2004; Lopez, Perez, Ochoa, & Ruiz, 2008).

Adolescent males who drink heavily are less likely to use condoms, and are more likely to have multiple partners (Armstrong, England, & Fogarty, 2012; Dunkle et al, 2006; Harrison, Cleland, Gouws, & Frohlics, 2005). Studies in sub-Saharan Africa, in particular, have found a strong association between alcohol consumption and unprotected sex, early sexual debut, multiple sexual partners and having an STI (Chersich et al., 2009; Fritz, Morojele, & Kalichman, 2010).

HIV/AIDS: Of the general South Africa population, the most HIV prevalent racial group is the African youth population (Jewkes & Morrell, 2012; Pettifor, O' Brien, MacPhail, Miller, & Rees, 2009; Simbayi, Chauveau, & Shisana, 2004; Shisana & Simbayi, 2002). For example, African youth aged 15–24 years had an HIV prevalence rate of 10.2%, followed by coloured youth (6.4%), and then white youth (3.2 %). Given the legacy of apartheid in South Africa, there are a multitude of socio-economic, social, behavioural and potentially biological factors that may contribute to the increased risk of HIV among black South Africans in comparison with individuals from other races (Pettifor et al., 2009). Most black adolescent

males grow up in townships and rural areas where there is a lack of recreational facilities and sex becomes one form of entertainment (Jewkes et al., 2009). Because they live in non-stimulating environments, most adolescent males find themselves resorting to alcohol and drug abuse, which in turn leads them to unsafe sex with casual partners (Audrain-McGovern, Rodriguez, & Wileyto, 2006; Chersich et al., 2009).

Lack of exposure to convincing HIV prevention campaigns by youth for youth leaves them susceptible to contracting HIV because of stereotypic dimensions perpetuated by culture, which impedes condom use, because it is perceived to interfere with passion and performance (DeCraen, Michielsens, Herbots, van Rossem, & Temmermen, 2012; White, Cleland, & Carael, 2000). As a result, many adolescent males practice unsafe sex and when their female partners attempt to negotiate safe sex, they are likely to be physically abused (MacPhail, 1998). By contrast, Pettifor and his colleagues (2009) determined that sexually experienced adolescent males who reported participating in LoveLife programmes were significantly less likely to be HIV infected (because of convincing encouragement to remain faithful to one sexual partner) as compared to adolescent males who never participated in the programmes. Similar to this, findings by Doyle et al. (2010) reported that among Tanzanian adolescent males, the adolescent sexual health intervention programme had outcomes of delayed reported sexual debut; reduced the reported number of sexual partners in the past twelve months; and increased reported condom use.

Mass Media: Mass media is another important dimension of young people's lives that may take on special significance during adolescence and particularly for sexual risk behaviour (Fischer, Greitemeyer, Kastenmüller, Vorgrincic, & Sauer, 2011; L'Engle, Brown, & Kenneavy, 2006). Much of the media that adolescents are exposed to includes sexual imagery, but rarely portrays consequences of risky sexual encounters or healthy sexual messages (Brown & Cantor, 2000; Tanski, Stoolmiller, Gerrard, & Sargent, 2012; Zillmann

& Bryant, 2013). For example, Emeozor (2005) found that owing to the disorganisation of primary societies, adolescent males learn about sexual misconduct in junk magazines, pornography and internet dating, while Le Roux (2010) is of the opinion that viewing of pornography at a too young age can lead to the individual becoming fixated on either pornography as the means of sexual gratification, or on the specific type of sexual activity portrayed as the means of sexual gratification.

A theory that offers an explanation for why media has such an effect on adolescent males is the cultivation theory. Cultivation theory states that watching much television creates a perception of social reality that matches or is closely related to the reality as it is portrayed by television content (Hetsroni, 2012; Le Roux, 2010). Adolescent males who are exposed to much sexual content in the media and who perceive support from the media, report more intentions to engage in sexual intercourse and other sexual activities (Kahlor & Eastin, 2011; L'Engle et al., 2006). In the process of discovery-learning of sexual behaviour, adolescent males often change their attitudes and values towards sex; however, many adolescent males once they perceive the world as sexually active, become sexually preoccupied to prove their masculine normality (i.e. virility) by having concurrent sexual partners (Bhana, de Lange, & Mitchell 2009; Louw & Louw, 2007).

A research study by Longe and Longe (2005), established that children and teenagers belonging to the age range 7–18 years constitute over 32% of Internet users in Nigeria. Moreno, Jelenchick, Koff, Eikoff, Diermyer, and Christakis (2012) found that adolescents (especially males) surf the Internet while doing their homework and the Internet serves as a platform for them to engage in sex chat rooms and eventually invite strangers for sexual escapades. In South Africa where the growth of Internet access has increased drastically to 91.3% in the period between 2000 and 2008, the Code of the Broadcasting Complaints Commission of South Africa (BCCSA) fails to combat exposure to explicit sex because

companies that advertise pornography make it easy for as little as R5 to download such content to one's personal phone (Le Roux, 2010). Other research (Bleakley, Hennessy, Fishbein, & Jordan, 2011; O'Hara, Gibbons, Gerrard, & Sargent, 2012) shows that movies, music and magazines contain an abundance of sexual content across a variety of media frequently used by adolescents. Donnerstein and Smith (2001) found that in households where parental control and influence are relatively low due to family violence, divorce and/or juvenile delinquency, more adolescents become exposed to risky sexual behaviour through the media as compared to households characterised by family cohesion.

Ideally, Greenfield (2004), offers some practical ways for parents to counter the influence that pornography has on their adolescents. These are:

- maintain an open family communication style;
- be open to discussing sex with your children;
- develop and maintain a warm and communicative parent-child relationship;
- make sure your child gets sex education;
- discuss media experiences with your child;
- explore the different forms of media with your child;
- put the computer in a public place in your home; and
- restrict the use of Internet and other ways of accessing pornography.

Religiosity: Religiosity, which is defined largely by participation in religious activities, has been consistently linked to higher marital stability and satisfaction (Larson & Swyers, 2002; Salas- Wright, Vaghn, Hodge, & Perron, 2012). According to Jessor's model (Jessor & Jessor, 1983), religiosity is an indicator of an adolescent's likelihood to behave in a socially acceptable manner or what the authors called a "conventional-behaviour structure." In this model, religiosity determines the amount of exposure to influences that do not support pre-marital sexual activity and serves as a mechanism to support individual self-control. The

more an adolescent participates in religious activities, the more likely is exposure to values that encourage chastity and the more likely the development of sexual norms that coincide with religious commitment. According to Wheeler, Ampadu and Wangari (2002), religiosity contributes towards psychological development of adolescents in the areas of self-esteem, self-realisation and the restoration of inner balance against depression, anxiety and anger. Wheeler et al. further contend that adolescents who endorse religiosity throughout their lives experience cognitive, emotional and psychological transformation, linking it to the original traditions, values and spiritual essence of African culture.

Adolescent males who are religious seem less likely to engage in premarital sex or use drugs (Kaplan, 2000; Tirri & Quinn, 2010). They tend to present a cognitive view of moral behaviour, judge what is right or wrong, make a plan of action and put the plan in action (Lefrancois, 2001). For example, when faced with daily problems of living, adolescent males may use their religious faith to cope (Parsai, Marsiglia, & Kullis, 2010; Kail & Cavanaugh, 2000) rather than revert to premarital sex and alcohol use (Larson & Swyers, 2002).

In the literature overview presented above, relevant literature was studied to investigate factors contributing to the sexuality of adolescent males, and to their engaging in adaptive or risky sexual behaviour. It can be concluded that adolescent male sexuality and sexual behaviour are firmly embedded in intrapersonal, interpersonal and societal factors that have either protective, enabling or adaptive functions or risk-laden, defeating or maladaptive influences. Such influences to a large extent determine the psychosexual and psychosocial outcomes of adolescent male sexuality and sexual practices, as have been explained by theoretical frameworks and/or models. Theories such as the social exchange theory, social learning theory, cognitive behaviour theory, theory of planned action and other theoretical parameters described above, provide a logical framework within which to anchor a study such as this.

Based on the wealth of information gathered from the literature study on factors influencing the sexuality of adolescent males particularly in an African context, this study intends to investigate the attitudes and values and the sexual behaviour (skills of decision making and communication about sexual matters), of African adolescent males. Furthermore, the relationship between these aspects of their sexuality and their experience of psychosocial well-being will be studied.

Psychosocial well-being as conceptualised in relevant literature will be discussed on the following pages.

5. Psychosocial Well-being of Adolescent Males

5.1 Well-being: Subjective, Psychological and Psychosocial

Well-being, which refers in general to optimal experience and functioning, has been vigorously studied in psychology over the past quarter century. To a significant degree this is due to the work of, amongst others, psychologists such as Diener (1984) who has focused the research on subjective well-being (SWB). Maluka (2004), with Diener's work in mind, described the term subjective well-being as individuals' evaluations of their lives which includes cognitive judgements such as satisfaction with life as a whole, affective evaluations (moods and emotions) such as the frequency and intensity of positive and negative emotional experiences and personal quality of life (satisfaction with specific personal domains of functioning, for example, with the self, close relationships and work). The concept of well-being is defined and explained in a variety of ways in literature and Costa and McCrae (1992) viewed well-being as a construct which has been used interchangeably with morale, mental health, life satisfaction and subjective well-being. An important perspective on well-being is the bio-psychosocial viewpoint that provides a framework in which to understand and conceptualise the multi-casual, complex and interrelated factors that affect a person's sense of well-being or general wellness. The bio-psychosocial approach is also seen as an

interactionist model in which the various biological (physical), psychological (mental) and social (interpersonal) features that influence one's wellness, are in constant interaction with one another and – in combination – are producing one's unique experiences and behaviour (Aknin, Barrington-Leigh, Dunn, Helliwell, Burns, Biswas-Diener, & Norton, 2013; Diener, 2012; Wissing & van Eeden, 2014). From the bio-psychosocial perspective a good definition of well-being is thus the one of INNE (2011), that well-being implies physical, cognitive, emotional, social and spiritual health or wellness and is seen as interactive processes of all that is good for a person such as meaningful social roles, being happy and hopeful, living according to healthy values, positive social relationships and support networks, ability to cope and personal security. For the purpose of this study, well-being is primarily considered from the psychosocial dimensions of the bio-psychosocial model and those will be focused on in the following discussion.

According to Wissing and Temane (2008), psychological well-being is an integrative, complex and holistic multi-faceted concept, while Reber and Reber (2001) were of the opinion that psychological well-being designates one who is functioning at a high level of behavioural and emotional adjustment and adaptiveness. Ryan and Deci (2001) introduced two psychological well-being dimensions, namely, hedonic wellness (where an individual regards well-being as the experience of pleasure and as pain to be avoided) and eudaimonic wellness (where an individual searches for meaning of life and self-realisation), as components of psychological health. Hedonism, the feeling well component, requires positive relationships with significant others (family members, community members) to ensure that positive emotions such as happiness, satisfaction, joy and contentment are experienced (Compton & Hoffman, 2013). Eudaimonia, the functioning well component, on the other hand entails agency and the use and development of human capabilities to create meaning in life (Hefferon & Boniwell, 2011; Oish & Kurtz, 2011). Ryan and Deci (2001) suggested that

people who fulfil three basic psychological needs namely: *competence*, the need to seek opportunities for growth and for the development of one's capabilities and to master the challenges in one's environment; *autonomy*, the desire to freely choose one's actions in line with one's integrated sense of self and voluntarily engaging in chosen behaviour; and *relatedness*, the need to have a sense of connection and caring with significant other people, the need to belong and to experience attachment (Hofferson & Boniwell, 2011), are likely to experience both subjective (hedonic) and psychological (eudaimonic) well-being.

Keyes (2007) emphasised that mental health is not merely the lack of psychological ill-being and problems, but rather depends on the presence of positive experiences such as positive emotions or emotional wellness, goal directedness and life competence or psychological wellness, as well as social contribution, -coherence, -actualisation, -integration and -acceptance, or social wellness. Keyes, Smotkin, and Ryff (2002) refer to six key components that make up the eudaimonic dimension of psychological well-being, namely self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth; all originating from Ryff's (1995) model of psychological well-being. In the following discussion, the aforementioned six aspects of optimal well-being will be the focus, specifically in relation to the psychosocial well-being of adolescent males.

Autonomy: With reference to autonomy (volition) in psychological well-being, qualities such as self-determination and self-regulation of behaviour from within are interwoven (Ryff & Keyes, 1995). In Erik Erikson's psychosocial theory, development of autonomy versus shame and doubt begins between ages 1 and 3, and is characterised by the willingness to try new things and to handle failure (Louw & Louw, 2007). Erikson also suggested that the mastery of autonomy provides the foundation for developing a strong sense of identity in adolescence and adulthood, provided that the toddler's environment is socially supportive (for example, caregiver(s) providing unconditional love toward the child) (Louw & Louw,

2007). In the process of becoming independent, adolescent males, according to Louw and Louw (2007), may strive to achieve **cognitive autonomy** (i.e. making decisions and assuming responsibility for these choices), **behavioural autonomy** (i.e. making choices regarding friendships, leisure time and finances), **emotional autonomy** (i.e. being self-reliant and independent of their parents and being able to exercise self-control) and **moral or value autonomy** (i.e. forming an own value system that may serve as a guideline for their own behaviour). Autonomous youth are described as individuals with healthy personalities and striving for continued personal growth (Weiten, 2010). Socially, they are sensitive to the needs of others, enjoy rewarding interpersonal relations and are not dependent on others for approval and are not uncomfortable with solitude (Cervone & Pervin, 2008). According to the five-factor model pioneered by McCrae and Costa (1997), adolescents who are autonomous would tend to score high on **openness** (a tendency to explore adventure, unusual ideas and variety of experience), **conscientiousness** (a tendency to show self-discipline, act dutifully, aim for achievements and show planned rather than spontaneous behaviour), **extraversion** (outgoing, display of positive emotions and the tendency to seek stimulation in the company of others), **agreeableness** (tendency to be compassionate and cooperative rather than suspicious and antagonistic towards others) and be low on **neuroticism** (a tendency to experience unpleasant emotions, such as anger, anxiety, depression, or vulnerability) (Judge, Jackson, Shaw, Scott, & Rich, 2007).

Deci and Ryan (2006) suggest that autonomy can only be developed through interdependent relationships. For example, when educators and parents provide autonomy for adolescent males to make decisions and the atmosphere (both at home and in the classroom) is conducive to learning, their (adolescent males') feelings of adequacy, efficiency and competence in coping with life become positive (Schultz & Schultz, 2009). Congruent with this finding, Zimmer-Gembeck, Chipuer Hanisch, Creed, and McGregor (2006) found that adolescent males who are autonomous are more involved in their school activities and

studies, feel happier when at school, feel that they are contributing to their school; thus increasing their sense of belonging within the school environment and being active in seeking out opportunities that meet their needs for autonomy, relatedness and competence. In contrast, Kostecky (2005) found that when adolescent males perceive themselves as lacking autonomy and support from parents and/or educators, they may be prone to external influences such as drinking alcohol, skipping classes, and engaging in risky sexual activities.

Drawing from self-determination theory which postulates that healthy psychological functioning implies adequate satisfaction of the needs for autonomy, competence and relatedness linked to a system of congruent and coherent goals (Ryan & Deci, 2006), as well as developmental theories of motivation (Judge et al., 2007), the need for autonomy represents an attempt to achieve greater freedom and self-regulation by the adolescent male rather than regulation by external factors. Such autonomy may lead to greater self-integration, feelings of personal control and self-actualisation (Ryff & Singer, 2008).

Self-Acceptance: Self-acceptance is another important feature of mental health which is considered to be a significant characteristic of self-actualisation, optimal functioning and maturity (Hayes & Ciarrochi, 2015; Ryff & Keyes, 1995). Self-acceptance can be characterised by behaviour which is guided primarily by internalised values rather than external pressure, a faith in one's capacity to cope with life, an attitude of responsibility, an objective acceptance of criticism, a sense of self-worth and an absence or low level of shyness or self-consciousness (Schultz & Schultz, 2009).

Life span theories, for example those by Carl Rogers and Abraham Maslow emphasised acceptance of self and holding a positive attitude towards oneself, as a central characteristic of healthy psychological functioning. They suggested that optimal psychological functioning requires the achievement of these characteristics and continuous development of one's potential to grow as a person (Weiten, 2010). In sex education programmes, Kirby (2007),

Kirby and Lari (2009), and Salazar, Crosby, DiClemente, Wingood, Lescano, and Brown (2005) found that adolescent males with high levels of self-acceptance (thus, self-esteem) are reported to have resisted peer influence to engage in risky sexual behaviour. Adolescent males with low self-regard have been found to have lower scores in the domains of cooperation, persistence and expectation for future interactions, when compared to adolescent males with high self-regard (Hay & Ashman, 2003; Hill, Burrow, & Sumner, 2013; Vrangalova & Savin-Williams, 2011). In a South African study, Eaton et al. (2003) found high self-esteem to be associated with the delay of onset of sexual activity and commitment to one sexual partner, condom-use or abstinence.

Personal Growth: Personal growth or self-actualisation refers to the processes of striving to actualise one's potential capacity, capabilities and talents and requires the ability and drive to set and achieve one's goals, through involvement in various interests and pursuits (Bar-On, 2005). The humanistic approach to personality development describes personal growth as being able to acknowledge one's own strengths and weaknesses and striving to become the best person one can be (Swartz et al., 2011). Personal growth or self-actualisation strivings in youth are associated with autonomous functioning. A fully functioning adolescent male is described as having an internal locus of control and evaluation of the self by personal standards instead of clinging to the collective fears, beliefs and the laws of the parents and peers (Engler, 2009; Louw & Louw, 2007; Schultz & Schultz, 2009; Weiten, 2010). Adolescent males with personal growth tend to have a more efficient perception of reality, possess a democratic character structure, are less likely to focus attention on race, creed, gender, religious affiliation and social class, and show neither excessive rejection nor uncritical acceptance of societal rules. They tend to show healthy detachment from the group culture (Ryckman, 2008). Luthar (2003) found that such adolescent males who do not use substances in efforts to alleviate emotional distress or to fit in with a crowd (social conformity), engage themselves in more health-promoting behaviour and are consequently

more physically healthy as they understand the hazards of smoking and excessive drinking, compared to their counterparts whose locus of control is externalised (Ryckman, 2008).

Actualising-oriented adolescent males tend to have social skills and personal characteristics that protect them against stress, such as ego strength, perseverance, optimism, self-efficacy (Cove, Eiseman, & Popkin, 2005) and their relations are characterised by complementary interactions (constructive and mutually satisfying) (Hakelind, 2007). They show less burnout (emotional exhaustion), have higher levels of personal accomplishment on academic levels and rely on their own abilities and judgements in solving problems (Ryckman, 2008). At school, they are engaged, and well adapted (Cove et al., 2005) and they display resilience (positive view of the future, sense of purpose and personal power) regardless of challenges they may encounter (Salama-Younes, 2011a; Theron, Cameron, Lau, Didkowsky, Ungar, & Liebenberg, 2011). Unlike adolescent males who drop out of school prematurely (before completing Grade 12), because of adversity, trauma, tragedy, threats, or even significant sources of stress (Department of Education, 2003), the self-actualisers exhibit positive behavioural adaptation and resist peer pressure which might lead to self-defeating behaviour (Wegner, Flisher, Chikobvu, Lombard, & King, 2008). In other words, such adolescent males' mental health could be viewed as flourishing; that is, reporting fairly high levels of psychosocial functioning, resilience (e.g. they try to learn from adversities) and intimacy (e.g. they have close relationships with family and friends) (Salama-Younes, 2011b).

Environmental Mastery: Environmental mastery is associated with the individual's ability to choose or create environments suitable to his or her psychological needs, and active participation in and mastery of the environment are important ingredients of an integrated framework of positive psychological functioning (Brassai, Piko, & Steger, 2012; Ryan & Deci, 2002). Communities that have more resources may independently influence adolescent

behaviour by providing informal control, shared supervision, or collective efficacy that encourages restraint of delinquency or drug use. Liebenberg and Roos (2008) suggested that an environment, in which pre-adolescent males have a sense of mastery and competence in managing themselves and their relationships, would be characterised by an accessible, interactive, negotiated space. In such a space they could have opportunities to exercise control over their environment, learn to draw on available resources (human relationships as well as physical resources in the environment) to make optimal use of opportunities, and to develop their cognitive, emotional, social and moral potential. Social support stands as a predicting environmental variable for psychological well-being and is defined as a complicated process in which an interface of mutual activities between an adolescent and a supportive network exists (Lavasani, Borhanzede, Afzali, & Hejazi, 2011). In particular, having parental support that is actively engaged in an adolescent's education can help youth cope with the obstacles posed by their environment (Nord & West, 2001).

Purpose in Life: According to Rathi and Rastogi (2007), having a purpose in life can help solve the identity crisis that an adolescent experiences during the developmental stage of stress and turmoil. Wong (1998) described meaning in life in terms of an individual's constructivist and culturally-based cognitive system that influences an individual's choice of activities and goals, and endows life with a sense of purpose, personal worth, and fulfilment. Some studies show that if an adolescent perceives life to be meaningful, then he/she will feel more psychologically healthy than those who do not perceive their lives to be meaningful (Rathi & Rastogi, 2007; Steger, Bundick, & Yeager, 2012). Thus, the role of meaning in an adolescent's life can be a central point for a successful transition into adulthood. An adolescent may derive meaning from a variety of sources, such as developmental tasks achieved, family and social environments and relationships, schooling and career orientation; all factors that influence meaning in life and psychological well-being of adolescent males (Rathi & Rastogi, 2007; Vrangalova & Savin-Williams, 2011).

Positive Relations with Others: The importance of healthy and supportive relationships for the development of a well-balanced and fulfilling sexuality in adolescence has been discussed before, particularly the parent-adolescent and adolescent-peer group interactions. At the level of task performance, positive relations with significant others at home and school result in better skill development and higher performance levels for adolescent males (Carlo, Mestre, McGinley, Samper, Tur, & Sandman, 2012; McArdle & Duda, 2008), because relational security seems to foster intrinsic motivation, enhance perceptions of learning and mastery, and bolster self-esteem in youth (Chow, Ruhl, & Buhmester, 2013; Owen, Astell- Burt, & Lonsdale, 2013). According to Louw and Louw (2007), such youth tend to engage in positive self-talk, self-encouragement, ask for help when needed, and see a lack of knowledge and skill as temporary and challenging.

The model of Ryff (1995) explicating prominent dimensions of psychological well-being was described and considered above, with reference to the psychosocial wellness of youth. This model is currently the most researched and applied theoretical framework of psychological well-being (Baumgardner & Crothers, 2010). Next, other conceptualisations of psychological well-being will be discussed briefly.

General Psychological Well-being (GPW):

The General Psychological Well-being model (GPW) is complex and multi-faceted and made up of positive intrapersonal, interpersonal and spiritual dimensions of human functioning. An individual who experiences high general psychological well-being may display positive cognitive, affective, conative, interpersonal, social and spiritual characteristics, as well as the absence of mental symptoms of distress (Wissing & Van Eeden, 2002; Wissing & Temane, 2008). This construct, as identified by Wissing and Van Eeden (2002), includes various strengths and facets of psychological wellness such as individuals' sense of coherence, satisfaction with life and positive affect balance. Khumalo (2011)

described GPW as a holistic concept encompassing both hedonic and eudaimonic features. GPW was identified from research done in the South African multicultural context and was operationalised with the GPWS, developed by Khumalo (2011) and validated for use in South African contexts.

The PERMA Model

The development of the PERMA Model by Martin Seligman (2011) emanates from Positive Psychology and from Seligman's statement that "the construct of well-being is the focal topic of positive psychology" (p. 15). The acronym "PERMA" stands for five essential elements of well-being theory, that is, Positive emotion; Engagement; Relationships; Meaning; and Accomplishment (Compton & Hoffman, 2013; Seligman, 2011).

Positive emotion: A capacity for having positive emotions is a fundamental human strength and encourages personal growth and social connection, restoration of love and kindness, and inculcation of optimism and generosity (Fredrickson, 2003; Padilla-Walker & Christensen, 2011). Positive emotions allow individuals to feel good about themselves and tend to increase a sense of trust, positive regard and the probability of positive communication between adolescents and parents (Compton & Hoffman, 2013; Lewis et al., 2011). Any positive emotion such as peace, gratitude, satisfaction, pleasure, inspiration, hope, curiosity, or love falls into this category and may buffer depression and suicidal ideation amongst adolescents (Coon & Mitterer, 2010; Gilbert, 2012). According to Wheeler et al. (2002), African adolescent males who display positive emotions tend to be spiritual in the sense that they embrace African values, namely interdependence, self-sacrifice, and dedication to family and community. Such youth are associated with greater life satisfaction and positive emotionality (Wood, Linley, Maltby, Baliousis, & Joseph, 2008). Hoyt, Chase-Lansdale, McDade, and Adam (2012) found that adolescent males with higher self-esteem were more cheerful, showed genuine empathy, the willingness to be truthful and were connected to their partners

as compared to their counterparts who expressed negative emotions in their interaction with others. According to Compton (2005), positive emotions relative to negative emotions appear to impact health status and longevity, and adolescents who respond to stressors with positivity tend to have better health outcomes than adolescents who experience mostly negative emotions.

Engagement: Engagement with life encompasses identification and utilisation of one's unique strengths to produce abundant gratification and authentic happiness in a situation, task, or project that requires focus and full participation (Lenzi, Vieno, Pastore, & Santinello, 2013; Seligman 2002). Engagement theory states that fulfilment and gratification emanates from active participation in activities that are intrinsically motivating (Adie, Duda, & Ntoumanis, 2012; Compton & Hoffman, 2013). Intrinsic motivation, as indicated before, refers to motivation that comes from within and is independent on external rewards (Coon & Mitterer, 2010). Individuals who are intrinsically motivated are likely to display increased competence, creativity, persistence and positive well-being when compared to individuals who are extrinsically motivated. Being creative and positively involved in life can create a new sense of identity and self-discovery (Compton, 2005; Crocetti, Jahromi, & Meeus, 2012). At school, adolescent males who engage themselves in projects can be innovative and flexible, and enhance their problem-solving and decision-making skills (Compton & Hoffman, 2013). However, when adolescents are reared in family settings in which parents are psychologically controlling, they may feel deprived and withdraw from engaging themselves constructively in connecting with peers to do projects together. In turn, this may create the experience of feelings of worthlessness and guilt, and decreased self-esteem in adolescents (Hirschfield & Gasper, 2011; McMakin, Burkhouse, Olino, Siegle, Dahl, & Silk, 2011; Padilla-Walker & Christensen, 2011).

Relationships: Seligman (2011) in his book entitled *Flourish*, pointed out that individuals with positive well-being express the need to belong to others and to be resourceful and independent in their fellowship with humanity. Their attitudes typically epitomise love, kindness, humility and forgiveness. Furthermore, de Wied, Branje, and Meeus (2007) found that such individuals are tolerant of others' faults and focus on the positive qualities in their peers and partners. As mentioned in the preceding sections, adolescent males who experience good communication with their caregivers tend to relate well with others and treat their partners with respect. They are self-actualisers, characterised by diligence, patience, and commitment. Drawing from Self-Determination Theory, needs for mutually supportive interpersonal relationships appear to be essential for enhancing adolescents' self-efficacy and self-esteem (Carr, 2011; Chow et al., 2013; Compton, 2005; Liem & Martin, 2011).

Meaning: Global meaning is composed of a search for both order and purpose and gives life significance (Park & Peterson, 2011). Throughout the lifespan, meaning may foster a sense of self-worth, helps create ways to justify actions and provides a sense of efficacy or control (Compton, 2005). Living a meaningful life embodies doing well, not only for oneself, but also for significant others; thus, altruism or prosocial behaviour (Compton & Hoffman, 2013; Kahne & Spote, 2008), which refers to any behaviour that has a positive impact on other people (Coon & Mitterer, 2010; Lewicka, 2005; Scannell & Gilford, 2010).

Drawing from Adler's theory of optimal mental health, an altruistic individual tends to have social interests, empathy with the human condition and an intimate interpersonal relationship with humanity (Lenzi et al., 2013; Ryckman, 2008). Adolescent males who are prosocial and experience meaning in life are more likely to spread goodwill, develop skills that build their schools or organisations, make constructive rather than destructive criticism and take actions that protect their schools from harm and danger (Caprara et al., 2014; Kassin, Fein, & Markus, 2011). Often, their selfless efforts contribute to personal growth and

make them feel healthier and happier. When performing acts of goodwill such as volunteering in guiding youth from committing crime and engaging in other anti-social acts, their respective communities tend to commend them and, in turn, this enhances their self-esteem (Becker & Eagly, 2004; Gilbert, 2012; Olino, Klein, Lewinsohn, Rohde, & Seeley, 2008; Steinberg, 2010; Veenhoven, 2011).

Accomplishment: Accomplishment refers to mastery of the environment, a sense of competence, the positive results for achieving desired goals and it is associated with fulfilling one's potential, skills, talents or strengths (Seligman, 2011; Wang & Eccles, 2012). Accomplishment is the outcome of living well, experiencing inner peace, appreciating life and pursuing virtues and strengths that enhance the self. For humanistic psychologists, accomplishment connotes flourishing because of self-actualisation (Compton & Hoffman, 2013; Howell, Keyes, & Passmore, 2013).

The PERMA model of Seligman described above is one of the most recent theoretical frameworks explicating psychological well-being and is in the process of being operationalised and researched. In the next section, the Values in Action (VIA) classification of character strengths and virtues, which are being valued across many cultures because of their significance (Peterson & Seligman, 2004; Van Eeden, Wissing, Dreyer, Park, & Peterson, 2008), will be discussed.

Character Strengths

Character strengths can be defined as unique positive traits reflected in an individual's psychological, behavioural and affective domains and further described as psychological ingredients, processes and mechanisms that define ones virtues (Khumalo, Wissing, & Temane, 2008; Peterson & Seligman, 2004). The character strengths begin to develop in early childhood and are inclined towards morality (Berkowitz, 2002; Dahlsgaard, 2005). This means that the adolescent's criteria for judgement shifts from self-oriented concerns to more

socially-oriented concerns (Seligman, Ernst, Gillham, Reivich, & Linkins, 2009; Sin & Lyubomirsky, 2009). Virtues, as habits of good behaviour and embedded within a cultural context and community, may serve as sources of human strength and resilience, and contribute to a sense of meaning and purpose in life (Compton & Hoffman, 2013; Giannopoulos & Vella-Brodrick, 2011). The most frequently reported virtues among nearly all nations are kindness, fairness, authenticity, gratitude, and open-mindedness (Park & Peterson, 2006; Proctor, Maltby, & Linley, 2011). According to the Value In Action (VIA) classification of character strengths and virtues by Peterson and Seligman (2004), individuals' well-being may be manifested through six virtues, namely wisdom; courage; humanity; justice; temperance; and transcendence and the related strengths of each of these virtues.

The six virtues and their relevant character strengths as conceptualised by Peterson and Seligman (2004) will briefly be discussed below.

Wisdom: Wisdom refers to a unique, positive result of developmental processes, of opinions or information, and implies knowledge that is social, interpersonal and psychological (Compton & Hoffman, 2013). Wisdom is a combination of intelligence, reasoning, creativity and open-mindedness (Helson & Srivastava, 2001). Louw and Louw (2007) state that wisdom is not the strength of older people only and that younger people, even youth, who have had certain life experiences and learned from coping with them could have pragmatic wisdom. The character strengths implied in wisdom are curiosity, love of learning, open-mindedness, creativity and perspective (Park & Petersen, 2006).

Courage: In optimal theories, courage is described as a quality necessary to sustain personal growth and has four dimensions: (1) wilfulness and intentionality, (2) mindful deliberation, (3) objective substantial risk, and (4) "a noble or worthy end" (Compton & Hoffman, 2013, p. 224). The character strengths involved in courage are valour, industry, integrity and

enthusiasm. Courage strengths seem to be corrective in nature and involve acts of will (Peterson, 2007). According to Eccles (2009), adolescent males who are authentic (able to recognise and take responsibility for their own actions) are more inclined to pursue their goals with zest, hope and positive energy. Such youth tend to approach tasks presented to them with increased self-esteem and cheerfulness as opposed to adolescents who are depressed as a result of lacking encouragement from their social context.

With reference to bravery as a character strength in adolescence, Peacock and Theron (2007) found that violence which erupts in impoverished social settings may have a negative psychological impact on adolescent males. By belonging to gangs, adolescent males may attempt to develop characteristics which conform to their environment in order to avoid being labelled as “sissy”, even when faced with danger. According to Markstrom, Li, Blackshire, and Wilfong (2005), perseverance refers to an ability that adolescents should have to recognise their volition regarding where to invest their energy and the desire to live a meaningful life with attainable goals. A lack of perseverance could be observed in adolescents making uninformed or impulsive decisions and being vulnerable to peer influence leading to substance abuse and practising unsafe sex.

Humanity: Humanity refers to a state of being kind, capable to give and receive love, encouraging the individual’s potential to flourish (Gander, Proyer, Ruch, & Wyss, 2012; Littman-Ovadia & Lavy, 2012). It incorporates the following strengths, namely kindness, love and social intelligence. Humanity strengths contribute to emotional well-being in individuals through relatedness on a person-to-person level (Peterson, 2007). Kindness refers to the ability to do good deeds to others and may manifest in showing generosity, compassion and love. Love means valuing intimate relations with significant others (e.g. love between teammates, friends, children and parents) and from a psychoanalytic viewpoint, love may entail feelings, behaviours, attitudes and motivation of a specific nature (Barnes & Stenberg,

1997; Kahne & Sporte, 2008; Manzo & Perkins, 2006). Peterson and Seligman (2004) described social intelligence in the form of one's relationship with other people and it includes group membership, persuasion, trust and political power. Through group membership, Singh and Srivastava (2008) and Wood and Giles-Corti (2008) found that adolescent males may show signs of mutual affection, cooperation and increased cohesiveness to their peers. According to Compton and Hoffman (2013), such responses are attributable to loyalty, warmth and emotional support.

Justice: Strengths of justice are the fourth cluster of virtues and are considered as broadly personal and important for positive interactions between individuals and their community members. These strengths consist of fairness, teamwork and leadership (Peterson & Seligman, 2004), are social in nature and underpin the individual's well-being in his/her community context (Flanegan, Syvertsen, & Stout, 2007; Peterson, 2007). Fairness refers to the degree to which an individual treats all people in the same way. To succeed in being fair, means letting neither subjective feelings nor decisions take control. Teamwork means being part of or member of the group, sharing the same responsibility and the same obligations (Peterson & Seligman, 2004; Scannell & Gilford, 2010). Leadership refers to the provision of clear direction, guidance and specific feedback to others (Compton & Hoffman, 2013), and the possession of qualities that foster an orientation toward influencing and helping others toward collective success (Flanegan, Syvertsen, & Stout, 2007; Peterson & Seligman, 2004). These strengths of justice are often displayed by youth in the South African context, where youth are involved and take the lead in political rallies and demonstrations for human rights and/or public services.

Temperance: Temperance is defined in terms of what an individual refrains from doing (Peterson & Seligman, 2004), and its strengths are protective in nature and guard against harm to self and others (Peterson, 2007; Vohs, Finkenauer, & Baumeister, 2011). According

to Compton and Hoffman (2013), temperance strengths encompass forgiveness, prudence, modesty and self-regulation. By forgiveness, Compton and Hoffman refer to the willingness to abandon one's right to resentment, negative judgement and indifferent behaviour toward the person who unjustly hurt him/her or others, while fostering qualities of compassion, generosity and unconditional love. Park et al. (2004) described prudence as saving for the future, careful planning for unexpected and expected contingencies and avoiding situations known to have led to uninformed decisions and irrational thoughts in the past. Modesty, as described by Peterson and Seligman (2004), occurs when one is humble and regards oneself as fortunate to be in a position where something good has happened to oneself. Finally, self-regulation refers to the capacity to control one's emotions and an exertion of self-discipline to pursue one's goals (Kheswa, 2006; Peterson & Seligman, 2004).

One would expect strengths of temperance to be underdeveloped in youth and yet Park and Peterson (2006) found prudence in youth associated with fewer externalising behavioural problems; Dahlsgaard (2005) found prudence in youth associated with popularity.

Transcendence: Transcendence refers to allowing oneself to establish positive connections with others; and thereby provide meaning to their lives (Buschor, Proyer, & Ruch, 2013; Peterson & Seligman, 2004). Transcendence strengths are connective in nature and contribute to a sense of meaning and to spiritual well-being (Peterson, 2007; Ruch, Proyer, & Weber, 2010). According to Compton (2005), religiousness or spiritual well-being can instil a sense of hope, creates a new identity and discourages unhealthy lifestyles such as alcohol and drug abuse in adolescents. According to African-centred psychology, spirituality is an integral, indispensable element of daily existence and a vital force that connects individuals to the rhythms of the universe, ancestors and the community (Wheeler et al., 2002) Transcendent functioning in any individual manifests as clear focus on the self and relationships, intense involvement in an experience, strong intentions to complete a task, and spontaneous

expression of personal power (Compton & Hoffman, 2013; Shryack, Steger, Krueger, & Kallie, 2010). When faced with adversity or disappointment, transcendent youth do not give up easily; instead they tend to be cheerful and able to sustain good attitude and mood (Peterson & Seligman, 2004), as they have a sense of hope and well-being (Compton & Hoffman, 2013). Drawing from hope theory, adolescents who are hopeful tend to be flexible enough to find alternative pathways to reach their desired goals and are inclined to feel more positive emotions owing to their cognitive, emotional and motivational stance toward the future (Peterson, Park, Pole, D' Andrea, & Seligman, 2008; Rand & Cheavans, 2009).

Character strengths are measured by means of the VIA-IS for adults (Peterson & Seligman, 2004) and the VIA-IS for youth (Park & Peterson, 2006). Numerous studies have found that the strengths of zest, hope, love and gratitude are strongly associated with well-being across all age groups (Buschor et al., 2013; Carr, 2011; Scannell & Gilford, 2010; Walker-Williams, van Eeden & Van der Merwe, 2013). A model of optimal mental health will be described next.

The Model of Positive Mental Health

According to Keyes and Lopez (2005), a state of complete mental health implies both the absence of mental illness as well as the presence of high levels of mental wellness manifested in the intra- and interpersonal domains of emotional, psychological and social functioning of the individual. Furthermore, Keyes (2006, 2009) indicated that well-being has a hedonic component that is associated with feeling good, as well as a eudaimonic component that is equated to functioning well. Keyes and Lopez (2005) also identified two clusters of symptoms that describe the experience of optimal well-being, namely; emotional vitality (emotional well-being-hedonia) and positive functioning (psychological and social well-being - eudaimonia). An integration of these conceptualisations of positive mental health came

about in operationalising these constructs by the Mental Health Continuum (Keyes, 2006) that assesses:

- Emotional well-being when a person has emotional vitality, is happy and satisfied with his/her life and has predominantly positive emotional experiences;
- Psychological well-being when Ryff's (1989) six dimensions of psychological health are manifested, namely self-acceptance, autonomy, personal growth, purpose in life, positive relations with others and environmental mastery;
- Social well-being when a person has goodwill towards others (social acceptance); when there is a belief that society can become a better place (social actualisation); when social contribution is made to achieve the former; when a person experiences social coherence or feels that society makes sense; and when a person feels a part of the community (social integration), with mutual support and communality (Keyes, 2005, 2006).

Keyes and Lopez (2002) introduced a classification system with a fourfold typology of mental health functioning, indicating:

- People flourish when they experience mostly positive emotions, happiness and overall satisfaction with their lives; when they are functioning well and are free from recent mental illness. Flourishing is seen as complete mental health and has been linked to good physical health (Keyes, 2002, 2005, 2007);
- People are struggling when they exhibit both high levels of wellness and mental ill-being, or moderate to high emotional, psychological and social well-being as well as elevated symptoms of mental distress (Keyes & Lopez, 2005);
- People are floundering when they experience low well-being, but elevated mental illness symptoms. Floundering is seen as a state of complete mental illness (Keyes & Lopez, 2005);

- People are languishing when they exhibit low levels of both well-being and ill-being, or a lack of severe mental health problems, but equally a lack of being emotionally, psychologically and socially healthy. Keyes (2002) terms languishing as a “life of quiet despair” (p. 607).

Of particular relevance to this study, is the research of Keyes (2006) on the prevalence of mental health of adolescents in the USA. Flourishing was found to be prominent in the 12-14 years age groups of youth, while adolescents from 15–18 years showed mostly moderate mental health. This brought Keyes to question the findings of Lewinsohn, Hops, Roberts, Seeley and Andrews (1993), amongst others, that about 20% of youth experience a mental illness by the age of 18. He found it dubious to assume complete mental health in the other 80% of adolescents. Keyes also importantly found that as mental health indicators in the youth increased, depressive symptoms decreased. Furthermore, a positive correlational pattern was found between mental health and positive psychosocial functioning (self-determination, school integration, self-concept and closeness to others). A negative correlational pattern occurred between mental health aspects and conduct problems (amongst others, risk behaviours). These findings indicate the importance of promoting mental health and psychosocial well-being in youth to enable them to cope with the challenges they face, also those relating to their sexuality and sexual behaviour.

In this study, the Mental Health Continuum was used as a measure of the psychosocial well-being of youth participating in the research.

In the preceding discussion, various theoretical frameworks and models of psychological well-being were introduced. These conceptualisations of the psychological well-being construct have been selected for consideration in this overview with full acknowledgement that they are not the only ones that could have been considered and that there are many other equally applicable models and frameworks available that, for the sake of

space, had been left out. It is interesting to note that Seligman (2011) describes well-being as a construct which has several measurable elements, each contributing to well-being, but none defining well-being. In this vein, the preceding discussion explored certain elements contributing to psychological well-being and although these elements are even measurable, no one exhaustively defines the whole construct.

In this study, the emphasis is on the psychosocial well-being of the youth studied. Psychosocial refers to the relationship between people's psychological aspects (thoughts, emotions and behaviour, etc.) and the social features (relationships, traditions, culture and workplace) in their lives. These psychological and social components are in constant interaction in all life contexts and thus manifest as psychosocial well-being (INNE, 2011; Reber & Reber, 2001).

In the discussion of the theoretical frameworks or models of psychological well-being given above, it was obvious that not one of the models was without a social aspect in the conceptualisation of mental health and well-being. Thus, no person could be psychologically well without integrated experiences of psychological aspects within healthy social contexts (Koen, 2012), or without having life experiences containing psychological and social well-being features in equal measures (Keyes, 2006; Reber & Reber, 2001). Linley and Joseph (2004) succinctly stated that "implicit within the concept of psychological well-being, is its location in the context of the individual within community and culture, rather than the individual in isolation. Thus, psychological well-being as we understand it "is concerned as much with collective well-being as it is with individual well-being" (p. 721).

5.2 Contextual Factors Promoting Psychosocial Well-being in Youth

As argued above, psychosocial well-being is the preferred concept for this study of youth in a collective African culture and it implies an extension of psychological well-being to include interpersonal and socio-cultural functioning in the concept of optimal mental and

physical wellness. In this regard, Weiten (2011) stated that psychosocial well-being in adolescence refers to identity formation and self-awareness with regard to sexual, moral and psychological development within a specific socio-cultural context. A wellness-enabling socio-cultural context would feature the following, amongst other factors:

Home or Family Life, Attachment and the Adolescent-Parent Relationship

According to Compton and Hoffman (2013), a healthy home or family is an institution that is characterised by commitment to the psychological, emotional and social well-being of its members through encouragement of individual autonomy and responsibility. Peterson and Chang (2003) found that when there are respectful patterns of communication among all family members, religious orientation and clear household rules and boundaries between adolescents and parents, an authoritative rather than authoritarian or permissive parenting style may produce adolescents who are resilient and flexible against adverse events. Furthermore, having quality ties with family members is an essential feature of what it means to be mentally and physically well as an adolescent (Khumalo, Wissing, & Temane, 2011). For adolescent males in particular, Compton (2005) found that households with good structure and discipline, a male role model, and encouragement of emotional responsiveness, contribute to their resilience. In contrast, when parents are involved in criminal acts or are abusive, have disordered family communication patterns, are poor, live in stressful and drug-friendly environments; the psychosocial well-being of adolescent males may be distorted (Coon & Miterrer, 2010).

The term ‘attachment’ refers to the strong emotional bond that develops between children and their primary caregivers (i.e. parents) (Bee & Boyd, 2003) and once formed early in life and maintained throughout childhood, it may contribute to life satisfaction in adulthood (Armstrong, England, & Forgy, 2012; Bowlby, 1969). According to Catalano et al. (2004), healthy bonding to caregivers may predispose adolescent males for the following

psychosocial well-being-related strengths, namely social, emotional, cognitive, behavioural and moral competence; self-efficacy; self-determination and positive identity formation; spirituality; beliefs in the future; prosocial norms; and involvement. The most widely used typology of attachment is that developed by Mary Ainsworth, as referred to by Louw and Louw (2007). The most prominent three types of attachment are secure, avoidant and ambivalent attachment (Engler, 2009).

- According to Weiten (2010), secure attachment is characterised by unconditional support and love that is invested by parents in their relationships with their sons. Such relationships may facilitate leadership qualities and positive well-being in youth (Louw & Louw, 2007), as reflected by characteristics of self-esteem, emotional adjustment and physical health (Catalano et al., 2004). Adolescent males reared in family settings where parents provide secure attachment are reported to maintain such secure relationships with significant others; being warm, outgoing and attentive to others, kind, easy going (i.e. affectothymia) and resilient (i.e. to positively function after experiencing adversity) (Schultz & Schultz, 2009). A longitudinal study conducted in South Africa showed that the ability of adolescent males to develop autonomy and simultaneously maintain attachment bonds with their parents, encourage the development of successful relationships with peers and partners (Louw & Louw, 2007). A study about adolescents' experience of the parent-adolescent relationship by Koen (2009), found that secure attachment was significantly related to positive parent-adolescent communication and to family satisfaction as experienced by adolescents. Parent-adolescent relationship satisfaction was closely related to the attachment experience within families and these were found to be a predictor of emotional well-being in adolescents.
- Avoidant and ambivalent attachments have been associated with emotional and social insecurity, relational incompetence due to lack of social skills and a host of behavioural challenges and adaptive difficulties (Carr, 2011; Schultz & Schultz, 2009). In Koen's

study mentioned above, attachment anger or emotional detachment from parents was the strongest predictor of emotional distress in youth in South Africa (Koen, 2009). Also, in a 2012 study on psychosocial well-being of families in South Africa, Koen found that from a large group of adolescents ($N = 772$), only 36% reported experiencing their families as psychosocially well. An alarming percentage (64%) indicated that they were not experiencing optimal psychosocial wellness in their families and these findings were in line with an in-depth study by Holborn and Eddy (2011) about the extent of family breakdown in South Africa. Prominent factors contributing to this situation were described before in this literature study and include divorce and the resulting single parenthood and fatherless homes, orphan hood, homelessness and child-headed households. Poverty, child abuse, family violence and delinquency are further risk-laden factors that negatively impact the psychosocial well-being of youth in South Africa.

Education and Healthy Schools

According to the National School Climate Council (2007), a healthy school should embody learners with the zeal to acquire knowledge, skills and values from the educators; school personnel are to ensure that a climate conducive towards teaching and learning prevails; and responsible parents are to support their children financially, emotionally and psychologically. Rueger, Malecki, and Demarey (2010) asserted that schools should have value-oriented programmes aimed at promoting morality, the inner peace of the adolescents as well as honesty and autonomy and respect for others' human rights. Basson (2008) was of the opinion that educators should act as role models, sources of support, and provide positive feedback to unleash the potential of every learner, while the South African Council of Educators' (SACE) Code of Conduct called for educators to exercise authority with compassion, avoid physical and psychological abuse, and refrain from any form of sexual harassment of learners. According to the theories of social and cultural capital (Brooks, Van

Noy, & McKenzie, 2010), when the social networks and information channels are open between parents, the School Governing Body (SGB) and the educators, and the value systems as well as the social norms are shared; there is a likelihood that adolescent learners may develop positive attitudes toward their studies and pursue tertiary education.

However, Suldo, McMahan, Chappel, and Loker (2012) suggested that schools which are characterised by violence could be a place of misery and shame for adolescent males who may be bullied and victimised by delinquent peers to engage in risk activities such as experimentation with sex, alcohol and drugs. For fear of being ridiculed, such youth may develop defence mechanisms such as suppression, by not reporting the atrocities done to them to their educators and parents, resulting in their academic performance deteriorating because of preoccupation with their experienced anxiety, and being unable to concentrate and actively participate during lessons. Furthermore, the outcomes of stressful experiences by such youth may include externalising behaviours such as aggression, disturbance in sleep patterns, conflicts and break-up of romantic relationships because of their inability to cope (Bach & Louw, 2010; Donald et al., 2010; Mume, Olawale, & Osundina, 2011; Zimmer-Gembeck & Skinner, 2008). Other common symptoms to be noticed among adolescent males with an inability to cope with adversity experienced in the school situation, may include regression, social withdrawal and loss of appetite (Ngqela & Lewis, 2012).

Constructive Peer Relationships

Drawing from group socialization theory which proposes that the most influential environmental factor in shaping the personality of an adolescent is the peer group (Harris, 1998), it should be borne in mind that during adolescence, despite the enriching relationships and emotional ties that young people may have with their parents and siblings, their need to belong to and make friends with significant others outside the family is inevitable (Bester, 2009). Intimacy with and commitment to friends appear in early adolescence and may

provide protection against risk behaviour such as alcohol consumption and smoking of tobacco, skipping of classes and rebelliousness (Carlo, Knight, McGinley, Zamboanga, & Jarvis, 2010; Joronen, 2005). Healthy peer groups could be determining factors with regard to an adolescent's happiness and emotional well-being (Bester, 2009; Johnston & Krettenauer, 2011) and by spending quality time with such peers, adolescents' positive thinking and setting of realistic future goals could result in the enhancement of their social world, linked with emotional and psychological well-being (Caprara, Steca, Gerbino, Paciolo, & Vecchio, 2005; Kocayoruk, 2010). In other words, virtuous friendship involves emotional concern and compassionate care, while an ability to share personal feelings with a trusted friend could make an adolescent male less likely to engage in risky sexual behaviour due to worry and substance abuse (Compton & Hoffman, 2013).

Irrespective of insecure attachment to parents as a result of divorce, poverty, and/or the inability to provide consistent support to the adolescent, Bester (2009) found that by maintaining constructive peer relationships, adolescent males' self-image can be strong. In the same vein, Rodgers and Rose (2002) found that quality friendship enhances adolescents' self-efficacy regardless of weak cohesion with the family, and in the friendship process their sense of self-worthiness is boosted because of appreciation and unconditional positive regard that they receive. According to Rueger et al. (2010), such youth may learn that friendship is based on reciprocity and it requires trust, equality, consideration and mutual understanding. Drawing from Fredrickson's (2001, 2002, 2003) Broaden and Build theory of positive emotions, Zeman, Cassans, and Adrian (2012) proposed that peers could be perceived as a reliable resource for adolescents' emotional well-being in the following manner: *intellectually*, youth may flourish by studying in groups, developing reasoning and problem-solving skills; *psychologically*, they could become resilient in spite of adversity, being optimistic about the future and learning to cope in their environment; and *socially*, they could be provided with support to acquire physical skills. According to the World Health

Organization (2012), such socially competent youth continue to attend school regularly, take part in extra-curricular activities (e.g. soccer, volleyball) and are likely to grow into happy and confident adults, who in turn contribute meaningfully to the health and well-being of significant others.

Community Safety and Environmental Support

As have been discussed before, adolescents' development is also connected to their social and cultural environments, especially their communities, because those transmit values and attitudes necessary for healthy living (Keyes, 1998; Liebenberg, Ungar, & Van de Vijver, 2012). According to Crone and Dahl (2012), the social environment or "ecology" in which adolescents develop, play a critical role in shaping their behaviour, attitude and sense of the self. For optimal functioning of youth, structures within the community (e.g. churches and non-governmental organisations, NGOs) should take initiatives in implementing programmes to alleviate risk factors such as instability caused by violence, crime, HIV/AIDS, and teenage pregnancy. Ungar (2011) has extensively found that a supportive and enabling socio-cultural ecology is a powerful determinant in the ability of youth to resile from adversity and trauma.

Flowing from the preceding literature study, psychosocial well-being of African male youth can be conceptualised for the purpose of this study, as their emotional, psychological and social well-being (Keyes, 2002), including their self-esteem and coping. These constructs will be discussed in the following section.

5.3 Constructs Used in this Study

In this research study, the sexual values and attitudes, as well as decision-making skills and comfort in communicating about sexual matters of African adolescent males will be investigated, in relation to their psychosocial well-being. Psychosocial well-being is

conceptualised for these purposes as their mental health and well-being, self-esteem and coping strategies, which will be explicated below.

5.3.1 Mental Health and Well-being

As discussed in a preceding section, Keyes (2002) conceptualised a state of complete mental health and well-being as one in which there is emotional, psychological and social well-being.

Emotional Well-being: The impact of positive emotionality can be substantial, ranging from higher well-being to better romantic relationships, improved memory and attention, exhibition of altruism and generosity, more successful careers, the promotion of creativity and better health (Lyubomirsky, King, & Diener, 2005). Fredrickson (2009) found that strong emotional well-being is associated with openness to new experiences, greater cognitive flexibility, and a deeper sense of meaning. Such individuals are comfortable in conveying love, kindness and spending time empowering others with positive experiences. The experience of positive emotions is the fundamental feature of the Broaden-and-build theory of Fredrickson (2002), which posits the ability of positive emotional experiences to broaden one's immediate thought-action repertoires. Such broadening of thought-and-action builds enduring personal resources and leads to personal growth and resilience through adaptive spirals of emotion, cognition and action (Carr, 2011; Fredrickson, 2009). A large body of evidence shows the positive effect of positive emotional experiences on the well-being of youth and salutary outcomes when used in positive youth development (Davidson & McEwen, 2012; Garcia, 2011; Gillham, Reivich, & Shatté, 2002).

According to Coon and Mitterer (2010), individuals who have sound emotional well-being tend to be emotionally mature (i.e. have the ability to manage, perceive and understand their own feelings and impulses and the feelings of others); thus, emotional intelligence.

Emotional intelligence (EI) can be described as the capacity to recognise the meaning of emotions and their relationship with thoughts, and to be able to reason on the basis thereof (Compton, 2005; Mayer & Salovey, 1997). Salovey and Mayer (1990) who pioneered the original model of emotional intelligence proposed that any individual who is emotionally intelligent must have the following five characteristics:

- The ability to accurately recognise what they are feeling when they are feeling it;
- The ability to handle interpersonal relationships;
- The ability to use emotions to motivate oneself (e.g. to guide one's emotions to remain focused and attain one's goals);
- The ability to recognise emotions in others, and ;
- The ability to regulate one's moods, handle stress, and rebound after experiencing an emotional setback.

As mentioned before, emotional well-being as conceptualised by Keyes (2006) refers to emotional vitality, happiness, experiencing mostly positive emotions and being satisfied with one's life in general.

Psychological well-being: This has been fully discussed before as the six components of Ryff's model (1989) that make up eudaimonic wellness.

Social Well-being: The five dimensions of social well-being are: social acceptance; social actualisation; social contribution; social coherence and social integration (Keyes, 1998). Social acceptance refers to the degree to which individuals hold positive attitudes towards others and how they relate to one another. Social actualisation refers to the extent to which individuals believe that their society can become a better place, while social contribution refers to how people believe that their involvement makes a valuable impact on their communities (Zhang, Chen, McCubbin, McCubbin, & Foley, 2011). Social coherence refers to people believing that their society is logical and understandable, while social integration

refers to the degree by which an individual feels that his/her role is important and acknowledged in the community (Compton & Hoffman, 2013; Kumar, 2014). Individuals who show social bonding tend to share their vision and goals and empower others, while taking charge of their lives and thereby enhancing their efficacy (Christens & Peterson, 2012; Zhang et al., 2011). Such individuals implement meaningful changes in their environment and assist where possible to reduce antisocial acts such as crime. This means that through empowerment, a sense of collective efficacy is experienced and there is cooperation amongst all community members (Compton & Hoffman, 2013). Adolescent males who exhibit social wellness may ensure that their surroundings (neighbourhood, school, parks) are secured and safe (Coon & Mitterer, 2010). Piliavin (2003) convincingly indicated that social involvement prevents youth from doing things that are damaging to themselves such as risky sex, drugs, and crime. Pro-social activities such as volunteering can teach youth citizenship, problem-solving, moral reasoning, empathy and to feel good about themselves.

The complete mental health construct of Keyes (2003) was selected for this study based on the fact that it was operationalised with the Mental Health Continuum scale, which was not only being used extensively in research worldwide, but the construct validity for research was also validated in South African research (Keyes, Wissing, Potgieter, Temane, Kruger, & Van Rooy, 2008). Furthermore, the MHC measures complete *psychosocial* well-being, in contrast to most other measures that measure mostly emotional and/or psychological well-being, some including a small segment of interpersonal wellness. No research has been done to investigate mental health and well-being in relation to sexuality aspects of youth.

5.3.2 Self-esteem

Self-esteem has been discussed in the preceding sections of sexuality and sexual behaviour as a strong precursor of various aspects of well-being, while in this paragraph it will be explored from the positive psychology perspective. According to Furr (2005), self-

esteem is related to optimism in the cultural context, and is composed of four features: (1) feeling that one is accepted by significant others; (2) being the recipient of positive evaluations from others; (3) believing that one compares favourably to other people or to one's ideal self; and (4) believing that one can initiate effective action in one's world.

Studies have found that self-esteem is associated with less delinquency, better anger control, more emotional intimacy and satisfaction in relationships, more ability to care for others, and a heightened capacity for creative and productive work (Collins, Haydon, & Hesemeyer, 2007; Compton, 2005; Ryan & Deci, 2000). According to Edwards, Ngcobo, Edwards, and Palavar (2005) and Slater and Tiggemann (2013), self-esteem may be physically related and enhanced through regular exercise and sport. Physical exercise increases assertiveness, confidence, intellectual functioning, sexual satisfaction, memory, and decreases alcohol abuse, depression, hostility, and mental illness symptoms. Haugen, Ommundsen, and Seiler (2013) found that regular exercising such as karate, weight lifting and jogging among adolescent males (in particular) is associated with psychological well-being. For example, a South African study about sport participation and psychosocial well-being by Malebo, Van Eeden, and Wissing (2007) found that sport participation was significantly related to higher levels of positive affect, sense of coherence and self-efficacy beliefs and to lower levels of negative affect, somatic symptoms and pessimistic life orientation, as experienced by a group of African students.

The self-esteem construct was included in this research, since it is the most researched self-related aspect in adolescence. It has also been used in relation to aspects of mental health and well-being and with coping strategies, albeit mostly with pathogenic variables. In this study self-esteem will be associated with salutogenic aspects of mental health and well-being as well as with adaptive coping strategies. No research could be found on self-esteem and sexual values, attitudes, decision-making and communication skills of adolescents.

5.3.3 Coping Strategies

Coping is the term conceptualised by Lazarus and Folkman (1990) as the process to describe how individuals use their cognitive and behavioural efforts to manage emotional and environmental stressors; and adaptive coping involves confronting challenges directly and reasonably in a task-oriented way. Weiten (2011) defines coping as “the active efforts to master, reduce, or tolerate the demands created by stress” (p. 547), and posits that coping is clustered into two broad categories, namely problem-solving and emotive-focused coping. Problem-solving efforts involve active involvement in alleviating stressful circumstances by seeking and utilising advice, assistance and relevant information from peers, educators or parents (Yendork & Somhlaba, 2014). Problem-focused coping enables adolescents to increase their self-esteem and self-regulation to buffer them against risky behaviours, and to respond to traumatic life events (e.g. divorce, death of parents, child abuse, academic failure) with what Martin Seligman called ‘**learned-optimism**’ (Compton, 2005). Adolescents that use problem-focused coping tend to view their lives in more positive terms, even when troubles seem overwhelming. Very often, they broaden their mental focus, explore and seek new experiences for their personal growth (Peterson & Chang, 2003; Rath & Nanda, 2012), and rather than to ruminate, such youth tend to approach the adverse circumstances with hope, positive attitude and fortitude (Jose & Brown, 2008).

Emotion-focused coping involves regulation of one’s thoughts and actions to relieve the emotional impact of stress (Carlo et al., 2012). Emotion-focused coping as an adaptive process to counteract stress, is reported to equip individuals with the self-control of emotions in the midst of challenges by enabling such individuals to comply, manage and remain focused (Skinner & Zimmer-Gembeck, 2009). For example, as compared to adolescent males who employ avoidance strategies in dealing with their problems, Ojala (2013) found that the

emotionally-focused youth do not sit back and do nothing, instead they become optimistic and resilient in their coping actions.

However, Garcia (2011) argued that adolescents are confronted by a wide range of stress-related risks such as depression, suicidal ideation, sexual abuse, HIV/AIDS infection, domestic violence and sibling rivalry as they interact with their peers, educators and family members. Drawing from Bronfenbrenner's (1979) ecological model, adolescent males who are raised in family settings characterised by hardships such as unemployment, divorce and substance abuse may lack coping self-efficacy to complete their schooling; relative to adolescents whose parents can afford to meet their educational needs (Coyle, Nochajski, Maguin, Safyer, DeWit, & McDonald, 2009). For example, in a study conducted by Pretorius (2009) on support systems and coping strategies used by South African children of divorced parents in Cape Town, 46% of adolescent males indicated that divorce of their parents created resentment in them, as well as social maladjustment and attention deficits as their academic performance deteriorated. Levels of aggression, uncooperativeness and conflicts with parents were strong and resulted in maladaptive behaviour such as early sexual intercourse and substance abuse. According to Kerig, Ward, Vanderzee, and Moeddel (2009), another precipitating factor of adolescents' failure to cope with stress could be physical abuse and verbal attacks by parents, especially when under the influence of alcohol. By experiencing parental hostility, such youth may feel powerless, helpless and hopeless, resulting in their negatively coping by leaving home and fending for themselves on the streets (Louw & Louw, 2007).

Religious coping may increase hope, positive emotions, compassion, generativity and optimism, promote personality integration and support healthy lifestyles (e.g. encouraging monogamous relationships and prohibit alcohol consumption) (Compton, 2005). Berg, Choi, Kauer, Nollen, and Ahluwalia (2009) found that adolescents who participate in church

activities report an overall higher emotional well-being as compared to adolescents who do not attend church. This may mean that such youth acquire spiritual skills that equip them to cope with adversities.

Two interesting theories explain the relationship between aspects of personality and the individual's ability to manage stress and cope with the demands posed. Suzanne Kobasa (1979) proposed a personality style that may enable some individuals to cope with life stressors, namely hardiness. Hardiness is a concept used to describe how well mentally and physically an individual reacts to a stressful situation (e.g. traumatic events, sexual exploitation) (Nolen-Hoeksema, 2008). It is defined as the combination of three cognitive factors involved with how individuals interpret their life experiences, namely a sense of control, greater cognitive flexibility, and a sense of commitment (Compton, 2005; Van Dyke, Glenwick, Cecero, & Kim, 2009). Individuals with hardiness are more inclined to take charge of their immediate surroundings and feel confident that they would cope and deactivate the stressful situation (Compton, 2005; Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009). Such individuals do not procrastinate and in coping with the situation, they draw strength from their environment. This approach is what Antonovsky (1987) referred to as General Resistance Resources (GRR), a feature of life orientation based on a sense of coherence, or the beliefs that life is understandable, manageable and meaningful. With a sense of coherence, a person would approach stressful experiences by seeking to comprehend what is involved, how manageable they are with the use of available resources and how to make sense of or find the purpose of what they are encountering (Antonovsky, 1987). Such individuals approach most stressful situations in a task-oriented way and view a particular situation as a catalyst for their personal growth which requires cognitive flexibility. They have a sense of purpose and are often resilient. In the process of solving their crisis, such individuals actively determine the direction that will effect a favourable change by engaging in transformational coping, described by Compton and Hoffman (2013), as that a person

facing a crisis would draw from positive social relationships with committed and reliable individuals in order to perceive the stressful situation as solvable. However, both hardiness and a sense of coherence as personality strengths underpinning sound coping behaviour only develop in early adulthood (Wissing & van Eeden, 2002).

The coping strategies construct was chosen for this study to represent the behavioural component of psychosocial well-being. Whereas mental health and well-being refer to intra- and interpersonal emotions and cognitions, and self-esteem is intrapersonal self-beliefs, the coping strategies dimension relates to coping behaviour. Although coping has been used in sexuality research with youth, it was mostly in a negative behavioural context and no research could be found on coping and sexual values, attitudes, decision making and communication features of youth.

In this study emotional, psychological and social well-being, together with self-esteem and coping behaviour, are the psychosocial variables that will be measured and their relationships with the sexual values and attitudes, decision-making skills and communication competences of African adolescents will be investigated through empirical research.

In the preceding parts of this literature overview adolescent sexuality – its development, risk and protective factors that either adaptively or detrimentally influence it – as well as how youth express their sexuality in sexual behaviour, was discussed. Thereafter conceptualisations of psychosocial well-being were considered and placed in context with adolescent sexual behaviour, in order to engage with the broad research question of this study, namely what is the nature of sexuality and sexual behaviour of African adolescent males and what is the relationship between their sexual behaviour and aspects of their psychosocial well-being? More specifically, the question is posed: What are the relationships between African male adolescents' values and attitudes toward their sexuality, their decision-

making skills and communication competence regarding sexual matters; and their emotional, psychological and social well-being, self-esteem and coping strategies?

In the following section, the research design with which to investigate the above stated question, the aims and objectives of the research, as well as the methods employed in the investigation, will be presented.

6. Research Methodology of this Study

According to de Vos, Strydom, Fouche, and Delport (2011), scientific research must be conducted within a certain paradigm; it must be systematic and the empirical findings must be guided by theory. Theoretical frameworks, in which the results of this study will be embedded, stem from the domains of Social Psychology, Developmental Psychology and Positive Psychology. In this section of the overview of this study, the empirical study will be described, including the general approach, data-collection and analysis methods, the participants and ethical considerations of this research.

6.1 Research Question and Research Design

Informed by the above exposition of literature, the research questions were formulated. The general question asks: What are the relationships between African male adolescents' values and attitudes toward their sexuality, their decision-making skills and communication competence regarding sexual matters and their mental health and well-being, self-esteem and coping strategies?

A research design is a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research (Durrheim, Painter, & Terre Blanche, 2006). In this study, a quantitative, once-off, cross-sectional survey design was implemented. Cross-sectional surveys involve observations of a representative subset of participants at one specific point in time, and may include data collection by questionnaires

and/or questioning the participants about a phenomenon of interest to them (Creswell, 2009). In a cross-sectional study, people from different age, gender, cultural or other demographic variables could be sampled and compared (Leedy & Ormrod, 2005).

6.2 Research Method

Quantitative research was defined by Creswell (2009) as an enquiry or investigation into a social or human phenomenon, based on a theory and composed of variables, measured with numbers and analysed with statistical procedures. It can be used to test and describe relationships and examine the cause-and-effect of relationships. According to Creswell (2005), quantitative research is a formal, objective, systematic process for obtaining quantifiable information about the world, and usually ends with confirmation or disconfirmation of hypotheses that were tested (de Vos et al., 2011). Furthermore, Leedy and Ormrod (2005) assert that quantitative research is deductive in its approach (beginning with hypotheses and drawing logical conclusions from them). Leedy and Ormrod further argue that to achieve objectivity, quantitative researchers must remain detached from the study, in other words, they should not influence the participants with their own personal values, feelings, and experiences by being personally involved.

The advantages of the quantitative method are that the sample is large, randomly selected and measuring instruments are predetermined (de Vos et al., 2011), and both the independent and dependent variables under investigation and the research problem can be stated in very specific and set terms (Neuman, 2000). Disadvantages are that the quantitative approach cannot indicate individual perspectives on a topic and does not allow for detailed descriptions or for identifying variables that have an exceptional influence (Gravetter & Forzano, 2006).

6.3 Research Aims and Participants of the Study

Based on the research question stated above, the aims of the research are:

General Aim

To investigate the relationships between adolescent males' sexual values and attitudes, decision-making and communication skills and their mental health and well-being, self-esteem and coping strategies.

Specific Aims

The specific aims of this study are to:

- investigate how the constructs used in this study are conceptualised in literature;
- determine descriptive statistics for this research group on all the variables measured, including means and standard deviations, reliability indices and correlations between scales;
- identify the correlational and regressional relationships between all latent variables; and
- identify guidelines from the research results that could be built into a proposed sexual education programme for adolescents.

6.4 Participants and Procedure

According to Creswell (2009), the population for a study is defined as individuals in a specific research universe who possess specific characteristics, while the sample is a selected small representation of the population. In this investigation, 552 participants were selected by means of convenience sampling due to the target group that the researcher had in mind, which was African adolescent males. Convenience sampling (also known as *accidental sampling*) makes no pretence of identifying a representative subset of a population. It takes participants that are readily available for the purpose of the study (Leedy & Ormrod, 2005).

The sample was selected from four secondary schools in the Vaal Triangle, Gauteng Province, South Africa. The selected population of learners in these schools was all the adolescent males in Grades 10, 11 and 12 and their age groups ranged from 13 to 21 years. This selection was determined by the research question and aims of this study. A pilot study was also performed with a group of ten participants in order to determine the face validity of the measuring instruments and to make minor adaptations where necessary.

For data collection the four secondary schools were approached with formal letters and asked to participate in the investigation into sexuality and psychosocial wellness of learners. After receiving consent from the schools' principals, the Gauteng Department of Education (Sedibeng West, District 8) and the North-West University (NWU-00032-11-58), letters with detailed information about the research were sent to all parents, asking for written consent for their adolescent males' participation in the study. None of the parents objected. Data was collected in February 2011 and the questionnaires in booklet form were administered in the classrooms of schools, during periods approved by principals and with the help of trained (by the researcher) Life-Orientation educators. During each session the learners were fully informed about the nature of the research, especially the sensitive topics explored by the questions. They were advised about their rights to withdraw at any time and about the voluntary and anonymous principles for their participation. Their assent for participation involved their right to leave before the test administration would start. A number of the learners indeed left the venues under the pretence that they preferred their soccer practice or had transport arrangements to adhere to. Grade 10, 11 and 12 adolescent males present at school that day participated and it took the participants approximately two hours to complete the questionnaires. The participants were free to ask questions if any of the items were unclear, since the questions were in English, the language of tuition at schools. The questionnaires were completed anonymously and treated with confidentiality. Debriefing was offered to participants after completion of the questionnaires and the responses expressed

were mostly about the interesting nature of the questionnaires and how they would like more discussion about the topics.

6.5 Data Collection

For the purposes of this study, validated questionnaires were used as the method of data collection to determine the opinion of a group of African adolescent males towards aspects of their sexuality and psychosocial well-being. The following measuring instruments were used: **For sexuality aspects of adolescent males:** Mathtech Sexuality Questionnaires for Adolescents: Attitude and Value Inventory and Behaviour Inventory by Kirby (1984). **For psychosocial well-being of adolescents:** Mental Health Continuum (MHC: LF) by Keyes (2005); Children's Coping Strategies Checklist (CCSC) by Ayers and Sandler (1999) and the Self-Esteem Scale by Rosenberg (1965). The five scales used in the study will be fully described in the manuscripts reporting on the research results.

The sexuality questionnaires mentioned above were published in the Handbook of Sexuality Related Measures (Davis, Yaber, Bauserman, Schreer, & Davis, 1998) and according to the authors, are available for use in research. The Rosenberg Self-Esteem scale is in the public domain for use in research. Permission for the use of the MHC-LF and the CCSC were obtained from the authors.

In this research study, of the 600 questionnaires received, 552 were used or filled out completely. The reasons for discarding 48 questionnaires might be due to the fact the items were sensitive or complex, that participants experienced some fatigue as completing the questionnaires took approximately two hours while language difficulties or cultural influences could also have played a role.

6.6 Data Analyses

Raw scores from the $N = 552$ questionnaires were electronically captured by a student

assistant who was paid for her services. After the data capturing, an overall scrutiny for errors was done by the study supervisor and the statistical consultant. The computer software package of SPSS 21 was used to analyse data by means of statistical analysis procedures such as determining means, standard deviations, skewness and kurtosis of frequency distributions, and reliability indices (Raykov's rho). Factor analyses with structural equation modelling were done using the Mplus 7-31 system.

6.7 Ethical Principles

This research procedure was approved by the Ethics Committee of North-West University (NWU-00032-11-28) under the following conditions: Parents had to be fully informed and give their written consent, and parents had the right to object at any time without restriction.

The Department of Education and the schools had to approve this procedure; and individual participants had to voluntarily assent to participate and could withdraw at any stage. The researcher also adhered to international ethical principles, such as those stated in the Helsinki Declaration (Burns & Grove, 2005), in order to conduct the research in an ethical manner. The rights of the participants were observed, namely voluntary participation with respect for their dignity, non-maleficence, anonymity and confidentiality (TerreBlanche et al., 2006). All participants were fully informed about the purpose and sensitive nature of the research and were given the opportunity to leave before test administration began. The researcher, assisted by trained educators, attempted to create a friendly and conducive atmosphere in which participants could complete the questionnaires, and debriefing was done by the researcher (a trained teacher) after the procedures. Despite the sensitive nature of the questionnaires, no discomfort was observed or reported; in fact, two principals requested for the research to be extended to other learners and specifically to girls.

7. Possible Contributions of the Study

This study could make the following contributions to the fields of positive psychology, education and other areas of psychology as a broad discipline.

- 1) This study could contribute to empirical knowledge on psychological, emotional and social well-being, self-esteem and coping and symptoms of mental distress amongst African youth within a South African context.
- 2) The results of this study could help youth counsellors, therapists and other practitioners devise interventions aimed at enhancing decision-making and communication skills of male youth in various cultures, with respect to healthy sexuality, sexual values and attitudes and sexual behaviour.
- 3) The findings of this study could serve as a foundation for future research, especially in the understanding of sexual values, health and behaviour and psychosocial well-being of adolescent males in a South African context.
- 4) The promotion of youth health and well-being is viewed as imperative by developing and emerging countries such as South Africa. Therefore, this should be in the forefront of health and socio-economic planning where the policy makers from the Department of Education, and Social Development and Health should take interest in the youth's psychosexual, health and well-being for the purpose of policy decisions and applications (Donald, Lowana, & Moolla, 2014). This could contribute to HIV/AIDS reduction, STDs prevention and the curbing of teenage pregnancies.
- 5) Finally, this study could contribute through the development of an evidence-based psycho-educational programme aimed at promoting healthy sexual behaviour and psychosocial well-being in youth.

8. Research Report Outline

The research results of this study will be reported in the form of three manuscripts intended to be published in scientific subject-related journals, as described by the General Regulation A 14.4.2 of the North-West University. These articles will be styled and formatted according to the American Psychological Association's (APA-6) specifications. The thesis will include:

Chapter 1: Literature overview of the study

Chapter 2:

- Manuscript 1: Sexual values and attitudes, self-esteem and mental health and well-being of African adolescent males.
- Manuscript 2: Aspects of sexual behaviour, coping and mental health and well-being of a group of African adolescent males.
- Manuscript 3: Guidelines for promoting the psychosexual and psychosocial health and well-being of African adolescent males.

Chapter 3: Conclusions, limitations and recommendations.

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CHAPTER TWO

MANUSCRIPTS OF THE STUDY

MANUSCRIPT ONE

**SEXUAL VALUES AND ATTITUDES, SELF-ESTEEM AND
MENTAL HEALTH AND WELL-BEING OF AFRICAN
ADOLESCENT MALES**

Abstract

The general aim of this study was to analyse the relationships between sexual values and attitudes, and self-esteem and mental health and well-being of African adolescent males. Specific aims were to identify best-fitting measurement and structural models through structural equation modelling with the Mplus 7.31 statistical programme; also to determine whether self-esteem is a mediation variable in the relationship between mental health and well-being and sexual values of the participants ($N = 552$), who were between 13 and 21 years old. In a quantitative cross-sectional survey design, validated questionnaires measured sexual values and attitudes (MSQA: AIV), self-esteem (RSES) and mental health and well-being (MHC: LF). Results showed that means and standard deviations corresponded with those in literature; correlations between variables were significant and theoretically expected; and reliability analyses indicated moderate to good internal consistency of scales. The measurement and structural models that were identified and tested met the statistical best-fit criteria. The bootstrap method for mediation effects showed that mental health and well-being had indirect effects via self-esteem (positive and negative) on sexual values and attitudes of the participating youth.

Key terms

Adolescence, mental health and well-being, self-esteem, sexuality, sexual values and attitudes.

In this study the sexual values and attitudes of a group of black adolescent males, their self-esteem and mental health and well-being were investigated, with the aim to determine the statistical relationships between these dimensions of adolescent psychosocial functioning. The purpose of the study was to obtain information about the quality of sexuality of adolescent males and specifically about features of their sexuality in relation to their well-being. Very little such information could be found in literature and the findings that exist are either old, from non-African contexts and do not combine the deeper aspects of sexuality such as values and attitudes with aspects of self-related-, emotional-, psychological- and social well-being, as intended in this study.

Developmental theorists have long identified adolescence, characterised by biological and psychological development, as a crucial period for the adoption of healthy behaviours relating to substance use, sexuality and self-management of mental health (Viner, Ozer, Denny, Marmot, Rsnick, Fatusi, & Currie, 2012). During the period of adolescence, relationships are defined; personal and social behaviours are refined; a clearer sense of self emerges; and the values and attitudes developed are likely to become established patterns of behaviour, making the period of adolescence a prime opportunity for the promotion of health- and well-being-related life choices (Ablorh-Odjidja & Joseph, 2007).

According to Lefrancois (2001), values could be defined as principles that parents or adults from a particular culture instil in youth, such as responsibility, respect, caring, honesty and justice. According to Engler (2009), however, attitude refers to a positive or negative feeling toward an object, person or situation and stems from a complex interaction of beliefs, feelings and values. More conceptually, Allport (1954) stated that attitudes are neuro-psychic states of readiness for mental and physical activity. Recently, Kassim, Fein, and Markus (2014) said that attitudes are positive, negative or mixed reactions to people, objects, situations or ideas, while King (2008) described attitudes as opinions and beliefs about

people, objects or ideas. Values, however, were more broadly viewed by classic theorists such as Allport (1954), and Cooper and McGaugh (1966), as attitudes oriented towards finding value or worth in experiences, as well as life frameworks (frames of reference) that direct behaviour toward the worthy or valuable. A value system is seen as an elaborate and articulated organisation of attitudes (Jahoda & Warren, 1966); thus, never unrelated to the attitude construct (Cooper & McGaugh, 1966).

Adolescence and Sexuality

From literature it is evident that the biological, emotional, psychological, moral, sexual and social changes that characterise adolescence also make of it a vulnerable phase of development, during which personal identity and adequate socialisation must be established (Berger, Karimpour, & Rodkin, 2008; Hopkins, 2010; Pisk, Mihanovic, Silic, Bagovic, & Vidovic, 2012). Louw and Louw (2014) stated that in the process of building their identity and establishing themselves, adolescent males grapple with the question, “**Who am I?**” and may strive to achieve **cognitive autonomy** (i.e. making decisions and assuming responsibility for these choices), **behavioural autonomy** (i.e. making choices regarding friendships, leisure time and finances), **emotional autonomy** (i.e. being self-reliant and independent of their parents and being able to exercise self-control) and **moral or value autonomy** (i.e. forming an own value system that may serve as a guideline for their own behaviour).

The mentioned four aspects of autonomy that characterise healthy identity formation also feature with regard to the adolescent male’s sexuality. Sexuality is an important aspect of an adolescent’s identity formation (Papalia & Feldman, 2012) and it is a dynamic process in which the interaction of biological, social, psychological, spiritual and cultural factors influence personality development, self-esteem and the ability to form quality interpersonal relationships (Connell, Coates, & Wood, 2014). According to Papalia, Olds, and Feldman (2009), sexual identity is formed from seeing oneself as a sexual being, recognising one’s

sexual orientation, understanding sexual stirrings and forming intimate or sexual attachments. Although this process is biologically based, the expression of one's sexuality (sexual identity) is culturally defined.

Intrapersonal or purely psychological variables that may influence the unfolding sexuality and sexual values and attitudes of adolescent males are amongst others, personality, self-esteem, self-regulation and control, self-efficacy, motivational factors, cognition, and coping abilities. These may all serve as protective or risk factors regarding self-defeating sexual choices and behaviour (de Looze, Contantine, Jermane, Vermeulen-Smit, & ter Bogrt, 2015; Schultz & Schultz, 2013).

In this study of the relationships between African adolescents' values and attitudes toward sexuality, their self-esteem and mental health and wellness, sexual values and attitudes were conceptualised from the work of Kirby (2002). In the latter's work, values were regarded as aspects of personal sexual values, personal sexual responses and satisfaction with personal sexuality and attitudes; as beliefs about sexuality in life, the importance of birth control, premarital sexual activity and the use of pressure in sexual activity. Factors that may play a role in adolescent values and attitudes toward sexuality and sexual activity are discussed below.

Adolescent Values and Attitudes

Although fairly open attitudes and values regarding sex and sexuality currently exist, the youth are still experiencing difficulties in making choices and decisions regarding healthy sexual behaviour. Young people are often confused by contradictory messages that they receive from various sources. Louw and Louw (2014) stated that parents and other authority figures discourage sexual activity among youth, but do not provide them with the information and guidance regarding healthy sexual attitudes and behaviour that they need. In fact, research has found that most adolescents do not regard their parents as their main source of

sexual knowledge, but turn to sources such as their peers and the media. The information from these sources is however, often faulty, contain half-truths and cannot provide a sound base on which to build healthy attitudes and values toward sex and sexuality (Louw & Louw, 2014). According to the authors, due to the influence of peers, the media and even the sexual content in popular music, adolescents perceive the world as sexually active and even sexually preoccupied. This may compel them to become prematurely sexually active and engage in behaviour for which they are not emotionally ready. According to Louw et al., other reasons given by South African youth for indulging in sexual activity are seeking physical pleasure, proving to peers that they are normal, proving their love to a partner, and being consumed by passion. Adolescent males mainly become sexually active to prove their normality (virility) because of peer pressure or to seek physical pleasure. According to Oshri, Tubman, and Burnette (2012), male adolescents may use sexual activity for self-soothing and other coping purposes. Kostelecky (2005) found that adolescent males, who were deprived of emotional nurturance and security in childhood, could develop feelings of worthlessness. In an attempt to cope with such feelings of emotional emptiness, they may resort to premature sexual activity, risky sexual practices and multiple sexual partners.

Nevertheless, family values and attitudes towards adolescents' sexuality and specifically toward sexual risky behaviour, violence and alcohol abuse can influence adolescents' sexuality, also developing sexual health and well-being. Parents who involve their children in sex-discussions (birth-control methods, premarital sex) may contribute towards preparing their adolescents for and taking precautions when they engage in sexual activities as compared to uninvolved parents (Viner et al., 2012). According to the World Health Organization (2012), adolescents who experience ease of communication with their parents are likely to report a wide range of positive health outcomes such as self-acceptance, sense of autonomy, purpose in life, positive relations with others and less physiological and psychological distress. In a study to identify mediators of the influence of family factors on

risky sexual behaviour, Simmons, Burt, and Tambling (2013) found that adolescent males, who reported to have emotionally supportive parents, rated sensitivity and similarity of values as more important in intimate relationships than physical attractiveness and sexual compatibility.

However, although there are sex education programmes designed and implemented for youth that often include parents, in African families an open and honest discussion of sexuality with parents or trusted adults is often absent or hindered by numerous factors (personal, cultural, social, religious) (Mturi, 2001; Senanayake & Faulkner, 2003). This leaves many African adolescent males deficient in values, attitudes and knowledge concerning safe sex negotiation, how to handle social pressures to engage in sexual activity, and the motivation to practice protected sex (Kigozi, 2006).

It is of great concern that the lack of role models and uninvolved parents increase adolescents' vulnerability to sexual risk behaviour and exposure to drugs and violence (Greif, Doodoo, & Jayarama, 2011), while this phenomenon may be ascribed to certain socio-cultural attitudes. Wamoyi and Wight (2014) found that among Africans, double standards of masculinity are often being socialised by women who emphasise that extra marital affairs should be accepted, because males wish to experiment in having sex with multiple sexual partners. As far as expressing the unfortunate stereotype about masculine sexuality, Wamoyi and Wight also found that married men would report gaining self-esteem through seducing women to maintain their sexual prowess. Arguably, Kim (2009) concluded that in such cultures adolescent males tend to develop parental habits and live vicariously, because adults have displayed questionable attitudes and values towards sexual relationships. In this regard, the gender role strain theory by Agnew (1985) – which is based on the concept that male sexual behaviours are influenced by cultural norms – could explain why adolescent males often believe that risk taking, alcohol use and violation of the right of their partners are

acceptable expressions of their masculinity. Therefore, they also tend to have casual sexual relationships and do not practice safe sex.

Furthermore, in most African cultures during an initiation period, traditional male circumcision, sexual values and positive lifestyles are inculcated by “*ikhankatha*” (traditional mentors) to enable “*amakrwala*” (newly graduated initiates) to be responsible and have positive relations with significant others (Nyembezi, Ruiters, van den Borne, Sifunda, Funani & Reddy, 2014). Makaula (2010) asserted that initiation schools serve the purpose of being educational; where morals that are expected to be preserved in a post-initiation process are instilled. However, some of *amakrwala* tend to engage in sexually risky-behaviours owing to poor guidance from unprincipled mentors, severe group pressures during initiation and through the myth that traditional male circumcision reduces the risk of HIV infection (Greely, Mahary, Letsoale, & Miti, 2012).

According to Garcia (2011), adolescents are confronted by a wide range of stress-related risks such as depression, suicidal ideation, sexual abuse, HIV/AIDS infection, domestic violence and sibling rivalry, as they interact with their peers, educators and family members. Research in South Africa found that the effects that fathers have on their sons’ cognitive development, intellectual functioning and academic performance are proportional to higher self-esteem, lower levels of risky sexual behaviour and fewer difficulties in forming sexual relationships (Holborn & Eddy, 2011). However, the large numbers of absent fathers in South African black families seem to be a source of psychological distress in youth (Kane-Berman, 2009; Nduna & Jewkes, 2012). The lack of emotional support from fathers may lead adolescent males to seek comfort from intergenerational relationships and be exposed to a variety of social ills, including abuse, prostitution, binge substance use and risky sexual behaviour (Grolnick & Pomerantz, 2009). Biblarz and Stacy (2010) argued that the absence of a father is often related to the extent of poverty, especially in low income families. Such

poverty could account for poor psychological well-being and self-defeating sexual behaviour among adolescent males (Holborn & Eddy, 2011). On the contrary, Adamsons and Johnson (2013) found that the presence of supportive fathers during adolescence could transmit emotional warmth, build sound self-esteem of youth and be a significant predictor of male youth's capacity for empathy, social skills, better peer relationships and behavioural adjustment. Lyons, Giordano, Manning, and Longmore (2011), on the other hand, argued that adolescent males with present fathers perform better at school, are less prone to violence and have higher self-esteem and self-confidence.

Another factor that likely influences adolescent sexuality and the quality thereof is environmental stressors which are often associated with a diminished sense of hope and meaning in youth (Brassai, Piko, & Stegger, 2012). In South Africa which is characterised by socio-economic inequalities, large numbers of African adolescent males grow up in poverty-stricken communities and tend to experience multiple environmental stressors such as drug availability, violence and crime (Mayosi, Flisher, Lalloo, Sitas, Tollman, & Bradshaw, 2009). In Butterworth, in the rural Eastern Cape Province of South Africa, Nduna and Jewkes (2012) found that adolescent males were distressed by undisclosed paternity, financial hardships, child abuse and disinheritance, which contributed greatly towards their languishing mental health. Regarding the link between low well-being and substance abuse, Brook, Rubenstone, Zhang, Morojele, and Brook (2011) found that environmental stressors present norms and role models of alcohol abuse, mobilising youth access to alcohol. Consequently, such youth experience challenges in terms of coping with adversities, encountering both mental (emotional) and physiological dysregulation (McEwan, 2008), while their lack of hope and of meaning may result in sexually aggressive behaviour and social withdrawal as opposed to active coping and relational competence.

A growing body of research indicates that safe schools are linked to health promotion, risk reduction and development of sexual values among adolescents (Cohen, McCabe, Mitchelli, & Pickerali, 2009). In this regard, Brooks, Van Noy, and McKenzie (2009) noted that the social school climate can mitigate negative environmental stressors that may lead to behavioural and academic outcomes. To support this, Kirby, Laris, and Rolleri (2006) in the review of 83 sex-educational programmes implemented in Sub-Saharan African schools (e.g. Tanzania, Uganda), found that a majority of adolescents who received sex-education delayed the onset of sexual activity and had higher levels of self-esteem and self-efficacy. Given that discussing sexual matters openly with adolescents is still regarded as a taboo in many African societies (Klein & Breck, 2010), Iyer and Aggleton (2013) found that schools may have educators who are inadequately trained and lack confidence to address issues of sexuality. Preston (2013) argued that the underlying reason for educators lacking confidence could be imbedded in religion and culture, irrespective of having received in-service training in sexuality education. Consequently, the danger of not instilling sexual values is that adolescent males may become reluctant to visit clinics to obtain contraceptives; they appear to be ignorant about issues of substance abuse; and may contract HIV/AIDS (Morake, 2011; Mothiba & Maputle, 2012).

Contrary to the bleak picture painted above, religion has been described as a protective factor for youth with regard to sexual behaviour, as religion delays the onset of sexual debut, encourages premarital sexual abstinence and relational faithfulness (Barkan, 2006; Eriksson, Lindmark, Axemo, Haddad, & Ahlberg, 2013). Drawing from Jessor's model (1992), religiosity is an indicator of the amount of exposure to influences that discourage pre-marital sexual activity while strengthening the development of sexual values that coincide with abstinence. In the finding of Fehring, Cheever, German, and Philpot (1998), religious affiliation and church attendance were associated with sexual norms and heightened self-esteem among culturally diverse youth.

From the above discussion, one can conclude that caring and involved parent-youth relationships, schools that support and guide youth and religious lifestyles are sources of healthy sexual value and attitude development. However, it would seem that these protective and supportive structures are often lacking in the modern African society where family breakdown and disharmony, absent fathers, socio-economic adversity, crime-related life styles, cultural customs and stereotypes related to masculinity, and a myriad of other societal ills prevail, rendering many adolescents vulnerable, uncertain and devoid of values and attitudes towards healthy and fulfilling sexual realities.

Psychological Variables of the Study

In this study self-esteem and mental health and well-being were the psychological variables investigated in relation to sexual values and attitudes of African adolescent males. These constructs will briefly be discussed.

Self-esteem entails a positive evaluation of oneself and involves feeling worthy, socially accepted and culturally/environmentally competent. According to Neff (2011), adolescent males with high self-esteem often display more happiness, optimism and intrinsic motivation than those with low self-esteem, while Strümpfer, Hardy, de Villiers, and Rigby (2009) posited that youth with self-esteem experience emotional well-being which enables them to function at optimal levels, psychologically and socially. Eiseman, Cove, and Popkin (2005) also found adolescent males with higher self-esteem to be socially competent, have personal characteristics that protect them against stress, and revealing less burnout (emotional exhaustion). High self-esteem thus has the propensity to give male youth the necessary confidence to solve problems adequately, encouraging coping efforts (Thoits, 2013). When adolescent males have high self-esteem, they are likely to utilize effective coping strategies that may protect them from experiencing mental distress (Orth, Robins, & Meier, 2009).

Various scholars documented that there is a linkage between self-esteem and adolescent males' sexual behaviour (Marshall, 2012; Marshall, Marshall, Serran, & O'Brien, 2009; Orth, Robins, & Roberts, 2008) and in this regard, Hewett, Mensch, and Erulkar (2004) stated that adolescents with a low level of self-esteem have a likelihood of engaging in risky sexual behaviour. Owing to low self-esteem, such male youth often tend to express their sexual prowess by being dominant over their sexual partners, being involved with multiple sexual partners, displaying aggressive behaviours and engaging in substance abuse (Jama Shai, Jewkes, Nduna, & Dunkle, 2012). In a study of self-esteem and the effects of poverty among male adolescents in two provinces, namely Limpopo and Eastern Cape, Swartz, Deutsch, Makoae, Michel, Harding, Garzouzie, and Van der Heijden (2012) reported that a high rate of substance use, participation in criminal activities, involvement in transactional sex for economic survival, inter-generational sexual relationships and high school dropout are factors related to low self-esteem and risky sexual behaviour and could be ascribed to divorce, absent fathers and peer pressure. To cope with their emotional inadequacies, Aymer (2008) found that adolescent males with low self-esteem tend to use maladaptive, aggressive and hyper-masculine behaviours as their coping strategies.

In comparison, Brennan and Sullivan-Marx (2012) were of the view that support from quality friends, effective schools and church could enhance adolescent males' self-esteem and afford them the opportunity to learn and practice their social-interaction skills, while Powell (2011) viewed peer acceptance as important for adolescent males' social and emotional development, self-esteem and well-being.

Self-esteem is regarded as a trait associated with adaptive functioning in almost every area of life. Campbell - already in 1990 - indicated self-esteem as a strong predictor of subjective well-being. Studies cited by Compton (2005) have associated self-esteem with social competence, anger control, intimacy and satisfaction in relationships, a caring ability in

relationships, creativity and academic competence. Self-esteem also provides advantages such as a sense of meaning and value, a guide to negotiating interpersonal relationships and is a by-product of personal growth (Deci & Ryan, 2002). In a relational context, self-esteem is described by Jordan and Zeigler-Hill (2013) as relational confidence which suggests one's capability to develop mutually growth fostering relationships which engender confidence in one's connections with others.

However, Louw and Louw (2014) cautioned against the simplistic interpretation of the value of self-esteem in adolescence, since it is known from developmental psychology that self-esteem in adolescence changes and often declines due to developmental challenges and the fact that the developmental domains (competencies) that inform a positive sense of self, are only emerging. As far as sexuality is concerned, Baumeister, Campbell, Krueger, and Vohs (2003) even found that a good self-image may lead to sexual risk taking and early sexual activity due to less inhibition. The authors also found that negative sexual experiences appear to decrease self-esteem in adolescence.

Mental health and well-being, the second psychological feature used in this study, were conceptualised from the work by Keyes. According to Keyes and Lopez (2002, 2005), a state of complete mental health implies both the absence of mental illness as well as the presence of high levels of mental wellness, manifested in the intra- and interpersonal domains of emotional, psychological and social functioning of the individual. Furthermore, Keyes (2006, 2009) indicated that well-being has a hedonic component that is associated with feeling good, as well as a eudaimonic component that is equated to functioning well. Keyes and Lopez (2005) also identified two clusters of symptoms that describe the experience of subjective well-being, namely emotional vitality or feeling good (emotional well-being, life satisfaction, positive emotions) and positive functioning (psychological and social well-being). An integration of these conceptualisations of positive mental health were done in

operationalising these constructs in the Mental Health Continuum (Keyes, 2006); the latter assessing:

- Emotional well-being as when a person has emotional vitality, is happy and satisfied with his/her life and has predominantly positive emotional experiences;
- Psychological well-being as when Ryff's (1989) six dimensions of psychological health are manifested, namely self-acceptance, autonomy, personal growth, purpose in life, positive relations with others and environmental mastery; and
- Social well-being when a person has goodwill towards others (social acceptance); when there is a belief that society can become a better place (social actualisation); when social contribution is made to achieve the former; when a person experiences social coherence or feels that society makes sense; and when a person feels a part of his/her community (social integration) with mutual support and communality (Keyes, 2005, 2006).

Keyes and Lopez (2002) introduced the term 'flourishing' to describe a person who experiences optimal levels of mental health and well-being. They also used the terms moderate mental health and especially languishing to indicate low well-being and low symptoms of mental illness. In their empirical work, they found that flourishing was prominent in the 12-14 years youth age group, while adolescents from 15-18 years showed mostly moderate mental health. This brought Keyes to question the findings of Lewinsohn, Hops, Roberts, Seeley, and Andrews (1993), amongst others, that about 20% of youth experience mental symptoms by the age of 18. Keyes found it dubious to assume complete mental health in the other 80% of adolescents. Keyes (2006) found that as mental health indicators in the youth increased, depressive symptoms and behavioural problems decreased. Furthermore, positive correlations were found between mental health and positive psychosocial functioning (self-determination, school integration, self-concept and closeness to others).

Mental health for adolescents indicates the capacity to contribute to, enjoy and benefit from an emotionally fulfilling family life and other relationships which meet their psychosocial needs and ensure that they have opportunities for personal growth (Patel, Flisher, Hetrick, & McGorry, 2007). Thoits (2013) stated that mental health is influenced by positive self-concept, high self-esteem and appropriate social values which lead to a well-developed, personal, social and sexual identity. Literature has documented that safe and supportive schools, together with quality family bonds and friendships can contribute to adolescent males developing to their full potential and attaining good health in the transition to adulthood (Viner et al., 2012). Furthermore, a positive correlational pattern was found between mental health and positive psychosocial functioning (self-determination, school integration, self-concept and closeness to others), while a negative correlational pattern occurred between mental health aspects and conduct problems (amongst others, risk behaviours). Adolescent males with mental health problems can experience a negative sense of self-worth, a diminished ability to cope at school and in the community, and display poor social skills and physical health (WHO, 2008).

Well-being has been described as a normal positive state of mind that encompasses complete life satisfaction and comprises both cognitive and affective components (Tomy, Norrish, & Cummins, 2011). Related to life satisfaction, Sun and Shek (2012) indicated that there are youth development constructs which could serve as predictors of flourishing in adolescent males, namely *moral competence, behavioural competence, cognitive competence, emotional competence, attachment, bonding, self-efficacy, self-determination, spirituality, clear and positive identity, prosocial norms, prosocial involvement and recognition for positive behaviour*. According to Levin and Currie (2010), such youth development constructs may yield positive outcomes in adulthood provided that parents, educators, church and community members play significant roles in the lives of adolescents. For example, the

school environment that stimulates high levels of social cohesion tends to develop adolescent males with greater likelihood of physical activity and better health outcomes as opposed to risk-taking behaviour (WHO, 2012). Wissing and Temane (2008) noted that in such school environments, male youth may display affective well-being, sound interpersonal relationships with significant others (educators and peers), spiritual wellness, as well as the absence of mental and physical symptoms of distress.

Research on adolescent mental health and sexuality or sexual behaviour has largely focused on mental problems in youth, associated with risk-related sexual activity and other problem areas such as teenage pregnancies, HIV infection or other sexually transmitted diseases. Work in the fields of resilience (Goldstein & Brooks, 2012; Ungar, 2011) and positive youth development (Lerner, Brentana, Dowling, & Anderson, 2002) focused more on strengths and adjustment competencies in youth and the associated positive outcomes thereof, but little research could be found on positive mental health or psychological well-being and healthy adolescent sexuality and the values and attitudes pertaining to it. Such dearth of research on positive sexuality in adolescence brings into perspective the value of a study such as this one.

In the above discussion, adolescent values and attitudes and the role of self-esteem that may guide sexuality were presented. Furthermore, mental health and well-being - based on the work by Keyes (2007) that indicated whether adolescent males flourish or languish - were discussed. The research question that underpinned the above discussion and that will be investigated in this research is: What are the relationships between sexual values and attitudes, self-esteem and mental health and well-being of a group of African adolescent males?

RESEARCH METHOD

A research method serves the purpose of providing specific direction for procedures used in a research study (Creswell, 2009). In this section the research design, aims of this study, participants involved, research procedures, ethical considerations, data collection and data analysis methods, will be discussed.

Research Design

In this research study, a quantitative research design as an enquiry or investigation into a psychosocial phenomenon was employed, to determine the statistical relationships between sexual values and attitudes, self-esteem, and mental health and well-being of a group of African adolescent males. More specifically, a cross-sectional survey design was used to collect data on the sexual attitudes and values, self-esteem and mental health and well-being of African adolescent males. A survey design describes and generalises from a sample the attitudes or opinions of a population, in order for inferences to be made in a numeric way about some characteristics about that population (Creswell, 2009).

Aims of the Study

The **general aim** of the study was to investigate the relations between sexual values and attitudes, self-esteem and mental health of African male adolescents in South Africa.

The **specific aims** were to study relationships and the directions thereof between the measured aspects of sexual values and attitudes, self-esteem and mental health and well-being of the participants in this study, by means of structured equation modelling; and to investigate whether self-esteem (RSES) mediates the relationships between mental health (MHC) and sexual values and attitudes of participants (MSQA: AVI).

Participants

A convenience sample (Maree, 2010) was selected from four secondary schools in the Vaal Triangle Area, Gauteng Province, South Africa, where the researcher resides. The selected population of learners in these schools included all the adolescent males in Grades 10 and 11; their age groups ranging from 14 to 21 years. This selection was determined by the research question and aims of this study. A pilot study was also performed with a group of ten participants in order to determine the face validity of the measuring instruments and to make minor adaptations where necessary. Table 1 shows the composition of the research group in this study.

Table 1

Characteristics of the Participants (N = 552)

| GROUPS | N | % |
|---------------------------|-----|------|
| School Status: | | |
| Grade 10 | 292 | 52.9 |
| Grade 11 | 260 | 47.1 |
| Age: | | |
| 14 years | 7 | 1.3 |
| 15 years | 51 | 9.3 |
| 16 years | 126 | 22.9 |
| 17 years | 154 | 27.9 |
| 18 years | 122 | 22.1 |
| 19 years | 67 | 12.2 |
| 20 years | 17 | 3.1 |
| 21 years | 7 | 1.3 |
| Religion: | | |
| Christian | 363 | 65.9 |
| Muslim | 4 | 0.7 |
| Hindu | 0 | 0.0 |
| None | 109 | 19.8 |
| Other | 74 | 13.4 |
| Parents' personal status: | | |
| Mother alive | 439 | 79.7 |
| Mother deceased | 109 | 19.8 |
| Father alive | 394 | 71.5 |
| Father deceased | 152 | 27.6 |
| Parents' marital status: | | |
| Married | 182 | 33 |
| Divorced | 115 | 20.8 |
| Living together | 59 | 10.7 |

Note: Not all participants provided their complete biographical information

Of the 552 learners that participated in the research study, 292 were in Grade 10 and 47.1% ($n = 260$) were in Grade 11. The majority of participants or 79.7% ($n = 439$) indicated that their mothers were alive, and a large group of 71.5 % ($n = 394$) of these African youth

males indicated that their fathers were alive. As far as religious affiliation was concerned, 65.9% ($n = 363$) of the participants indicated to be Christians, 0.7% ($n = 4$) followed the Muslim religion, with 13.4% ($n = 74$) belonging to other religious affiliations, and 19.4% ($n = 109$) indicated that they did not belong to any religious group. Finally, the learners were asked to respond to parents' marital status and 33% ($n = 182$) indicated that their parents were legally married as opposed to 20.8% ($n = 115$) whose parents were divorced and 10.7% ($n = 59$) indicated that their parents live together.

Research Procedures and Ethical Considerations

Four secondary schools were approached with formal letters in which they were asked to participate in the investigation into sexual values, attitudes and mental health of adolescent male learners. After receiving consent from the schools' principals and the Gauteng Department of Education (Sedibeng West, District 8), letters containing detailed information about the research and the ethical principles guiding the research were sent to all parents asking for written consent for their adolescent males' participation in the study. None of the parents objected. The research was also approved by the North-West University Research Ethics Committee (NWU-00032-11-58).

Data was collected in February 2011 and the questionnaires in booklet form were disseminated in the classrooms of schools with the help of trained (by the researcher) Life-Orientation educators during periods approved by the principal. During each session, the learners were fully informed about the nature of the research, especially the sensitive topics explored by the questions. They were advised about their rights to withdraw at any time and about the voluntary and anonymous principles for their participation. Their assent for participation involved their right to leave before the test administration would start and a number of the learners indeed left the venues indicating that they preferred their soccer practice or had transport problems. It took the participants approximately two hours to

complete the questionnaires, while they were free to ask questions if any of the items were unclear, since the questions were in English, the language of tuition at schools.

The questionnaires were completed anonymously and treated with confidentiality. Debriefing by the researcher who is also a trained teacher, was offered to participants after completion of the questionnaires and the responses expressed were mostly about the interesting nature of the questionnaires and how they would like more discussion about the topics.

Data Collection

The measuring instruments used in this study for data collection purposes are discussed below.

The *Mathtech Sexuality Questionnaires for Adolescents: Attitude and Value Inventory (MSQA: AVI; Kirby, 1984)* contain questions in three areas of sexuality, namely knowledge, attitudes and values, and behaviour. These scales were intended to measure attitudes, values, skills and behaviour of adolescents that either lead to positive and fulfilling sexuality or reduce unwanted pregnancy among adolescents (Kirby, 1984). The sub-scales use a Likert-style response with four response options varying from 1 (*strongly disagree*) to 4 (*strongly agree*).

The dimensions included in the 70-item Attitude and Value Inventory are the following: Clarity of long-term goals; *clarity of personal sexual values*; understanding of emotional needs; understanding of personal social behaviour; *understanding of personal sexual responses*; attitude toward various gender role behaviours; *attitude toward sexuality in life*; *attitude toward the importance of birth control*; *attitude toward premarital intercourse*; *attitude toward the use of pressure and force in sexual activity*; recognition of the importance of the family; self-esteem; *satisfaction with personal sexuality*; and satisfaction with social relationships. In this study selected sub-scales (those in italics above) of the inventory for

attitudes and values were used. Item examples are “I am very happy with my friendships”, “birth control is not very important” and “I have a good understanding of my own feelings and reactions”. Higher scores represent more favourable values and attitudes.

The subscales of the Attitude and Value Inventory had Cronbach alpha scores ranging between 0.58 and 0.94 (Kirby, 1984). Using Kirby’s Mathtech Sexuality Questionnaires for Adolescents (attitude, values and behaviour), Tobey, Hillman, Anagurthi, and Somers (2011) found that the Cronbach alpha coefficient for adolescent males was 0.89 and 0.88 for adolescent females. In South African research using these questionnaires, Musarugwa’s (2001) research study was conducted at a school in Maokeng, Kroonstad, Free-State Province, to investigate adolescents’ attitudes and values towards sexual behaviour.

Permission for use of the MSQA inventory was found in the publications of Kirby (1984) and Davis, Yarber, Bauserman, Schreer, and Davis (1998).

Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The self-esteem measure consists of ten items with five measuring positive self-esteem and five measuring negative self-esteem; it is a measure which has been frequently used and validated. There is a 4-point agreement-disagreement Likert-response format for all the items in which the participants’ responses range from 4 (*strongly agree*) to 1 (*strongly disagree*). The examples of items on the RSES include statements such as “I feel that I have a number of good qualities” and “I certainly feel useless at times”. The RSES has high reliability with test-retest correlations in the range of 0.82 to 0.88 and Cronbach alpha coefficients for various samples are in the range of 0.77 to 0.88 (Rosenberg, 1965). Reliability (internal consistency) for black South Africans has been found to range between 0.78 and 0.92 (Westaway, Rheeder, van Zyl, & Golele, 2000). Another South African study that used the RSES was by Walker-Williams, van Eeden and van der Merwe (2012), with a Cronbach alpha of 0.85. The RSES is in the open domain for use in research.

Mental Health Continuum (MHC: LF; Keyes, 2005). Keyes' MHC scale with 39 items measures a person's degree of emotional or subjective well-being; psychological well-being as described in Ryff's model (Salam-Younes, 2011); and social well-being as conceptualised by Keyes (1998). Emotional well-being is firstly measured by six items that enquire, on a five-point scale, how much of the time during the past 30 days an individual felt cheerful, in good spirits, extremely happy, calm and peaceful, satisfied and full of life. The second component is a single item that asks: 'Using a scale from 0 to 10, where 0 means "the worst possible life overall" and 10 means "the best possible life overall", how would you rate your life overall these days?'

The second section of the questionnaire contains 18-items from Ryff's (2001) and Ryff and Keyes's (1995) psychological well-being measure, divided into the following six subscales, each represented by three items, namely self-acceptance, positive relations, personal growth, purpose in life, environmental mastery, and autonomy. The third section contains Keyes's (1998) 15-item measure of social well-being, which operationalises how much individuals see themselves as thriving in their public (social) life. The five three-item subscales are social coherence, social integration, social acceptance, social contribution and social actualisation. The psychological and social well-being scales are responded to on a seven-point disagree-agree scale. Keyes (2005) reported Cronbach's reliability indices for emotional well-being of 0.91; and 0.81 respectively for psychological- and social well-being. No studies could be found in South Africa that had used the Mental Health Continuum (MHC: LF) by Keyes (2005) with youth, although numerous studies exist using MHC: SF with 14 items and reporting good reliability indices (Wissing & Temane, 2008; 2013).

Permission for use of the MHC: LF in this study was obtained from the author.

In this study, of the 600 questionnaires received, 552 were used or filled in completely. The reasons for 48 incomplete questionnaires might be due to the fact that the items were

sensitive or complex, that participants experienced some fatigue as completing the questionnaires took approximately two hours; furthermore language difficulties or cultural influences could also have played a role. These incomplete questionnaires were discarded.

Statistical Analyses

The data was analysed using the Mplus version 7.31 (Muthén & Muthén, 1998-2014). The items of the questionnaires, namely the MSQA: AVI, RSES and MHC were defined as being categorical and WLSMV (*weighted least squares with corrections to means and variances*) was used as estimator. To assess measurement and structural model fit, the comparative fit index (CFI; > 0.95), Tucker-Lewis index (TLI; > 0.95), the root mean square error of approximation (RMSEA; < 0.08), and the Chi-square difference test specifically for the categorical estimator, were used. Reliabilities of scales measured by items rated on a continuous scale were computed using a formula based on the sum of squares of standardised loadings and the sum of standardised variance of error terms (Wang & Wang, 2012). This was done as an alternative for Cronbach alpha which does not provide a dependable estimate of scale reliability when latent variable modelling is used. Mediation analyses were done by means of the bootstrapping method of Preacher and Hayes (2008).

Results and Discussion

The main aim of this study was to investigate the relationship of aspects of sexual values and attitudes of African adolescent males in South Africa, with their self-esteem and mental health and well-being. The results of the research conducted towards meeting this aim are discussed below.

Descriptive Statistics

Descriptive statistics describe the main attribute of a sample, some tendencies of the variables and underlying assumptions, while also addressing specific research questions

(Pallant, 2010). Table 2 summarises descriptive results for the variables of the MSQA: AVI, the RSES and the MHC: LF as used in this analysis. The means and standard deviations are similar to those indicated in literature that had used the same scales. The skewness (the asymmetry and deviation from a normal distribution) and kurtosis values of the MHC subscales indicate a tendency of skewness to the left, but with values below 1; that is still acceptable. Kurtosis values are <3, indicating platykurtic distribution which means that all values are widely spread around the mean. Skewness and kurtosis values for the RSES are acceptable. For the MSQA: AVI, however, the values for both skewness and kurtosis are slightly outside the parameters, indicating a high probability of extreme values.

Table 2
Descriptive Statistics for Measurements (N = 552)

| Scales | Min. | Max. | Mean | SD | Skewness | SE | Kurtosis | SE |
|----------------------|------|------|------|-------|----------|-------|----------|-------|
| 1. MHC Emotion | 1 | 6 | 4.25 | 0.735 | -0.739 | 0.106 | 1.316 | 0.211 |
| 2. MHC Psychological | 2 | 7 | 4.39 | 0.865 | -0.916 | 0.104 | 1.441 | 0.208 |
| 3. MHC Social | 1 | 7 | 4.68 | 0.915 | -0.332 | 0.104 | 0.562 | 0.208 |
| 4. RSES | 0 | 3 | 1.77 | 0.328 | 0.080 | 0.104 | 1.230 | 0.208 |
| 6. MSQA: AVI | 1 | 3 | 2.61 | 0.255 | -1.086 | 0.105 | 3.409 | 0.210 |

Note: MHC = Mental Health Continuum; RSES = Rosenberg Self-Esteem Scale; MSQA: AVI = Mattech Sexuality Questionnaires for Adolescents: Attitudes and Values Inventory

Identified Factors for Further Analysis

By means of confirmatory factor analyses (CFA), using the Mplus version 7.31 statistical software programme (Muthén & Muthén, 1998-2014), the distinctness of the assessed variables for values and attitudes toward sexuality, for self-esteem and for mental health and well-being of a group of African male adolescents, was determined. This brought

about a reduction of items so that for the MSQA: AVI 22 out of 70 items, for the RSES 8 out of 10 items and the MHC 22 out of 39 items - which loaded significantly on the identified factors - were used in the various analyses performed. The main reasons for the reduction of items were two-fold: Firstly, only items that specifically measured aspects relating to values and attitudes about sexuality in the MSQA: AVI were used, which is in line with the aims of the study; Secondly, the refined nature of the Mplus program brings about a gradual exclusion of items that do not significantly contribute to the final statistical outcomes, in this case a measurement model. Thus, the results that are further reported were mostly obtained with analyses using the reduced items for the measuring instruments.

The following nine factors were identified through CFA:

For mental health and well-being (MHC), the emotional well-being (MHCE) factor had six items describing subjective well-being (happiness) and positive emotions, e.g. *In general, I feel I am in charge of the situation in which I live; I have confidence in my own opinions, even if they are different from the way most other people think.*

On the psychological well-being (MHCP) factor, ten items loaded representing mostly intrapersonal well-being, e.g. *I like most parts of my personality; I think it is important to have new experiences that challenge how I think about myself and the world.*

The social well-being (MHCS) factor had six items describing interpersonal and communal wellness, e.g. *Maintaining close relationships has been difficult and frustrating for me; People would describe me as a giving person, willing to share my time with others.*

For self-esteem (RSES), the positive self-esteem factor (RSESPOS) had four items indicating positive self-worth experiences, e.g. *I feel that I have a number of good qualities.*

The negative self-esteem factor (RSESNEG) had four items indicating low levels of self-worth, e.g. *I certainly feel useless at times.*

For sexual values and attitudes of the youth (MSQA: AVI), the clarity of values factor had loadings of six positive items of the personal sexual values and the personal sexual responses subscales, e.g. *I am clear about what is right or wrong for my sexual behaviour; I have a good understanding of my own feelings and reactions.*

The unclarity of values factor had eight negative items of the personal sexual values and the personal sexual responses subscales, e.g. *I am confused about my personal sexual values and beliefs; I experience trouble regarding values and beliefs about my own sexual behaviour.*

On the beliefs factor loaded three items of the pre-marital sex subscale describing negative attitudes toward pre-marital sexual activities, e.g. *Contraceptives are not important; Premarital sex should not be practiced.*

On the intimacy factor five items loaded describing attitudes toward pre-marital intercourse, the use of demands in sexual activity and sexuality in life, e.g. *A sexual relationship is one of the best things that a person can have; Premarital sex is acceptable for as long as people are in love.*

Reliability of/and Correlations Between Factors

Table 3 shows reliability indices of the factors identified from the MSQA: AVI, the RSES, and the MHC: LF, using the approach of Raykov (2004) and proposed by Wang and Wang (2012) as being more suitable when using structured equation modelling. The calculation is based on utilising the standardised factor loadings (χ) and standardised variance of errors (β), while including the correlation of errors (Erasmus, Rothmann, & van Eeden, 2015). The scale reliabilities obtained by using the described method are expressed as a ρ -value, ranging between $\rho = 0.62$ and $\rho = 0.87$ for the factorial scales identified in this investigation. According to the classic criteria of Nunnally and Bernstein (1994), these reliability values could be interpreted as fair to good and are indicative of reliable scores

obtained in this current research group (Steiner, 2003).

Table 3

Reliabilities and Correlations of Scales

| Factors | ρ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|----------------------------------|--------|---------|---------|---------|---------|---------|--------|--------|--------|------|
| 1. MHC Emotion | 0.71 | 1.00 | | | | | | | | |
| 2. MHC Psychological | 0.87 | 0.48 | 1.00 | | | | | | | |
| 3. MHC Social | 0.82 | 0.41 | 0.80 | 1.00 | | | | | | |
| 4. RSES Positive | 0.62 | 0.28** | 0.54** | 0.49** | 1.00 | | | | | |
| 5. RSES Negative | 0.71 | -0.19** | -0.37** | -0.32** | -0.49** | 1.00 | | | | |
| 6. MSQA: AVI Clarity of values | 0.71 | 0.16** | 0.31** | 0.27** | 0.46** | -0.54** | 1.00 | | | |
| 7. MSQA: AVI Unclarity of values | 0.71 | | -0.16** | -0.14** | -0.23** | 0.24** | -0.10 | 1.00 | | |
| 8. MSQA: AVI Beliefs | 0.72 | | | | | | 0.11 | 0.24** | 1.00 | |
| 9. MSQA: AVI Intimacy | 0.69 | | | | 0.22** | | 0.32** | | - | 1.00 |
| | | | | | | | | | 0.60** | |

Note: MHC = Mental Health Continuum; RSES: Rosenberg Self-Esteem Scale; MSQA: AVI: Mathtech Sexuality Questionnaire for Adolescents: Attitudes and Values Inventory;

Values below 0.10 are not displayed; ** $p < 0.01$; medium practical significance > 0.30 ; large practical significance > 0.50 .

Table 3 also shows the correlations obtained among the MSQA: AVI scores, the RSES and the MHC: LF. A cut-off value of 0.10 was selected and all correlations are significant ($p < 0.01$). An investigation of the correlations between the latent variables in this research shows that significant positive correlations existed between emotional, psychological and social well-being, positive self-esteem, clarity of values and attitudes toward intimacy. Significant negative correlations were found for emotional, psychological and social-being, positive self-esteem, clarity of values with negative self-esteem and unclarity of values. Negative self-esteem had a positive correlation with unclarity of values. Beliefs (negative attitudes toward premarital sex) had positive correlations with both clarity and unclarity of values, where one would have expected a negative relationship with clarity of values. Beliefs also had a strong negative correlation with attitudes toward intimacy as could be expected; and intimacy had positive correlations with positive self-esteem and with clarity of values.

The Measurement Model

In line with a specific aim stated for this study, the relationships between variables of the MSQA: AVI, the RSES and the MHC: LF were analysed by using Mplus (Muthén & Muthén, 1998-2014). Confirmatory factor analyses were done with the scales used and an initial measurement model (Model 1) was specified and tested for statistical fit. In order to test whether this model represented the best fitting model, three alternative models (Models 2, 3 and 4) were similarly specified and tested. The models were specified as follows:

Model 1 consisted of the following: Mental health and well-being as a second order latent variable, made up of three first order latent variables, namely MHCE (6 items), MHCP (10 items), and MHCS (6 items); RSESPOS (4 items) and RSESNEG (4 items) as first order latent variables; and unclarity of values (8 items), clarity of values (6 items), beliefs (3 items), and intimacy (5 items), also as first order latent variables.

Model 2 consisted of the following: Mental health and well-being as a first order latent variable with 22 items; RSESPOS and RSESNEG as described in Model 1; unclarity and clarity of values, beliefs and intimacy, as described in Model 1.

Model 3 consisted of the following: Mental health and well-being as described in Model 1; RSES as a first order latent variable with 8 items; unclarity and clarity of values, beliefs and intimacy, as described in Model 1.

Model 4 consisted of the following: Mental health and well-being as described in Model 1, RSESPOS and RSESNEG as described in Model 1; unclarity and clarity of values, beliefs and intimacy as a first order latent variable with 22 items.

Table 4 below displays the four models.

Table 4

Fit Statistics of Competing Measurement Models

| Model | χ^2 | df | RMSEA | TLI | CFI |
|---------|----------|------|-------|-------|-------|
| Model 1 | 1614 | 1248 | 0.023 | 0.950 | 0.952 |
| Model 2 | 1905 | 1251 | 0.031 | 0.910 | 0.915 |
| Model 3 | 1706 | 1254 | 0.026 | 0.938 | 0.941 |
| Model 4 | 2838 | 1263 | 0.047 | 0.785 | 0.796 |

Note: *df* = degrees of freedom; RMSEA = Root Mean Square

Error of Approximation; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index

In Table 4 it is evident that Model 1 has the best statistical fit of the four models. The RMSEA model fit was acceptable (lower than 0.05), as were the fit indices for CFI and TLI (above 0.90). A Chi-square (χ^2) of 1614 (*df* = 1248) was obtained for Model 1. Note: Given that the measurement models were non-nested, the Chi-square difference test could not be computed. Furthermore, the Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC) which can be used for comparison of non-nested measurement models are not available when the WLSMV estimator is used.

Structural Model

A structural model (Model 5) was specified and tested based on the best fitting measurement model (Model 1). Model 5 was analysed and the fit results compared with three competing models (Hancock & Mueller, 2011) are shown in Table 5. With the WLSMV estimator the Chi-square value cannot be reliably calculated in the regular way (Satorra & Bentler, 1998; also see www.statmodel.com) and must be done using the `diffest` option.

Table 5

Fit Statistics of Competing Structural Models

| Model | χ^2 | df | RMSEA | TLI | CFI |
|----------|----------|------|-------|-------|-------|
| Model 5 | 1643 | 1249 | 0.024 | 0.946 | 0.949 |
| Model 5a | 2490 | 1251 | 0.042 | 0.829 | 0.839 |
| Model 5b | 1706 | 1253 | 0.026 | 0.938 | 0.941 |
| Model 5c | 1765 | 1253 | 0.027 | 0.930 | 0.934 |

Note: df = degrees of freedom; RMSEA = Root Mean Square Error of Approximation; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index

Table 5 shows that Model 5 is the best fitting of the four models, as evidenced by the Chi-square and difference testing values (Table 6), the RMSEA fit values and the TLI and CFI fit statistics.

Table 6

Difference Testing for Competing Structural Models

| Model | $\Delta\chi^2$ | Δdf | p |
|----------|----------------|-------------|-------|
| Model 5a | 140 | 2 | 0.000 |
| Model 5b | 40 | 4 | 0.000 |
| Model 5c | 62 | 4 | 0.000 |

Note: $\Delta\chi^2$ = Chi-square difference; Δdf = degrees of freedom difference; p = statistical significance

Figure 1 below shows the standard path coefficients estimated by Mplus version 7.31 for Model 5.

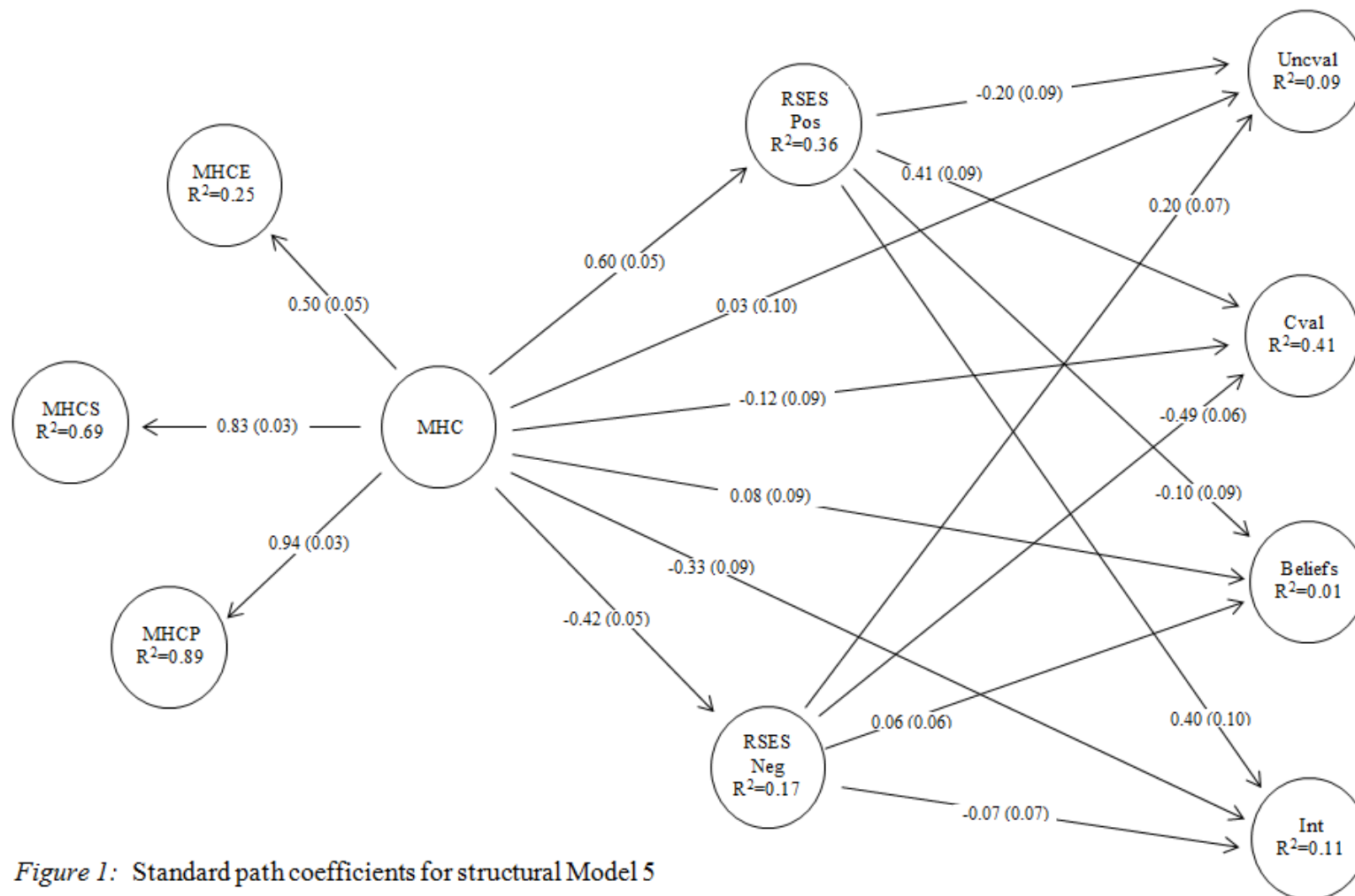


Figure 1: Standard path coefficients for structural Model 5

Note: MHC: Mental Health Continuum (E=emotional; S=social; P=psychological); RSES: Rosenberg Self-Esteem Scale (Pos=positive; Neg=negative); Uncval: Unclearly of values; Cval: Clarity of values; Int: Intimacy

The second aim for this study as stated before was to determine whether self-esteem as a mediating variable between mental health and well-being and sexual values and attitudes could be identified by means of structural equation analyses of latent variables. A mediating variable serves to clarify or explain the relationship between an independent and a dependent variable; thus, a mediating relationship occurs when a third variable plays an important role in directing the relationship between two other variables (Baron & Kenny, 1986), e.g. mental health and well-being and sexual values and attitudes. The bootstrapping method was used to construct two-sided bias-correlated confidence intervals in order to evaluate mediation effects and the statistical significance thereof (Preacher & Hayes, 2008). The mediational effects are given in Table 7.

Table 7

Indirect Effects of Mental Health, via Self-esteem, on Sexual Values and Attitudes

| Variable | Positive self-esteem | | | Negative self-esteem | | |
|---------------------|----------------------|------|--------------|----------------------|------|----------------|
| | Est. | SE | 95% CI | Est. | SE | 95% CI |
| Unclassified values | - | - | - | -0.08* | 0.04 | [-0.16, -0.01] |
| Clarified values | 0.24** | 0.07 | [0.11, 0.38] | 0.20** | 0.04 | [0.12, 0.28] |
| Intimacy | 0.24** | 0.08 | [0.08, 0.40] | - | - | - |

Note: Est = Estimate; SE = Standard error; 95% CI = 95% Bias-correlated confidence interval

Table 7 shows that 95 percent bootstrap confidence intervals (5000 trials) for all indirect effects do not include zero (Preacher & Hayes, 2008). Therefore, it is concluded that mental health and well-being had an indirect effect via self-esteem (positive and negative) on sexual values and attitudes.

The results of this study as given in the preceding discussion indicate that the two aims stated for this study have been met. Relationships and direction thereof between variables have been determined by means of structural equation modelling. Furthermore, self-esteem as a mediating variable between mental health and well-being and values and attitudes of

sexuality was identified.

Discussion of Research Findings

The purpose of this study was to investigate the relationships between mental health and well-being, self-esteem and values and attitudes towards sexuality of N=552 male African adolescents.

Three scales namely the MHC:LF, the RSES and the MSQA:AVI were used to assess the aspects mentioned above and acceptable ρ -values, representing reliability indices for the identified factors based on data from the scales used, were found ($\rho = 0.62-0.87$). The means and standard deviations found were compared and found similar to those reported in literature for the same measuring instruments. The frequency distributions on the scales for the participants in this research indicated a tendency toward skewness and also toward platykurtic distributions, although still acceptable for most measurements. The MSQA: AVI indicated a high probability of extreme values.

Correlation analyses revealed that, as could be theoretically expected, the three components of mental health and well-being correlated significantly positively with positive self-esteem and with clarity of personal sexuality values in this group of participants. Similarly, these components of mental health and well-being related negatively with negative self-esteem and with unclarity or confusion regarding sexual values. Positive self-esteem further related significantly positively with clear sexual values and negatively with unclear values. These findings correspond with those of Keyes (2004) and Mann, Hosman, Schaalma, and de Vries (2004) who indicated the strong correlations between mental health and self-esteem, in which both these aspects of the healthy and well-functioning person are interdependent and reciprocally enhancing. In the current findings, it is interesting to note that the strongest correlations were with the psychological well-being component of the

mental health continuum. It would seem that it is this dimension of mental health that has the strongest influence on behavioural aspects of the young person, since emotional stability fluctuates during adolescence and the young person's social well-being is still developing and often under pressure (Louw & Louw, 2014; Mash & Wolfe, 2013; Parritz & Troy, 2011).

As far as values about sexuality are concerned, the strongest correlations of clear and unclear values were with the self-esteem factors, both positive and negative. It would seem that in this research group, self-esteem had a strong influence on having either clarity of personal sexual values, understanding personal sexual responses and being satisfied with personal sexuality, or being uncertain and confused about these matters in their relational experiences (Harper, 2004; Higgins, Mullinax, Trussel, Davidson, & Moore, 2011; Mann et al., 2004). No causative conclusions could be made based on the correlational findings and the current correlations had medium (>0.30) to large (>0.50) practical significance (Cohen, 1977; Steiner 2003).

A measurement model was identified from factor analyses of the data obtained by means of the measuring instruments and was compared with competing models to determine the statistical fit. The identified measurement model proved to have the best statistical fit of the data. The path coefficients of the structural model indicated that mental health and well-being (MHC) could possibly - via self-esteem (RSES) - have an influence on sexual values and attitudes (MSQA: AVI). By means of the bootstrap method of determining mediation effects of Preacher and Hayes (2008), the indirect effects of MHC - via RSES - to MSQA: AVI were determined.

The results of the mediation analyses showed that self-esteem, both positive and negative, transferred the effects of mental health and well-being to the identified sexual values and attitudes of African adolescent males. Thus, African male youth that experience mental health and well-being may have clarified values about their sexuality and mostly

healthy attitudes toward aspects of intimacy, because of the mediating influence of their positive sense of self-esteem. On the other hand, African male youth with mental health and wellness who experience negative self-esteem may have some unclarified as well as certain clarified values pertaining to their sexuality. By implication, one could also speculate that male youth with both low mental well-being and low self-esteem may have unclarified sexuality values and negative sexual attitudes that may manifest in risky sexual behaviour (Mash & Wolfe, 2013).

The relationship between mental health and well-being and self-esteem is a complex one, although scores of research findings focus on the correlational links between the two constructs (Beck, 2001; Harter, 1999; Zimmerman, 2000). More studies abound in associating self-esteem with pathogenic aspects of mental health such as anxiety, depression, aggression, and delinquency (Garber & Flynn, 2001), than with salutary aspects of mental health and well-being such as flourishing, character strengths, subjective well-being etc. (Furnham & Cheng, 2000; Keyes, 2005; Seligman, 2011).

In the field of positive psychology, research is emerging to address the classic emphasis on pathogenic factors; in more recent research results, the association between self-esteem and various positive aspects of mental health has been reported (Compton & Hoffman, 2013; King, 2008). The three dimensions of mental health and well-being used in this study also relate positively with self-esteem, for example positive emotions (Fredrickson, 2009) and subjective well-being (Furnham & Cheng, 2000; Zimmerman, 2000); Ryff's (1989) conceptualisation of psychological well-being (Ryff & Singer, 2000), and Keyes' (1998) conceptualisation of social well-being (Keyes & Lopez, 2002). Furthermore, Mann et al. (2004) followed an integrative approach in researching the role of self-esteem in a broad-spectrum view on mental health promotion. These authors stated succinctly that self-esteem is crucial to mental health and well-being and that self-esteem can be considered as a core

element in mental health promotion and as a strong basis for a broad-spectrum approach to mental health and wellness enhancement.

However, Mann et al. (2004) also emphasised that the relationship between self-esteem and mental health is bi-directional in nature in which there are reciprocal influences, as seem to be the case in this study. On the one hand, the authors stated that self-esteem not only serves as a basic feature of mental well-being, but also as a buffer against the effects of negative intra- and interpersonal influences. Self-esteem is seen as a defence mechanism that promotes well-being by protecting internal balance and as a predisposing factor that provides the rationale or motivation for behaviour through enabling and reinforcing successful (healthy) behaviour. Similarly, the terror management model of self-esteem views self-worth as a function to protect people from the pervasive and deeply rooted (existential) anxiety inherent in being human (Goldenburg & Shackelford, 2005). Robinson and Compton (2008) found that self-esteem would more likely defend against negative emotions, than promote happiness. Components of behaviour for which self-esteem could be an antecedent are attitudes, beliefs, values, perceived needs and abilities (Green & Kreuter, 1991).

On the other hand, self-esteem seems to be an outcome variable of mental health features such as health behaviour, effective coping and problem solving, optimism, character strengths and a sense of control (Carr, 2011; Harter, 1999; WHO, 2008). As stated before, the empirical literature highlights the negative outcomes of low self-esteem and in many cases there is a lack of clarity regarding causal relations between self-esteem and problems or disorders. Flay, Allred and Ordway (2001) importantly stated that there is reason to believe that self-esteem could serve not only as a cause of mental health features, but also as a consequence of either mental ill-health behaviour or of healthy and adaptive behaviour. As far as this study is concerned, self-esteem is one of the core features of the psychological well-being component of mental health and well-being as measured by the MHC (Keyes,

2002), since a positive evaluation of oneself and one's past - i.e. self-acceptance and -worth - is a dimension measured in this scale (Keyes, 2005).

Thus, the findings of this study that self-esteem mediates the relationship between mental health and well-being and sexuality values and attitudes, seem to support the literature indicating a bi-directional relationship between emotional, psychological and social dimensions of mental health and well-being, and self-esteem. Self-esteem could therefore be seen as an important feature in interventions aimed at mental health promotion (Mann et al., 2004) and, as intended with this study, psychosexual health promotion of youth.

The relationship between self-esteem and values and attitudes of youth toward sexuality is equally intricate and very little research could be found in this regard. As was mentioned before, literature abounds with findings on low self-esteem and deviant sexuality, risky sexual behaviour and abusive sexuality in youth (Mash & Wolfe, 2013). The mediating relationship found in this study could perhaps indicate cognitive and socially constructed features within these participants as far as self-esteem and their sexual values and attitudes are concerned.

Harter (1999) and Markus (1977) have described self-esteem as part of the self-concept, which is the sum of an individual's beliefs and knowledge about his/her personal attributes and qualities of worth. It is seen as part of a cognitive schema that organises abstract and concrete views about the self and directs the processing of self-related information from intra- and interpersonal sources. Harter viewed self-esteem as evaluative and affective in its functioning and closely related to all aspects of self-concept that are self-affirmative. Self-esteem could thus, as a mediating variable in this study, serve a cognitive function to transfer the effects of mental health and well-being to sexuality values and attitudes, which are also seen as social-normative beliefs that serve as cognitive behavioural determinants (Ajzen, 1991).

Furthermore, Hewitt (2009) emphasised self-esteem as a socially constructed, evaluative and affective dimension of the individual. People internalise the positive and affirmative feedback about themselves that they experience, perceive and infer from significant social sources, resulting in cognitive and inferential processes in which they observe and evaluate their behaviour and competencies to form and maintain their sense of self-worth (Mann et al., 2004). Hewitt was also of the opinion that good self-esteem is indicative of a positive and integral personal and social identity, namely a sense of security in the social context, cultural competence, skilful interaction with others, and the ability to balance personal and social expectancies. In line with the view of self-esteem as a socially constructed aspect of personality (Hewitt, 2009), mental health and well-being as measured in this study have a very strong social well-being component ($\chi^2=0.89$) (Keyes, 2002). Thus, the socially based self-esteem component mediated the wellness effects to values and attitudes, which are also social normative beliefs (Ajzen, 1991). It would therefore seem that this study's findings - based on data obtained from adolescent males in a largely African collective culture - support the theoretical contention of Banfield, Wyland, Macrae, Münte, and Heatherto (2004) and Hewitt (2009), that self-esteem portrays the selves of socially and culturally situated individuals, who live the norms and values (also sexual) of the cultures and societies to which they collectively belong.

In this study, the aims were to determine the relationships between mental health and well-being, self-esteem and values and attitudes about the sexuality of African male adolescents. The aims were met through identifying best fitting measurement and structural models by means of structural equation modelling, as well as identifying self-esteem as a mediating variable transferring the indirect effects of mental health and well-being to sexual values and attitudes.

There were various limitations in this study: First, the MSQA: AVI is an old scale and

although still in use for mainly survey research, factor analyses utilised to identify the relevant factors by means of which sexual values and attitudes could be conceptualised, could not be found. This scale has also not been validated for use with South African youth. Research along these lines is recommended. Second, the MHC: LF has not been validated for use in South African research, whereas the MHC: SF has (Keyes, Wissing, Potgieter, Temane, Kruger, & Van Rooy, 2008). The use of the MHC: SF is thus recommended for future research on the psychosexual well-being of South African youth. Third, the RSES has been validated for use in South Africa and has also been used extensively in research with youth. However, one wonders whether the use of a collective self-esteem measurement would not have produced richer results in this study. Research in this regard is recommended. Fourth, although English is the language of tuition at the schools where the research had taken place, the researcher is of the opinion that more valid and richer results could have been obtained with scales in the mother tongue of the youth. Nonetheless, despite these limitations the study was successful; it had reached the targeted aims and could lead to further research interest into mental health and well-being, self-esteem and the values and attitudes of youth toward their sexuality.

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MANUSCRIPT TWO

**SEXUAL BEHAVIOUR AS DECISION MAKING AND
COMMUNICATION SKILLS, COPING STRATEGIES AND
MENTAL HEALTH AND WELL-BEING OF AFRICAN
ADOLESCENT MALES**

Abstract

The general aim of this study was to investigate the relationships between sexual decision-making skills and ease of communication, and coping strategies and mental health and well-being of African adolescent males. Specific aims were to identify statistically best-fitting measurement and structural models through structural equation modelling with the Mplus 7.31 statistical programme and to identify latent classes of variables by means of Latent class analysis. In a quantitative cross-sectional survey design, consenting participants ($N = 552$) aged between 13-21 years completed validated questionnaires measuring sexual behaviour (MSQA: BI), coping strategies (CCSC) and mental health and well-being (MHC: LF). Results showed that means and standard deviations agreed with those in literature; correlations between variables were significant and in line with theory; and reliability ρ -values showed moderate to good internal consistency of the scales used in this research group. The identified and tested measurement and structural models met best-fitting statistical criteria and three latent classes named flourishing, moderate mental health and languishing were identified, in which 28%, 56% and 16% of participants were categorised, respectively.

Key terms

Adolescence, communicating with ease about sexuality, coping strategies, mental health and well-being, sexuality, sexual decision making skills.

In this study the sexual behaviour seen as decision making and communication skills of a group of black adolescent males, their coping strategies and mental health and well-being were investigated, with the aim to determine the statistical relationships between such dimensions of adolescent psychosocial functioning. The purpose of the study was to obtain information about the quality of sexuality of adolescent males and specifically about features of their sexual behaviour in relation to their well-being. Very little such information could be found in literature and the findings that exist are either old, from non-African contexts and do not combine aspects of sexual behaviour such as decision making and communication, with aspects of healthy coping-, emotional-, psychological- and social well-being, as intended in this study.

Adolescence is a transitional stage from ages 11 to 18 years, characterised by youthful openness, flexibility and malleability and may be an optimal period to learn mental and physical health-promoting outlooks and behaviours (Bach, 2011; Shaffer & Kipp, 2007). Because of the extensive physical development during puberty, adolescent males become increasingly aware of their sexuality, beginning to manifest – among other aspects – their sexual orientation. The latter refers to the dominant sexual behaviour pattern of an individual, specifically a preference for sexual behaviour toward a person of the same gender (homosexual) or opposite gender (heterosexual), or indiscriminate of both genders (bisexuality) (Louw & Louw, 2014). However, given that adolescence is often marked by exploration and experimentation, male youth's sexual orientation and behaviour could still be fluid (i.e. may change over time) (Mock & Eibach, 2012).

Adolescence and Sexuality

It is clear from literature that the biological, emotional, psychological, moral, sexual and social changes that characterise adolescence also make it a vulnerable phase of development, during which a personal identity and adequate socialisation must be established

(Berger, 2008; Hopkins, 2010; Pisk, Mihanovic, Silic, Bagovic, & Vidovic, 2012). In the process of building their identity and establishing themselves, adolescent males grapple with the question, “**Who am I?**” and may strive to achieve **cognitive autonomy** (i.e. making decisions and assuming responsibility for these choices), **behavioural autonomy** (i.e. making choices regarding friendships, leisure time and finances), **emotional autonomy** (i.e. being self-reliant and independent of their parents and being able to exercise self-control) and **moral or value autonomy** (i.e. forming an own value system that may serve as a guideline for their own behaviour) (Louw & Louw, 2014). According to Thoits (2013), inadequate identity development may impair self-related growth and well-being of adolescents, among other developmental aspects. However, adolescent males with a well-developed identity show interest in expanding their knowledge about themselves, and scrutinizing self-relevant information that accommodates their views about the self. Very often, the following dimensions of personality are noticeable, namely open-mindedness, commitment, self-discipline, problem-focused coping and decision making (Berzonsky & Ciecuch, 2014).

The four aspects of autonomy that characterise healthy identity formation also apply with regard to the adolescent male’s sexuality. Sexuality is an important aspect of an adolescent’s identity formation (Papalia & Feldman, 2012) and is a dynamic process in which the interaction of biological, social, psychological, spiritual and cultural factors influence personality development, psychological well-being and the ability to form, as well as ensure the quality of interpersonal relationships (Connell, Coates, & Wood, 2014). According to Papalia, Olds, and Feldman (2008), sexual identity is formed from seeing oneself as a sexual being, recognising one’s sexual orientation, understanding sexual stirrings and forming intimate or sexual attachments. Although this process is biologically based, the expression of one’s sexuality (sexual identity) is culturally defined.

As far as research on the sexuality of adolescents is concerned, many studies exist that look at negative aspects relating to young people's sexual behaviour such as risky sexual practices and the consequences thereof. The definition of sexual health of the World Health Organization recognises that sexual health goes beyond avoiding negative outcomes, including the positive and satisfying aspects of sexuality. Sexual health is seen as a state of physical, emotional, mental and social well-being in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, cited in Public Health Agency of Canada, 2008).

In this study sexual behaviour of adolescents was conceptualised as their decision-making skills regarding sexual practices and experiences; and the ease with which they can communicate with parents, peers and partners about sexual matters (Kirby, 2002).

Adolescent Decision Making

As far as decision making is concerned, a prominent perspective on adolescent decision making is the behavioural decision theory of Arnett (2004). This theory stated that the decision-making process includes identifying all possible choices and the consequences that would result from a choice; evaluating the consequences; assessing the likelihood of the consequence and integrating the consequence. In a time when adolescents have to make important decisions regarding, for example, career choice, substance use and sexual activity, one wonders whether adolescents can make decisions competently, considering the cognitive processes stipulated by the behavioural decision theory mentioned above (Louw & Louw, 2014).

Louw and Louw (2014) stated that competent decision making involves not only cognitive aspects, but also psychosocial factors. A deficiency in either area impairs the

decision-making process. This means that even though adolescents may have the same cognitive ability as adults in making a decision (such as evaluating the pros and cons), they are more influenced by psychosocial factors such as the emotions at the time and their desire to be accepted by others and will thus make different decisions, also concerning sexual behaviour. Research found that adolescent males who are experiencing strong emotions and having difficulty regulating them, may have poor decision-making skills. Such youth may be prone to risky sexual behaviour in an effort to block negative feelings (Hessler & Katz, 2010; Valois, Zullig, Kammermann, & Kershner, 2013).

Because adolescents have not yet achieved the brain maturation of an adult, Singer (2007) found that due to incomplete development of the neurological cognitive control system in adolescents, some youth may engage in risk-taking behaviours. The underdeveloped frontal cortices of the brain may fail to exert the cognitive control required to suppress the urges and behaviour involved in many of the risky choices adolescents make (Louw & Louw, 2014; Somerville, Casey, & Jones, 2010). Furthermore, since the frontal cortex (for cognitive control) only develops later, the limbic system is dominant in adolescence, favouring potentially rewarding experiences. Therefore, since approval by peers is rewarding, adolescents are more likely to engage in risky behaviour in the company or under the influence of peers. Although they may understand the riskiness of behaviour, adolescents do not seem to have control over the risky behaviour when there is a prospect of reward (Louw & Louw, 2014).

It seems clear that the competence of adolescent decision making is dependent on complex neuro-cognitive and psychosocial developmental processes. One could thus wonder whether – although adolescence is a stage of readiness for decision-making processes and skills to develop – youth are fully capable of making decisions regarding sexual activities and experiences that are always beneficial and devoid of risk? An interesting finding in this

regard was reported by Higgins, Mullinax, Trussell, Davidson, and Moore (2011) that a strong factor associated with physical satisfaction in sexual behaviour for male adolescents, was that they felt that their sexuality-related decision making was guided by their own values and feelings.

Adolescent Communication

Regarding the ease with which adolescents can communicate about sexual matters with parents, peers and partners, such communication skills and confidence are closely linked to the child rearing practices that the adolescent experienced and the cultural framework within which such practices occurred (Papalia et al., 2008). Communication about sexual matters may transmit sexual values, beliefs, expectations and knowledge from parents to children (de Looze, Contantine, Jermane, Vermeulen-Smit, & ter Bogrt, 2014). To discuss sexuality with youth has been found to be universally beneficial as Rink, Montgomery-Anderson, and Anastario (2014) reported in a study in which they investigated caregiver-youth sexual health communication in Greenland. A large group (73%) of parents indicated that they educate their children about the importance of respect and not pressuring other people to have sex, while 87% indicated how important sexual communication with their children is to prevent them from contracting sexually transmitted infections and HIV/AIDS. Reporting from a study among adolescent males in Sub-Saharan Africa, Maticka-Tyndale and Tenkorang (2010) found that positive association with significant adults influence the youth's decisions regarding condom use and dating. However, the outcomes of uninvolved parental monitoring during adolescence and not being emotionally connected to their children range from adolescents experimenting with alcohol and drugs; early sexual debut; peer pressure; and premature school-dropout (Setswe et al., 2014; Shisana et al., 2009).

Although the basis for communication appears to be innate, the skills for social signalling which are the structures for communication are heavily dependent on learning,

culture and socialisation processes (Louw & Edwards, 1993). Two aspects of social interaction through communication that are most important are learning the rules and acquiring the skills. A great deal of human interaction is rule-governed and there are different rules for relationships between parents, peers and partners, as well as for different social situations. However, knowing the rules or scripts is of little use if the adolescents do not have the social skills (Louw & Edwards, 1993). It is noteworthy that Seiffge-Krenke, Aunola, and Murmi (2009) had found that between 46% and 82% of all stressful everyday life experiences mentioned by adolescent males, pertain to interpersonal relationships; especially those involving conflicts with partners, parents and peers. Of concern in this regard is that Wight, Plummer, and Ross (2012) had found that parents and adolescent males often experience discomfort talking to one another about sexuality, as some parents believe that communication about sexuality could influence youth to be more sexually active.

A result of such reluctance to convey relevant and adequate information to youth about sexuality was reported by Namasi et al. (2009). These authors found that in societies that are culturally embedded and do not talk about sexual matters with youth, a disproportionate number of adolescent males tend to be aggressive and often lack skills to negotiate birth control methods (i.e. using a condom) with their partners. Furthermore, although literature emphasises that sexual and reproductive health communication are principal means for parents to convey sexual values and attitudes, beliefs and expectations to their adolescents (Ayalew, Mengistie, & Semahegn, 2014), Giordano (2014) found that faulty communication within ethnic male-peer groups may have more influence than parental guidance, as boys tend to be socialised by peers to suppress their emotions in order to be deemed masculine. As mentioned before, such an inability to regulate emotions has been linked to poor sexual decision making (Houck et al., 2014). For example, Jewkes and Morrell (2010) found that to prove their masculinity, a group of African adolescent males in KwaZulu-Natal, reported to

have assaulted their girlfriends when they refused to engage in unprotected sex and to be involved with multiple sexual partners.

When parents engage their adolescent males in discussions about sexual matters, research by Aspy et al. (2007) found that such adolescents remain inactive longer or use condoms if sexually active. Nolen-Hoeksema (2008) stated that when adolescent males have been provided with sex education by their parents, they become less prone to risky practices and engage in healthy sexual behaviour with fewer sexual partners. In addition, such adolescents are more likely to display relational self-confidence and respect and empathy towards their sexual partners (Whitehead, 2007). Wilbraham (2009) pointed out that parental communication about sexual matters is assumed to naturalise sexuality as the central axis of identity construction for adolescents; and to sensitise them against sexual risks through informing them of their rights, choices and responsibilities.

Research by Bester (2007), and Fares and Raju (2007) revealed that the family is central to the psychosexual well-being of adolescent males. In healthy families, the parents and caregivers provide role models for interpersonal relationships; they teach about the roles of males in both family and wider contexts; and the parent-adolescent male communication about sexuality and sexual health may increase knowledge, thereby helping adolescent males to be more responsible decision makers. In other words, the prediction from such upbringing (i.e. involved and educative parents) would be that those adolescent males are more likely to form quality friendships and partner attachments.

Koen (2009), however, found that attachment anger or emotional detachment from parents was the strongest predictor of emotional distress in youth in South Africa. Also, in a 2012 study on psychosocial well-being of families in South Africa, Koen found that from a large group of adolescents ($N = 772$), only 36% reported experiencing their families as psychosocially well. An alarming percentage (64%) indicated that they were not experiencing

optimal psychosocial wellness in their families. These findings were in line with an in-depth study by Holborn and Eddy (2011) about the extent of family breakdown in South Africa. Based on such findings, one could assume that a large portion of adolescent males do not have the protected factor of supportive parenting regarding their sexual development in their lives and thus fall back onto peers and public sources for guidance.

In this study mental-health and well-being and coping strategies were the psychological variables investigated in relation to sexual behaviour of adolescent African males. These constructs will be discussed below.

Psychological Variables of the Study

Mental health and well-being. Intrapersonal or purely psychological variables that may influence the unfolding sexuality and sexual behaviour of adolescent males are, amongst others, personality, self-esteem, self-regulation and control, self-efficacy, motivational factors, cognition, values and attitudes, and coping abilities. These may all serve as protective or risk factors regarding self-defeating sexual behaviour (de Looze et al., 2014; Schultz & Schultz, 2013). As far as mental health and well-being are concerned, according to Keyes and Lopez (2005) a state of complete mental health implies both the absence of mental illness as well as the presence of high levels of mental wellness manifested in the intra- and interpersonal domains of emotional, psychological and social functioning of the individual. Furthermore, Keyes (2006, 2009) indicated that well-being has a hedonic component that is associated with feeling good, as well as a eudaimonic component that is equated to functioning well. Keyes and Lopez (2005) also identified two clusters of symptoms that describe the experience of subjective well-being, namely emotional vitality (emotional well-being or hedonia) and positive functioning (psychological and social well-being or eudaimonia). An integration of these conceptualisations of positive mental health came about

in the operationalising of these constructs by the Mental Health Continuum (Keyes, 2006) that assesses:

- Emotional well-being when a person has emotional vitality, is happy and satisfied with his/her life and has predominantly positive emotional experiences. Emotional well-being expressed as positive emotions has been associated with adolescent sexual health by researchers such as Higgins, Mullinax, Trussell, and Moore (2011).
- Psychological well-being when Ryff's (1989) six dimensions of psychological health are manifested, namely self-acceptance, autonomy, personal growth, purpose in life, positive relations with others and environmental mastery. The self-acceptance aspect of psychological well-being has been widely researched in association with self-related features such as self-esteem, self-efficacy, self-concept and self-regulation; of these features self-esteem has been associated with either risky or adaptive aspects of sexuality (Mann, Hosman, Schaalma, & de Vries, 2004). Higgins et al. (2011) found sexual health and satisfaction related to autonomy in youth, while positive relations with parents, peers and partners have been associated with healthy sexual development and behaviour by authors such as Mann et al., Higgins et al., and others as discussed in the preceding literature review. Very little research could be found on sexuality in youth and aspects such as personal growth, purpose in life and environmental mastery.
- Social well-being when a person has goodwill towards others (social acceptance); when there is a belief that society can become a better place (social actualisation); when social contribution is made to achieve the former; when a person experiences social coherence or feels that society makes sense; and when a person feels a part of the community (social integration), with mutual support and communality (Keyes, 2005, 2006). According to Crone and Dahl (2012), the social environment or "ecology" in which adolescents develop, play a critical role in shaping their behaviour and mental

health and wellness. For optimal functioning of youth, structures within the community (e.g. churches and non-governmental organisations, NGOs) should take initiative in implementing programmes to alleviate risk factors such as instability caused by violence, crime, HIV/AIDS, and teenage pregnancy.

Although many township families are disrupted by parental loss due to HIV/AIDS-related illnesses, divorce and economic pressures (Theron et al., 2011), extended kinship (e.g. grandparents, uncles and neighbours) has been documented to be instrumental in enhancing positive mental health and resilience among youth, providing them with collective principles of reciprocal respect, compassion and shared resources against anti-social behaviour (Mokwena, 2007; Roos & Temane, 2007). In this regard, when adolescents realise that in their communities there are social bonding and social integration, they may share their vision and goals to empower others, while taking charge of their lives; thereby enhancing their coping skills and well-being (Christens & Peterson, 2012; Zhang et al., 2011). Furthermore, Zeman, Cassans, and Adrian (2012) proposed that peers could be perceived as a reliable resource for adolescents' emotional well-being in the following manner: *Intellectually*, youth may flourish by studying in groups and develop reasoning and problem-solving skills; *Psychologically*, they could become resilient in spite of adversity, be optimistic about the future and learn to cope in their environment; and *socially*, they could be provided with support to acquire physical skills.

Of particular relevance to this study, is the research of Keyes (2006) on the prevalence of mental health of adolescents in the USA. Flourishing (optimal mental health) was found to be prominent in the 12-14 years age groups of youth, while adolescents from 15-18 years showed mostly moderate mental health. This brought Keyes to question the findings of Lewinsohn, Hops, Roberts, Seeley, and Andrews (1993), amongst others, that about 20% of youth experience a mental illness by the age of 18. He found it dubious to assume complete

mental health in the other 80% of adolescents. Keyes also found that as mental health indicators in the youth increased, depressive symptoms decreased. Furthermore, a positive correlational pattern was found between mental health and positive psychosocial functioning (self-determination, school integration, self-concept and closeness to others), while a negative correlational pattern occurred between mental health aspects and conduct problems (amongst others, risk behaviours). These findings indicate the importance of promoting mental health and psychosocial well-being in youth to enable them to cope with the challenges they face, also those relating to their sexuality and sexual behaviour.

As far as the mental health and well-being in relation to sexual behaviour of adolescents are concerned, much research exists on the negative aspects of health and well-being associated with deviant and self-defeating sexual behaviour. Fewer studies have, however, examined positive mental health and well-being in relation to healthy, satisfying and self-enhancing sexual practices in youth. This paucity of research may exist because of the natural inclination to focus on psycho-sexual difficulties of adolescents. Also the study of well-being may seem less relevant than the obvious urgent problem-saturated development aspects of adolescence such as sexual risk behaviour and substance abuse. However, the lack of research on psycho-sexual health and well-being limits our understanding of positive adolescence and how adolescents' well-being could be facilitated and enhanced (Tweed, Biswas-Diener, & Lehman, 2011). This study may make a contribution in that regard.

Coping strategies, the second psychological variable used in this study, was conceptualised from the work of Ayers and Sandler (1999) on children's coping strategies and included aspects of problem-focused coping, positive reframing coping and support-seeking coping strategies. Coping is the process of managing demands (internal or external) that are perceived to be overwhelming and exceeding the personal resources of the individual (Smyth & Filipkowski, 2010; Thabet, EL-Buhaisi, & Vostainis, 2014), and may consist of sets of

responses occurring over time in which the environment and the individual influence each other (Taylor, 2006). Coping can be seen as an on-going, multi-step process by which adolescent males attempt to deal with life's daily stressors (Coon & Mitterer, 2010; Kassin, Fein, & Markus, 2014).

Early work on coping (e.g. Lazarus & Folkman, 1984) distinguished two general types, namely problem-focused coping and emotion-focused coping. In *problem-focused coping*, an adolescent male may use cognitive and behavioural efforts to reduce environmental stressors and to overcome the source of the problem (Kassin et al., 2014). The ability to deal effectively with stressful situations stimulates personal growth and equips youth with skills that enable the adolescent to move on the developmental path towards adulthood (Geldard & Geldard, 2009). *Emotion-focused coping* involves efforts to regulate emotions encountered during a stressful situation (Taylor, 2006). Efforts to clarify, reflect about and work through emotions constructively are more likely to lead to positive adjustment regarding daily concerns. For example, rather than resorting to drug use and risky sexual behaviour, an adolescent male may regulate the emotions associated with the stressors by talking to a friend or seeking advice from significant others such as parents or educators, and so develop a plan of action (Smyth & Filipkowski, 2010). Interestingly, Horton (2002) found that male adolescents are more likely to resort to physical and sexual coping strategies to deal with emotional issues.

Social support refers to helpful coping resources provided by family, friends and significant others in one's environment, that an individual can use when he/she is in need of advice, approval and protection in order to deal with stressors (Cicognani, 2011). Social support may be therapeutic in nature, as it offers emotional connectedness, sympathy, reassurance and a sense of how to take care of oneself (Kassin et al., 2014). Findings from a number of longitudinal studies suggested that adolescents with secure attachment

relationships manage stress with a sense of mastery; they choose effective coping strategies in stressful situations and are protected from experiencing emotional or behavioural distress (Patel, Flisher, Hetrick, & McGorry, 2007; Seiffge-Krenke, 2011). Kassin et al. (2014) were also of the opinion that religious coping activities by adolescent males may contribute to their positive functioning, and protecting them against risky sexual practices. Religious activities as a form of social support may offer benefits of relaxation in prayer, social unity and adoption of healthy and prosocial behaviour. Adolescent males who use their religious faith to cope with daily problems of living, rather than revert to premarital sex and alcohol use (Kail & Cavanaugh, 2000; Larson & Swyers, 2002), are more likely to experience psychological development in the areas of self-esteem, self-realisation and the restoration of inner-balance against depression, anxiety and anger (Wheeler, Ampadu, & Wangari, 2002).

As mentioned before, coping among adolescent males are not only influenced by internal aspects (e.g. self-esteem, personality traits), but also by external factors such as parental socio-economic status, divorce, a drug-related environment and peers (Kassin et al., 2014). A distorted self-esteem due to negative peer influence, poor social support and dysfunctional family life (Stickley, Koyanagi, Koposov, Schwab-Stone, & Ruchkin, 2014) has been associated with maladaptive coping behaviour such as drug and alcohol abuse, engagement in destructive behaviour, carrying of weapons and multiple sexual partners during adolescence (Backer-Fulghum, Patock-Peckman, King, Roufa, & Hagen, 2012). The disproportionate exposure to community violence of African adolescent males, as a result of living in economically-disadvantaged communities, contributes significantly towards lower self-esteem, emotional numbing and self-defeating coping behaviour (Gaylord-Harden, Cunningham & Zelencik, 2011). Drawing from Bronfenbrenner's (1979) ecological model, adolescent males who are raised in family settings characterised by hardships such as unemployment, divorce and substance abuse, may lack coping self-efficacy to complete their

schooling, relative to adolescents whose parents are available to meet their educational and other needs (Coyle, Nochajski, Maguin, Safyer, & DeWit, 2009).

The relationship between adolescent coping strategies and low levels of psychological well-being (e.g. depression) has been extensively investigated (Cicognani, 2011), but there is less information on the relationship of coping behaviours with positive well-being, especially among adolescent males in South Africa. Also, adolescence is a period accompanied by drastic increase in the frequency at which stressful events occur (Mezulis, Funasaki, Charbonneau, & Hyde, 2010). It is thus a difficult stage to distinguish whether the relationships between coping, well-being and sexual behaviour of adolescents are similar when coming from diverse sociocultural backgrounds (Smith & Somhlaba, 2014). The field of positive psychology has produced numerous constructs of positive coping strategies and subsequent health and well-being-related results, such as positive or adaptive coping, pro-active coping, and coping self-efficacy, amongst others. Adaptive coping, pro-active coping and coping self-efficacy all seem to moderate the stress-health relationship and reduce the illness-promoting (pathogenic) impact of stress on the immune system and, in doing so, conserve immune competence (Carr, 2011). Furthermore, all three coping constructs have been associated with competence in coping abilities and with various health and well-being-related outcomes (Folkman, 2011; Taylor, 2011).

In the above discussion, adolescent sexuality, decision making and communication as aspects of sexual behaviour, as well as the mental-health and well-being that may guide sexuality and aspects of behaviour that flow from their sexual awakening, were presented. Furthermore, coping strategies that the youth may employ to deal with the challenges they face pertaining to their sexuality – amongst other life issues – were discussed. The research question that underpinned the above discussion and that will be studied in this paper is: What are the relationships between aspects of behaviour such as decision-making skills and ease of

communication about sexual matters; their mental health, well-being and coping strategies of a group of African adolescent males?

METHOD

A research method serves the purpose of providing specific direction for procedures used in a research study (Cresswell, 2009). In this section the research design, aims of this study, participants involved, research procedures and ethical considerations, data collection and data analysis methods, will be discussed.

Research Design

In this study, a quantitative research design was employed to investigate the relationship between aspects of sexual behaviour, mental health and well-being and coping strategies among a group of African adolescent males. Quantitative research is systematic and objective in its methods, using numerical data from a selected subgroup of the population in order to generalise the findings to the population being studied (Leedy & Ormrod, 2005; Maree, 2010). It is a procedure for collecting, analysing and interpreting data obtained by using validated psychological measuring instruments with a relatively large group of participants (Creswell, 2009; de Vos, Fouche, & Strydom, 2011). The advantages of quantitative research, amongst others, are that 1) each and every question is answered by all participants; 2) information can be interpreted easily; and 3) each participant receives the same set of questions phrased in exactly the same manner which facilitates the yielding of more comparable results (Miller, 2007).

Aims of the Study

The general aim of the study was to investigate the relationships of aspects of sexual behaviour (decision-making skills and ease of communication) with mental health and well-being dimensions and coping strategies of African male adolescents in South Africa.

The specific aims were:

1. To assess the construct validity and reliability of measures of sexual decision-making skills and ease of communication (MSQA: BI), coping strategies (CCSC), and mental health and well-being (MHC: LF);
2. To test a structural model through estimating regression paths from well-being (emotional, psychological and social) to the respective factors that constitute coping strategies and sexual decision-making skills and ease of communication; and
3. To identify underlying latent classes that are not identified through specifying the best fit models.

Participants

A convenience sample (Durrheim & Painter, 2006) was drawn from four secondary schools in the Vaal Triangle Area, Gauteng Province, South Africa, where the researcher resides. The selected population of learners in these schools was adolescent males in Grades 10 and 11 and between 14 and 21 years of age. This selection was determined by the research question and aims of this study. A pilot study was also performed with a group of ten participants in order to determine the face validity of the measuring instruments and to make minor adaptations where necessary. Table 1 shows the composition of the research group in this study.

Table 1

Characteristics of the Participants (N = 552)

| GROUPS | N | % |
|------------------|-----|------|
| School Status: | | |
| Grade 10 | 292 | 52.9 |
| Grade 11 | 260 | 47.1 |
| Age: | | |
| 14 years | 7 | 1.3 |
| 15 years | 51 | 9.3 |
| 16 years | 126 | 22.9 |
| 17 years | 154 | 27.9 |
| 18 years | 122 | 22.1 |
| 19 years | 67 | 12.2 |
| 20 years | 17 | 3.1 |
| 21 years | 7 | 1.3 |
| Religion: | | |
| Christian | 363 | 65.9 |
| Muslim | 4 | 0.7 |
| Hindu | 0 | 0.0 |
| None | 109 | 19.8 |
| Other | 74 | 13.4 |
| Parental status: | | |
| Mother alive | 439 | 79.7 |
| Mother deceased | 109 | 19.8 |
| Father alive | 394 | 71.5 |
| Father deceased | 152 | 27.6 |
| Married | 182 | 33 |
| Divorced | 115 | 20.8 |
| Living together | 59 | 10.7 |

Note: Not all participants provided their complete biographical information

Of the 552 learners that participated in the research study, 52.9% ($n = 292$) were in Grade 10 and 47.1% ($n = 260$) were in Grade 11. Most of the participants fell into the age group of 16-18 years of age, developmentally known as the peak adolescent phase. The majority of participants ($n = 439$) indicated that their mothers were alive and a large group ($n = 394$) of these African youth males indicated that their fathers were alive. The breakdown of the parental marital status was as follows: 33% ($n = 182$) parents were legally married, as opposed to 20.8% ($n = 115$) whose parents were divorced; 10.7% ($n = 59$) indicated that their parents lived together. A large portion of the participants belonged to Christian religions (66%), while other religious groups were represented by 33.9% of the participants.

Research Procedures and Ethical Considerations

Four secondary schools were approached with formal letters, asking for male learners in Grades 10 and 11 to participate in the investigation into aspects of their sexual behaviour, mental health and well-being and coping strategies. After receiving consent from the schools' principals and the Gauteng Department of Education (Sedibeng West, District 8), detailed letters with information about the research and the ethical principles guiding the research were sent to all parents, requesting their written consent for their adolescent sons' participation in the study. None of the parents objected. The research was also approved by the North-West University Research Ethics Committee (NWU-00032-11-58).

Data was collected in February 2011 by means of questionnaires in booklet form which were disseminated to participants during periods approved by the principals and with the assistance of trained Life-Orientation educators who had been trained by the researcher. During each session, the learners were fully informed about the nature of the research, especially the sensitive topics explored by the questions. They were advised about their rights to withdraw at any time and about the voluntary and anonymous principles guiding their

participation. Their assent for participation involved their right to leave before the test administration would start. Grade 10 and 11 adolescent males present at school on that day participated, although a number of learners indeed left the venues owing to sport practices, transport issues and the long distances they had to travel back home (since the LO periods were last). Participants were free to ask questions if any of the items were unclear, since the questions were in English, the language of tuition at schools. It took the participants approximately two hours to complete the questionnaires. The questionnaires were completed anonymously and treated with confidentiality. Debriefing by the researcher who is also a trained teacher, was offered to participants after completion of the questionnaires. The responses expressed were mostly about the interesting nature of the questionnaires and how participants would like more discussions about the topics.

Measuring Instruments

Mathtech Sexuality Questionnaires for Adolescents: Behaviour Inventory (MSQA: BI; Kirby, 1984). These questionnaires contain questions in three areas of sexuality: Knowledge, attitudes and values, and aspects of behaviour. In this study, selected subscales of the inventory for behaviour (MSQA: BI) were used. The MSQA scales were intended to measure attitudes, values, skills and behaviour of adolescents that either lead to positive and fulfilling sexuality or reduce unwanted pregnancy among adolescents (Kirby, 1984). The subscales use Likert-style response scales with four response options varying from 1(*strongly disagree*) to 4 (*strongly agree*).

The 42-item Behaviour Inventory measures three aspects of several kinds of behaviour, namely the skill with which the behaviour is performed, the comfort experienced during that behaviour, and the frequency of that behaviour. In this study, the skill and comfort parts of this inventory were used, including the following subscales: Social decision-making skills; sexual decision-making skills; communication skills; assertiveness skills; birth control

assertiveness skills; comfort engaging in social activities; comfort talking with friends, girl/boyfriend and parents about sex; comfort talking with friends, girl/boyfriend and parents about birth control; comfort talking with parents about sex and birth control; comfort expressing concern and caring; comfort being sexually assertive (saying no); comfort having a current sex life, whatever it may be; and comfort getting and using birth control.

Item examples are: “When things you’ve done turn out poorly, how often do you blame others?” and “When you have to make a decision about your sexual behaviour, how often do you first discuss it with others?” The mean score for these scales should be determined by adding the values of responses and dividing them by the number of items. Higher scores represent more favourable behaviour.

The subscales of the Behaviour Inventory’s reliability indices ranged from 0.38 to 0.88 (Kirby, 1984). Using Kirby’s Mathtech Sexuality Questionnaires for Adolescents (attitude, values and behaviour), Tobey, Hillman, Anagurthi, and Somers (2011) found that the Cronbach alpha coefficient for adolescent males was 0.89 and 0.88 for adolescent females. In South African research using these questionnaires, Musarugwa’s (2001) research was conducted at a school in Maokeng, Kroonstad, Free State Province, investigating adolescents’ attitudes and values towards sexual behaviour. Permission for use of the MSQA inventories was found in the publications of Kirby (1984) and Davis, Yarber, Sauserman, Schreer, and Davis (1998).

Mental Health Continuum (MHC: LF; Keyes, 2005). Keyes’ MHC scale with 39 items, measures a person’s degree of emotional or subjective well-being; psychological well-being as described in Ryff’s model (Salam-Younes, 2011); and social well-being as conceptualised by Keyes (1998). Emotional well-being is measured by six items that enquire, on a five-point scale, how much of the time during the past 30 days an individual felt cheerful, in good spirits, extremely happy, calm and peaceful, satisfied and full of life. The second component

is a single item that asks: Using a scale from 0 to 10, where 0 means “the worst possible life overall” and 10 means “the best possible life overall”, how would you rate your life overall these days?” The second section of the questionnaire contains 18-items from Ryff’s (2001), and Ryff and Keyes’ (1995) psychological well-being measure, divided into the following six subscales, each represented by three items: Self-acceptance, positive relations, personal growth, purpose in life, environmental mastery, and autonomy. The third section contains Keyes’ (1998) 15-item measure of social well-being which operationalises how much individuals see themselves as thriving in their public (social) life. The five three-item subscales are social coherence, social integration, social acceptance, social contribution and social actualisation.

The psychological and social well-being scales are responded to on a seven-point disagree-agree scale. Keyes (2005) reported Cronbach’s reliability indices for emotional well-being of 0.91 and 0.81 for psychological and social well-being respectively. Studies in South Africa using the Mental Health Continuum (MHC: LF) by Keyes (2005) with youth could not be found, although various studies have used the MHC: SF and reported good reliability indices (Wissing & Temane, 2008). Permission for use of the MHC: LF was obtained from the author.

The Children’s Coping Strategies Checklist (CCSC; Ayers & Sandler, 1999). The CCSC measures strategies used by children and adolescents to cope with stressful situations and circumstances they encounter. Coping skills are represented in thirteen dimensions and measured with 54 items. Dimensions include the following:

- ❖ Active coping strategies (Act cop)
 - Problem-focused coping (Prob cop)
 - Cognitive decision making (Cdm)
 - Direct problem solving (Dps)

- Seeking understanding (Su)
- Positive cognitive restructuring (PCR)
 - Positivity (Pos)
 - Control (Con)
 - Optimism (Opt)
- ❖ Distraction strategies (Dist str)
 - Distracting actions (Da)
 - Physical release of emotion (Pre)
- ❖ Avoidance strategies (Avoid Cop)
 - Avoidant action (Ava)
 - Repression (Rep)
 - Wishful thinking (Wish)
- ❖ Support-seeking strategies (Sup Str)
 - Support for actions (Supa)
 - Support for feelings (Supf)

In this study, the active coping strategies and support-seeking strategies' subscales of the CCSC were used. The items are presented as statements and by using four response options, the person indicates how often he responded in such ways. Ayers and Sandler (1999) found alpha reliability indices of 0.88 for the active coping strategies; 0.65 for the avoidance strategies; and 0.86 for the support-seeking strategies. The authors also reported good construct validity for the CCSC by means of congruent, discrimination and criterion validity measures performed (Ayers & Sandler, 1999). Using the CCSC in a South African context, Pretorius (2009) found a Cronbach alpha for the problem-focused coping component of the active coping scale to be 0.78, and for the positive cognitive restructuring component of the active coping scale, 0.77. Marais (2011) found reliability coefficients ranging from 0.64 to

0.90 for the main subscales of the CCSC in a local sample of youth ($n = 262$). Permission for use of the CCSC was obtained from the authors.

Of the 600 questionnaires received in this study, 552 were complete. The reasons for the 48 incomplete questionnaires might be due to the fact the items were sensitive or complex; that participants experienced some fatigue as filling out the questionnaires took approximately two hours; and language difficulties or cultural influences could also have played a role. These incomplete questionnaires were discarded.

Statistical Analyses

The data was analysed using Mplus version 7.31 (Muthén & Muthén, 2008-2014). The items of the three questionnaires discussed above were defined as being categorical, using WLSMV (weighted least squares with corrections to means and variances) as estimator. To assess measurement and structural model fit, the comparative fit index ($CFI > 0.90$), Tucker-Lewis Index ($TLI > 0.90$), the root mean square error of approximation ($RMSEA; < 0.80$) and Chi-square difference testing were used. Reliabilities of scales measured by items rated on a continuous scale were computed, using a formula based on the sum of squares of standardised loadings and the sum of standardised variance of error terms (Wang & Wang, 2012). This was done as an alternative for Cronbach alpha which does not provide a dependable estimate of scale reliability when latent variable modelling is used. Latent class analysis was conducted by means of the Vuong-Lo-Mendell-Rubin Likelihood Ratio Test (LRT).

Results and Discussion

By means of confirmatory factor analyses (CFA), using the Mplus statistical software programme (Muthén & Muthén, 2008-2014), the distinctness of the assessed variables for aspects of sexual behavior (MSQA: BI), mental health and well-being (MHC: LF) and coping

strategies (CCSC) of a group of African male adolescents, was determined. This brought about a reduction of items of the questionnaires used, so that for the MSQA: BI 15 out of 42 items, for the MHC: LF 22 out of 39 items, and for the CCSC 15 of 54 items were used in the various analyses performed. The main reasons for the reduction of items were two-fold: Firstly, only items that specifically measured aspects relating to sexual behaviour in the MSQA: BI were used, in line with the aims of the study; secondly, the refined nature of the Mplus programme brings about a gradual exclusion of items that do not significantly contribute to the final statistical outcomes, in this case a measurement model. Thus, the results that are further reported were mostly obtained with analyses using the reduced items for the questionnaires.

Descriptive statistics

Descriptive statistics are statistical procedures used to describe, organise and summarise samples of data (Reber & Reber, 2001) and to summarise and represent features of data on a single variable (Terre Blanche et al., 2006). In Table 2 below, descriptive results based on the data of the CCSC, MHC: LF and the MSQA: BI used in this research, are displayed. The means and standard deviations for these scales correspond with those found in literature for the same measuring instruments.

Table 2

Descriptive Statistics, Reliability Coefficients, and Correlations

| Variable | Mean | SD | ρ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|--------------------------------------|------|------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| CCSC: | | | | | | | | | | | |
| 1. Support-seeking coping strategies | 4.04 | 0.65 | 0.82 | - | | | | | | | |
| 2. Problem-focused coping strategies | 4.99 | 0.56 | 0.67 | 0.26** | - | | | | | | |
| 3. Coping | 4.52 | 0.47 | - | 0.33** | 0.78** | - | | | | | |
| MHC: | | | | | | | | | | | |
| 4. Emotional well-being | 5.25 | 0.69 | 0.71 | 0.07** | 0.16** | 0.21** | - | | | | |
| 5. Psychological well-being | 5.41 | 1.14 | 0.87 | 0.12** | 0.29** | 0.37** | 0.46** | - | | | |
| 6. Social well-being | 5.28 | 1.28 | 0.82 | 0.12** | 0.28** | 0.36** | 0.45** | 0.79** | - | | |
| 7. Mental health | 2.31 | 0.84 | - | 0.13** | 0.32** | 0.41** | 0.51** | 0.90** | 0.88** | - | |
| MSQA: BI | | | | | | | | | | | |
| 8. Decision-making behaviour | 4.74 | 0.63 | 0.67 | 0.18** | 0.44** | 0.56** | 0.07* | 0.13* | 0.13* | 0.14* | - |
| 9. Communication | 4.67 | 0.68 | 0.78 | 0.05 | 0.12 | 0.15 | 0.10** | 0.17** | 0.17** | 0.19** | 0.14* |

Note: CCSC: Children's Coping Strategies Checklist; MHC: Mental Health Continuum; MSQA:BI: Mathtech Sexual Questionnaire for Adolescents: Behaviour Inventory;

* $p < 0.05$

** $p < 0.01$

Medium practical significance $r > 0.30$

Large practical significance $r > 0.50$

The reliability indices for the factors of the scales used are given as ρ -values which are considered to be more suitable when using structural equation modelling. These values were calculated using the unstandardised factor loadings (γ) and unstandardised variance of error (β), while including the correlation of error (Raykov, 2004; Wang & Wang, 2012). The ρ -values found range from 0.67 to 0.82 and such reliability scores could be considered as fair to good (Nunnally & Bernstein, 1994; Steiner, 2003).

The correlations reported in Table 2 are mostly significant on the $p < 0.01$ level. Correlations below 0.10 were not taken into account. Significant positive correlations were found between the coping measures and those of mental health and well-being, as well as those of sexuality decision making and communication. Mental health and well-being were also significantly positively associated with sexuality decision making and communication, although with lower correlational values. It is interesting to note that the strongest correlations occurred between the coping strategy factors and mental health and well-being, sexuality decision making and communication. Four correlations of coping strategies with mental health and well-being show medium practical effect significance. Sexuality decision making correlates with coping strategies and with problem-focused coping strategies, with medium to strong practical effect significance. No causality conclusions could be made on these results.

The measurement model

To meet a specific aim stated for this research, the construct validity and reliability of the MSQA: BI, CCSC and MHC: LF were assessed by means of Mplus (Muthén & Muthén, 2008-2014). Confirmatory factor analyses were done on the MSQA: BI, CCSC and the MHC: LF. An initial measurement model (Model 1) with latent variables was specified and examined for statistical fit. To be able to test whether this model represented the best fitting model, alternative models (Models 2, 3 & 4) were similarly specified and tested. The models were specified as follows:

Model 1 consisted of the following: Coping strategies as a second order latent variable, with two first order latent variables, namely support-seeking strategies (8 items), and problem-focused coping (7 items); mental health and well-being as a second order latent variable, with three first order latent variables, namely MHCE (6 items), MHCP (10 items) and MHCS (6 items); sexual behaviour as a second order latent variable, with two first order latent variables, namely Decision making (6 items) and Communication (9 items).

Model 2 consisted of the following: Coping strategies as a first factor latent variable with 15 items; mental health and well-being as in Model 1; and sexual behaviour as in Model 1.

Model 3 consisted of the following: Coping strategies as in Model 1; mental health and well-being as a first order latent variable with 22 items; and sexual behaviour as in Model 1.

Model 4 consisted of the following: Coping strategies as in Model 1; mental health and well-being as in Model 1; sexual behaviour as one second order latent variable consisting of two first order factors of decision making and communication, with six and nine items respectively.

Table 3 shows the statistical fit of the four models.

Table 3

Fit Statistics of Competing Measurement Models (N = 552)

| Model | χ^2 | <i>df</i> | CFI | TLI | RMSEA |
|---------|----------|-----------|------|------|-------|
| Model 1 | 1597.49 | 1260 | 0.96 | 0.95 | 0.02 |
| Model 2 | 1959.84 | 1262 | 0.91 | 0.91 | 0.03 |
| Model 3 | 1877.93 | 1263 | 0.92 | 0.92 | 0.03 |
| Model 4 | 1638.43 | 1261 | 0.95 | 0.95 | 0.02 |

Note: *df* = degrees of freedom; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

In Table 3 it is seen that Model 1 has the best statistical fit of the tested models. The RMSEA model fit was acceptable (lower than 0.05), as were the fit indices for the CFI and TLI (above 0.90). A Chi-square χ^2 of 1579.49 ($df = 1260$) was obtained for Model 1. *Note:* Given that the measurement models were non-nested, the Chi-square difference test could not be computed. Furthermore, the Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC) which can be used for comparison of non-nested measurement models are not available when the WLSMV estimator is used. These findings meet the specific aim of this study mentioned before and it is evident that the construct validity and reliability of the measurements used are acceptable.

The structural model

A structural model (Model 5) was specified and tested based on the best fitting measurement model (Model 1). Model 5 was analysed and the fit results, compared with two competing models (Handcock & Mueller, 2010), are shown in Table 5.

Table 5

Initial Framework Fit Indices and Standardised Path Coefficients

| Measures | | Indirect effects (Model 1) | Direct effects (Model 2) | Direct and indirect effects (Model 3) |
|-----------------------------------|------------------------------|-------------------------------|-----------------------------|--|
| Fit indices | χ^2 | 1673.42 | 1746.06 | 1598.78 |
| | <i>Df</i> | 1262 | 1263 | 1261 |
| | CFI | 0.95 | 0.94 | 0.96 |
| | TLI | 0.95 | 0.94 | 0.96 |
| | RMSEA | 0.02 | 0.03 | 0.02 |
| Direct effects on mental health | Coping | - | 0.42** | 0.51** |
| | Decision-making behaviour | 0.29** | 0.15** | -0.17 |
| | Communication | 0.15** | 0.19** | 0.12* |
| Direct effects on decision making | Coping | 0.87** | - | 0.60** |
| Direct effects on communication | Coping | 0.17* | - | 0.18* |

Note: *df* = degrees of freedom; TLI = Tucker-Lewis Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation

* $p < 0.05$

** $p < 0.01$

In Table 5 it can be seen that the three models were specified according to their effects on latent variables, namely indirect effects, direct effects and direct and indirect effects. Model 3 is the full structural model with both direct and indirect effects and is clearly the best fitting of the models according to the χ^2 , *df*, CFI, TLI and RMSEA indices.

With the WLSMV as estimator, the chi-square cannot reliably be calculated in the regular way and must be done using the difftest method (Sattorra & Bentler, 1999;

www.statmodel.com). Table 6 shows the difference testing for changes in the chi-square of competing models, and also indicates Model 3 as the best fitting model; thus meeting the second specific aim of this study.

Table 6

Difference Testing for Changes in Chi-square in Competing Structural Models

| Model | $\Delta\chi^2$ | Δdf | <i>p</i> -value |
|---------|----------------|-------------|-----------------|
| Model 1 | 19.13 | 1 | 0.00** |
| Model 2 | 30.64 | 2 | 0.00** |

** $p < 0.01$

Latent Class Analyses (LCA)

The data of 552 participants who responded to the MHC: LF questionnaire was explored using a frequency analysis, utilising SPSS22 (IBM, 2013), where after latent class analysis (LCA) with Mplus 7.31 (Muthén & Muthén, 2008-2014) was conducted to group participants, based on their levels of mental health and well-being - specifically emotional, psychological and social well-being. A series of models with an increasing number of latent classes were tested. When there was a significant improvement from the reference model to a model with more classes, that model was retained. All models were evaluated by means of the lowest BIC value comparing the different models, and relative entropy (called entropy by Mplus and referring to measures of classification uncertainty) ranging from 0 to 1 (smaller than 0.60 not acceptable, higher is better). The number of classes in a mixture analysis is tested by Mplus using the Vuong-Lo-Mendell-Rubin likelihood ratio test (VLMR LRT), the Lo-Mendell-Rubin adjusted LRT (LMR ALRT), as well as the parametric bootstrapped likelihood ratio test (PBLRT) (Wang & Wang, 2012). The quality of class membership was indicated by posterior class membership probabilities and the entropy values.

A number of steps were followed to estimate the LCA model. Firstly, an optimal number of latent classes were determined; secondly, the latent class classification was examined; thirdly, the latent classes were named; and finally, latent class membership was predicted. To establish the number of latent classes, four models with different numbers of latent classes were estimated and compared, beginning with a single class model and increasing the number of classes by one each time. Table 7 shows the fit indices, indicating that the AIC (2403.70), BIC (2429.58) and ABIC (2410.53) values of the one class model were the largest, meaning that this model had the worst fit.

Table 7

Comparison of Different LCA Models (N = 552)

| Model | AIC | BIC | ABIC | VLMR LRT <i>p</i> -value | LMR ALRT <i>p</i> -value | PBLRT <i>p</i> -value |
|-------------|---------|---------|---------|--------------------------------|--------------------------------|--------------------------|
| 1-class LCA | 2403.70 | 2429.58 | 2410.53 | n.a | n.a | n.a |
| 2-class LCA | 1976.70 | 2019.83 | 1988.09 | 0.01 | 0.01 | 0.00 |
| 3-class LCA | 1670.70 | 1731.09 | 1686.65 | 0.01 | 0.01 | 0.00 |
| 4-class LCA | 1539.12 | 1616.76 | 1559.62 | 0.04 | 0.05 | 0.00 |

Three further steps were used to test the hypothesised model of three classes: Step one was to find the best log-likelihood values for the models. The three-class solution replicated the best log-likelihood value (-821.35) several times, using the default number of starting values. To verify that a better log-likelihood cannot be found, a second run was done which increased the number of random starting values to 800, with final stage optimisations at 80, and found the same best-replicated log-likelihood value. Step two was to conduct a 4-class analysis to make sure that the $k - 1$ class model (three classes) proved to be the best log-likelihood value found in Step 1. An OPTSEED value 851 945 from the previous run was applied in the 4-class run. The Vuong-Lo-Mendell-Rubin LR test for three rather than four classes had a log-likelihood

value of -821.35 (2 times the log-likelihood difference = 139.58, difference in the number of parameters = 4, Mean = -3.02, $SD = 97.05$, $p = 0.04$). The Lo-Mendell-Rubin Adjusted LR test (value = 134.27) was not statistically significant ($p > 0.05$). Step three did a 3-class analysis using the same OPTSEED value as in step 2 with LRT starting values = 0 0 100 20. The Parametric Bootstrapped LR test for two rather than three classes was statistically significant ($p < 0.01$), rejecting the two-class model in favour of the three-class model (Wang & Wang, 2012). The p -values of the VLMR LR test, and the LMR ALR test of the three-class model were smaller than 0.05 (for both $p = 0.01$). The three-class model further had smaller AIC, BIC, and ABIC values and thus fitted the data best.

The quality of the latent class membership was examined next. The entropy values for the two-class and three-class LCA were 0.73 and 0.83 respectively, which point to a good classification (Clark, 2010). The posterior class membership probabilities for the three-class LCA model were also all larger than 0.91, which was acceptable according to the cut-off value of 0.70 or greater, as suggested by Nagin (2005).

The classes were then labelled based on their means for emotional well-being (EWB), psychological well-being (PWB) and social well-being (SWB). Class 1 (moderate in well-being) had average scores and included 309 (56.0%) of the participants. Class 2 (languishing, with low well-being) had the lowest means and included 87 (16.0%) of the sample. Class 3 (flourishing, with optimal well-being) had high mean scores and included 154 (28.0%) participants. Figure 1 illustrates the three latent classes. The three graphs in Figure 1 are “parallel”, showing that there are three distinct classes.

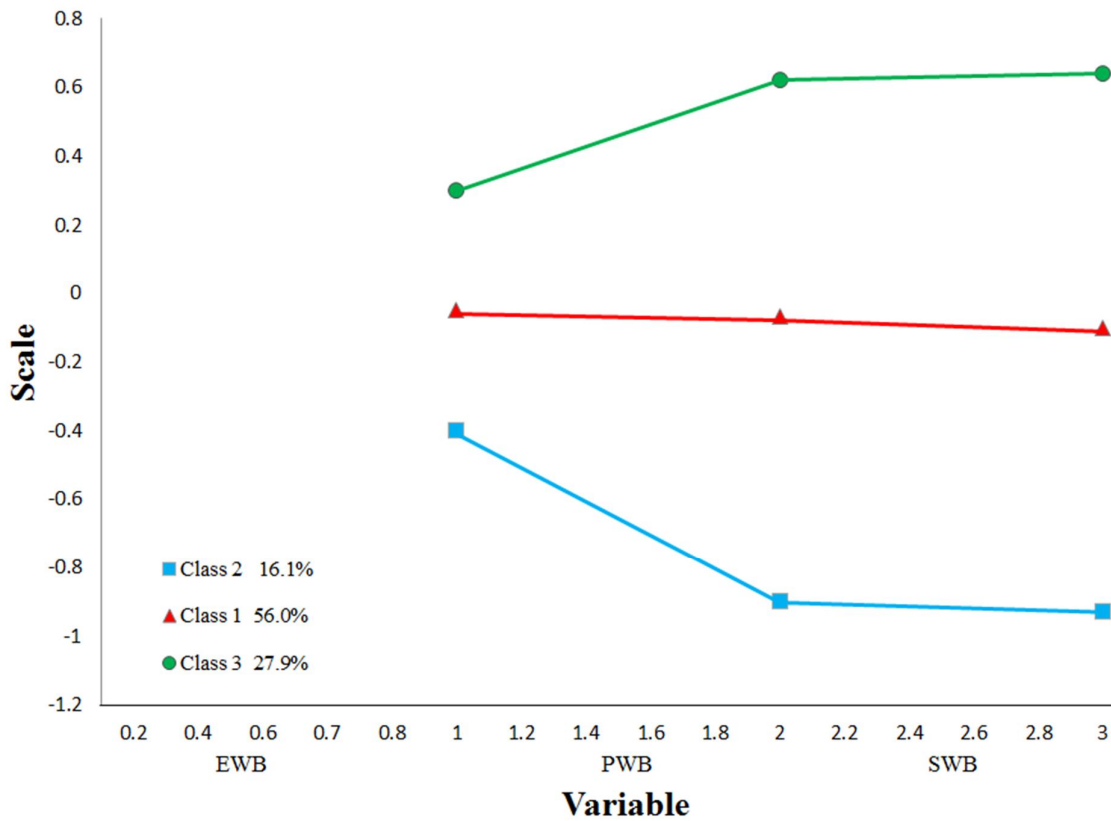


Figure 1: The three latent classes

The following covariates were further introduced to predict class membership: Support-seeking coping strategies, problem-focused coping strategies, sexual decision making and sexuality communication (see Table 8). All the fit statistics were acceptable, namely AIC = 1578.87, BIC = 1673.77, and ABIC = 1603.03.

Table 8

Regression Coefficients for the Different Latent Classes

| | Languishing ON | Moderate mental health ON | |
|-----------------------------------|--|---------------------------|-----------------|
| Support-seeking coping strategies | -0.28 | -0.26 | |
| Problem-focused coping strategies | -4.82*** | -3.02*** | |
| Sexual decision making skills | 0.61 | 0.06 | |
| Sexual communication | -1.38** | -0.92*** | |
| | Languishing (1) compared to | | |
| | Moderate mental health (2) | | Flourishing (3) |
| Support-seeking coping strategies | 0.02 | 0.28 | |
| Problem-focused coping strategies | 1.80* | (1 < 2) | 4.82*** (1 < 3) |
| Sexual decision making skills | -0.55 | -0.61 | |
| Sexual communication | 0.46 | 1.38*** (1 < 3) | |
| | Moderate mental health (2) compared to | | |
| | Flourishing (3) | | |
| Support-seeking coping strategies | 0.26 | | |
| Problem-focused coping strategies | 3.02*** (2 < 3) | | |
| Sexual decision making skills | -0.06 | | |
| Sexual communication | 0.92** (2 < 3) | | |

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Flourishing (compared to languishing) adolescent males are more likely to use problem-focused strategies ($\beta = 4.82$) as the main method of coping, and communication ($\beta = 1.38$) as

the main behavioural mechanism. Languishing male adolescents are less likely than moderately mentally healthy male adolescents to use problem-focused strategies ($\beta = -0.80$) as a coping mechanism. Flourishing adolescent males are more likely to use problem-focused strategies ($\beta = 3.02$) and communication ($\beta = 0.92$) than moderately mentally healthy male adolescents.

Discussion

The purpose of this study was to investigate the relationships between mental health and well-being, coping strategies and aspects of sexual behaviour, namely decision making and communication, of $N = 552$ African male adolescents.

Three scales, namely the MHC: LF, the CCSC, and the MSQA: BI were used to assess the aspects mentioned above and acceptable p -values indicating reliability indices for the identified factors based on data from the scales used, were found ($p = 0.67 - 0.82$). The means and standard deviations found were compared and seemed similar to those reported in literature for the same scales.

Correlation analyses showed that, as one would theoretically expect, the three dimensions of mental health and well-being correlated significantly positive with adaptive coping strategies, as well as with sexuality decision making and communication skills. Coping strategies had the most significant correlations with the other variables. These findings support those in literature that indicate the interrelatedness of emotional, psychological and social dimensions of mental health and well-being, adaptive coping strategies such as problem solving and social support; and healthy sexual behavioural features such as the skills to make decisions and to communicate about sexuality matters (Heppner & Lee, 2009, Keyes, 2004; Taylor, 2011; Tugade, 2011; Willers et al., 2013). The strong and significant correlations of coping strategies to solve problems and obtain social support, with mental health and well-being and with sexual decision-making behaviour, seem to indicate that problem-solving abilities and perceiving social support when needed, have enabling influences on youth when dealing with

developmental challenges. (Aldwin, 2011; D’Zurilla & Nezu, 2006; Malouf, Thorsteinsson, & Schutle, 2007; Taylor, 2011). Positive problem-solving experiences have enhancing cognitive, self-related, emotional and psychological effects; and social support has strong relational, affiliative and stress-buffering effects (D’Zurilla & Nezu, 2006; Taylor, 2011). Heppner and Lee (2009), and Malouff et al. (2007) recommended that problem-solving skills training could be included in all intervention programmes aimed at enhancing the quality of life and overall well-being of young people.

In line with the specific aims stated for this study, a measurement model was identified from factor analyses of the data that had been obtained by utilising the measuring instruments and was compared with competing models to determine statistical fit. The identified model proved to meet the fit indices for a best fitting model. Also, a structural model was specified and tested based on the identified best fitting measurement model. The best fitting full structural model indicated both direct and indirect effects on all latent variables. These identified models met the first two specific aims of the study.

LCA was used to group participants with similar response patterns regarding their emotional, psychological and social well-being. Based on the fit indices, three classes were identified as optimum. After inspection of the classes, they were named flourishing, moderately mentally healthy, and languishing. The flourishing, moderately mentally healthy and languishing classes comprised 28%, 56% and 16% of the male adolescents respectively. These findings are comparable to those by Keyes (2006, 2007) who found that 38% of USA youth were flourishing; 56% were moderately mentally well; and 6% were languishing. In South African research with youth, Koen (2012) found that 38% of youth were flourishing; and 64% reported moderate to low mental health and well-being, whilst Schalkwyk (2009) found 42% of youth flourishing; 53% moderately well; and 5% languishing. What is clear when comparing the participants in the current research’s results to those mentioned above is that the moderate

scores are similar, but the flourishing levels are lower, with more youth languishing. This may be explained by the personal and socio-contextual challenges faced by the youth in this study. The use of the MHC: LF could also have played a role since the other studies mentioned here had used the MHC: SF, which was validated for use among South African youth.

The probability that a class member demonstrated the characteristics associated with this class was larger than 91% for all three classes. Figure 1 demonstrated that those flourishing had the highest levels of EWB, PWB and SWB; and those languishing had the lowest levels. In this study, emotional well-being suggested that young men experienced happiness, were interested in and also satisfied with life. Psychological well-being meant that the young men felt that they accepted most parts of their personalities, could manage daily responsibilities, had close and trusting relationships, had challenging experiences that fostered their growth, were confident about their ideas and opinions and life had a sense of meaning and direction. Social well-being implies that they felt they had something to contribute to society, that they belonged, that society could become a better place, that people were basically good, and that the dynamics of society made sense (Keyes, 2002; Lamers et al., 2011). Michalec, Keyes, and Nalkur (2009) succinctly defined flourishing as “a state of positive mental health; to thrive, to prosper and to fare well in endeavours free of mental illness, filled with emotional vitality and function positively in private and social realms” (p. 391).

Flourishing male adolescents were more likely to use problem-focused coping strategies and sexuality communication skills than both moderately healthy and languishing male adolescents. Moderately healthy male youth are more likely than those who are languishing to use problem-focused coping strategies. These results remind one of the notion by Barber, Bagnsby and Munz (2010) that individuals may need to reduce avoidance strategies and increase engagement strategies to increase flourishing.

The findings obtained through LCA met the third specific aim of this study. The results support the notion of Keyes (2006, 2007) that flourishing in youth not only diminishes from adolescence to adulthood, but – specifically - that flourishing youth function better than moderately mentally healthy youth, who in turn function better than languishing youth. Based on his findings, Keyes concluded that flourishing in youth is associated with developmentally desirable outcomes (e.g. low depression, few conduct and risk-related problems and high psychosocial functioning); therefore flourishing should be strongly facilitated and protected in youth. In line with Keyes' findings were those of Wissing et al. (2008) that flourishing South African youth reported positive affect, coping competence, self-efficacy, ego-resilience, sense of coherence, satisfaction with life, self-regulation and perceived social support with low levels of depression, negative affect and physical symptoms of stress. One could speculate from the current findings that flourishing youth would also have adaptive coping strategies and healthy sexuality practices that would, in turn, enhance their mental health and well-being.

The results of this research could contribute to the development of intervention strategies towards healthy sexual decision-making and communication skills in youth, problem solving and support-seeking competence, and the promotion of emotional, psychological and social well-being. Such psycho-educational programmes would correspond with Keyes' (2007) flourishing; Heppner and Lee's (2009) problem-solving skills; Ungar's (2005, 2014) resilience; and Sun and Shek's (2011) youth development interventions.

It is not clear why the support-seeking coping strategy and the decision-making facet of sexual behaviour did not yield significant results in the prediction of class membership, as one would have expected. It could be speculated that the decision-making skills, particularly pertaining to sexual practices, of these youth have not been fully developed or refined, as was discussed in the literature review before. The decision-making skills - explored by the MSQA: BI - have a strong cognitive content and also focus on aspects of taking sexual responsibility.

One wonders to what extent these higher order skills are present in adolescent males such as those in this study. It could also be remembered that during adolescence, communication (a predictor of class membership) is a strong interpersonal skill, especially in the peer context where the young male must assert himself. Regarding sexuality, such youth would rather joke, brag or gossip about sexual encounters (often imaginary), to boost their image among peers – so they would rather talk about than deeply think about aspects of sexuality.

As far as the social support coping strategy is concerned, it may also be considered from what was discussed in the literature review with regard to the lack of openness about sexual matters between African parents and their adolescent children. Thus, as far as aspects of sexuality are concerned, it seems likely that participants could not relate the perceived social support as explored by questionnaire items, to their personal experiences with parents or other adults, in which communication about and support for sexual matters were discouraged. Further research into these facets of adolescent sexuality is recommended.

In this study, the main aim was to determine the relationships between mental health and well-being, coping strategies and sexual decision making and communication of African male adolescents. The general and specific aims were met through identifying best fitting measurement and structural models by means of structural equation modelling, as well as latent class analyses identifying three latent classes of mental health and well-being, comprised of the 552 participants in this study.

There were various limitations in this study. First, the MSQA:BI is an old scale and although still in use for survey research mainly, factor analyses to identify the relevant factors by means of which sexual decision-making skills and communication competence could be conceptualised, could not be found. It has also not been validated for use with South African youth. Research along these lines is recommended. Second, the MHC:LF has not been validated for use in South African research; whereas the MHC:SF has (Keyes et al., 2008). The

use of the MHC:SF is thus recommended for future research into the psychosexual well-being of South African youth. Third, the CCSC has not been validated for use in South Africa, although it has been used in South African studies. One wonders whether using one of the many youth coping scales that have been validated locally would have yielded a different picture of youth coping strategies. Research in this regard is recommended. Fourth, although English is the language of tuition at the schools where the research had taken place, the researcher is of the opinion that more valid and richer results could have been obtained with scales in the mother tongue of the youth. Nonetheless, despite these limitations, the study was successful. It had reached the anticipated aims and could lead to further research interest into mental health and well-being, coping strategies and sexual decision making and communication skills of the youth in South Africa.

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MANUSCRIPT THREE

**GUIDELINES FOR PROMOTING HEALTHY SEXUAL
BEHAVIOUR AND PSYCHOSOCIAL WELL-BEING OF
AFRICAN ADOLESCENT MALES**

Abstract

In this study, guidelines and strategies for a proposed sexual education programme aimed at promoting the sexual and mental health and well-being of male youth, were presented. The guidelines were based on empirical findings from preceding research and on relevant literature. It was proposed that the programme consists of eight strategies or sessions that, although having individual focus themes, all contribute to the overall aim of the programme. The eight themes and activities related to each theme are: Sexuality, preparing for the journey toward healthy sexual lives, sexual values and attitudes, sexuality and the language of the body, sexuality and the relational context, self-esteem, problem-focused coping, flourishing, and finally, wrapping up and the way forward. An evaluating discussion concluded the paper.

Key terms:

Guideline, intervention, psycho-education, psycho-sexual, sexual education for adolescents, strategies.

Proposed guidelines for a psycho-educational programme aimed at promoting the healthy sexual behaviour and psychosocial well-being of African adolescent males will be discussed in this paper. The development of healthy sexual practices and psychosocial strengths in youth is needed to build their personal resources, to enable them to cope with risk factors (deviant peers, dysfunctional families) and adversity that they often face. This is in line with growing evidence indicating that certain strengths of character, e.g. kindness, self-regulation and wisdom (perspective), as well as other psychosocial strengths can buffer the negative effects of stress and trauma, even preventing the onset of disorders (Joseph & Linley, 2006; Peterson & Seligman, 2004; Peterson, Park, Pole, D'Andrea, & Seligman 2008; Seligman, Steen, Park, & Peterson, 2005). Park and Peterson (2009) argued that character strengths, for example, manifesting in a range of thoughts, feelings and actions are foundations of lifelong healthy development, and they are essential for the well-being of the entire society.

The aim of this study was to propose guidelines for a sexual education or psycho-education programme that will equip African adolescent males with decision-making and communication skills pertaining to their sexuality; also equipping them with overall intra- and interpersonal skills with which to promote their psychosexual and psychosocial well-being. The proposed guidelines were informed by the results of empirical findings from African adolescent males ($N = 552$) who voluntarily participated in a quantitative research study conducted at four high schools in the Vaal Triangle, Gauteng Province, South Africa, as well as a literature review that preceded the empirical research.

Psycho-Education/Sexual Education

Sexuality education refers to an age-appropriate and culturally relevant approach to teaching young people about sexual practices, by providing scientifically accurate and non-judgemental information (UNESCO, 2009). It comprises developmentally intentional processes by which adolescents acquire knowledge about themselves as sexual, gendered beings from

biological, psychological to sociocultural perspectives (Goldfard & Constantine, 2011). Somers and Surmann (2005) described sex education as aimed at abstinence plus to develop clear values and help prepare the youth to make safe and well-informed decisions about sex, in order to prevent their exposure to sexually transmitted infections, unplanned fatherhood and possible criminal offence due to a failure to negotiate safe sex with their partners.

According to Jones (2011), conceptualisations of sexuality education can be classified into four main types, namely conservative, liberal, critical and postmodern. *Conservative* sexuality education promotes the transmission of hetero-normative principles, which are widely acceptable in many African societies. In a normative process of sexual development for adolescents in a cultural context, the majority of male youth would refrain from gang-activities, substance use and unsafe sexual practices (Guzman & Kouyoumdjian, 2013). Such a normative context provides ideological norms to youth about what it means to be a healthy sexual person (Preston, 2013), and opportunities to engage in sound conversation about sex and the values and attitudes attached to it (Fine & McClelland, 2006).

Liberal sexuality education is geared towards empowering adolescents with sexual self-efficacy and knowledge for personal choice and growth. It is non-restrictive, non-judgemental and amoral. *Critical* sexuality education is underpinned by feminism and post-colonialism theories and promotes integrated person-centred action, based on the principles and values which address power inequalities. Finally, *postmodern* sexuality education discourses promote the theoretical exploration of sex, gender and sexuality frameworks which are influenced by post-structural theories such as queer-theory. In general sexual education could serve to eradicate the individual's confusion, anxiety and other environmental or social factors, which may hinder progress towards psychosexual maturity (Fristad, 2006) and may assist in equipping the youth to deal with many different emotional, behavioural and mental issues, including sexual empowerment, sexual aggression and attachment (McBride, 2009).

Schaalma, Abraham, Gillmore, and Kok (2004) asserted that sex-education should be evidence-based, needs-driven and socio-ecological in approach, considering that many cultures, both modern and premodern still have strong sexual taboos. Evidence-based programmes such as *SHARE* (Sexual Health and Relationships: Safe, Happy and be Responsible of Abraham, Wight, & Scott, 2002) and the Long Live Love (Schaalma & Kok, 2009) encouraged high school adolescent males to discuss and rehearse what they would do in social situations where risky sexual behaviour might occur. The feedback received from such programmes reported substantial behavioural changes amongst adolescents, because the programmes improved the quality of adolescents' sexual relationships while reducing the incidence of unsafe sex and unwanted pregnancies (Wight & Abraham, 2000). Kirby (2002a) found that effective sex-education programmes included activities that addressed the social context of sexual behaviour and provided modelling and practice of communication, negotiation and refusal skills.

Universally there are a myriad of sexual education programmes and projects in existence. Although most of such programmes purport to promote healthy sexuality in youth, they mostly focus on prevention of adolescent sexual ill-health or sexually-related problems -emotional, behavioural or interpersonal in nature. A few examples of existing programmes, mostly in South Africa, are briefly discussed below.

In New Zealand, sexuality education has been presented since 1910 (Smyth, 2000) with the aim to promote heterosexuality, stable family life and prevent sexual promiscuity among young people (Allen, 2008; Cameron-Lewis & Allen, 2013); while in Jamaica, the benefit of sexuality education has contributed positively to low HIV prevalence among young people aged 15–24 years, reported to be at 1% of the HIV positive population (Jamaica Ministry of Health, 2010; UNESCO, 2009). Well-designed sex and HIV education programmes can potentially reach large numbers of youth, including those who have dropped out of school (Kirby, Laris, & Rolleri, 2007). For example, in the United States, Lawrence, Crosby,

Brasfield, and O'Bannon (2002) found that the Becoming a Responsible Teen programme led to either abstinence or condom use among many sexually active youth who had multiple sexual partners.

In preventing sexually transmitted infections (STIs) amongst 15–18 year-old Grade 11 learners in the Midland of KwaZulu-Natal, James, Reddy, Ruiter, McCauley, and van den Borne (2006) found that by reading a comic created by a trained Life Orientation educator, learners had developed positive attitudes towards condom use since they acquired knowledge about the spread of STIs. The idea of such a programme was that sexual education had the potential to enable adolescents to practice safe sex and seek advice from parents and clinics. Other programmes that are regarded as effective are those that involve role-playing. Role-playing has been found to assist in behaviour modification (Abreu & Newcomb, 2002), as well as the modelling and practice of communication skills (Kirby, 2002b). In Limpopo Province, South Africa, two innovative community-based programmes, namely Sisters for Life and The Intervention with Microfinance for AIDS and Gender Equity (IMAGE), which are facilitated through a curriculum of gender and HIV education to address sexual norms, partner communication and gender-based violence by means of role play and group discussion, have been found to bring about significant positive change in adolescent males who perceived women as sexual objects (Hatcher, de Wet, Bonell, Strange, Phetla, Proynk, & Hargreaves, 2011).

Peer-led sexual education is a skills-based programme delivered by adolescents themselves and it is believed that through interaction they influence one another's attitudes and behaviour (Kim & Free, 2008). For example, in Tshwane, South Africa, the Tshwane Peer Education and Support Programme promotes accurate information about HIV/AIDS, addresses peer norms and establishes psychosocial support to high school learners on an on-going basis (Visser, 2007). In a study conducted amongst Grade 11 learners in Pietermaritzburg, KwaZulu-

Natal, Karnell, Cupp, Zimmerman, Feist-Price, and Bennie (2006) found that the use of peer-group leaders and character monologues brought about desired outcomes in terms of reducing alcohol abuse and changing risky sexual behaviour. In their study, Karnell and his colleagues found that after a period of eight weeks learners, who had been randomly selected for the programme, reported that they refrained from unsafe sex and the misuse of alcohol.

From the above, it is clear that in sexual education programmes, various methods and modes of facilitation are used and often combined. Skills development in such programmes are either *knowledge-based* through providing information and creating awareness, *behaviour-based* through modelling and role-play of sound sexual behaviour and/or behaviour modification of unhealthy sexual practices, or *socialization- (group dynamic) based* through the involvement of peer facilitators or role models with whom the youth identify; thus acquiring skills through vicarious or social learning.

A brief discussion of trends in and approaches to sexual education was given above, while frameworks for sexual education programmes will be explained below.

Frameworks for Sexual Education Programmes

Historically, studies have mainly focused on self-defeating or problematic sexual practices of youth and have often failed to address broader perspectives of sexuality that shape the internal sexual, psychological and emotional aspects, guiding them to practice healthy sexual behaviour (Kalmuss, Davidson, Cohall, Laraque, & Cassell, 2003; Kirby, 2002a). It is also unclear to what degree sex education has an impact on adolescents' sexual attitudes, values and overall well-being (Drew, 2013), while Somers and Surmann (2005) found that male youth are often educated and equipped too late or not at all with communication, assertiveness and decision-making skills about sexuality. According to Drew (2013), youth that are inclined to obtain sexual information from unconventional sources such as pornography, movies, printed and social media, and deviant peers rather than trusted adults within the family

and parents, often – as a consequence – reveal a lack of sexuality competence or confidence and may thus fall back on trial and error attempts, often resulting in negative consequences.

Two models used to conceptualise sexuality education for African adolescent males that have been widely used for sexual education purposes, are the Health Belief Model (HBM) and the Information Motivation-Behavioural Skills Model of Sexual and Reproductive Health Behaviour (IMB) by Fisher, Fisher, Misovich, Kimble & Malloy (1996).

The HBM, according to Janz, Champion, and Stretcher (2002), is an intrapersonal (individual, knowledge and beliefs) theory used in health promotion to design intervention and prevention programmes. It was designed in the 1950s and continues to be one of the most popular and widely used theories in intervention sciences. The focus of the HBM is to assess health behaviour of individuals through examining the perceptions and attitudes of someone towards disease, as well as the negative outcomes of certain actions. The HBM assumes that behaviour change occurs with the existence of three ideas at the same time:

1. An individual recognises that there is enough reason to give relevance to a health concern (perceived susceptibility and severity), e.g. the risk of sexually transmitted diseases.
2. The person understands that he or she may be vulnerable to a disease or negative health outcome (perceived threat), e.g. HIV infection or unwanted fatherhood due to unprotected sex.
3. The individual realises that behaviour change can be beneficial and the benefits of such change will outweigh any costs of doing so (perceived benefits and barriers), e.g. healthy and competent sexuality outweigh peer criticism and own embarrassment.

In other words, the HBM addresses four major components of compliance with a recommended health action: Perceived susceptibility, or the youth's opinions about how likely the behaviours they partake in could lead to negative outcomes; perceived seriousness, or how

serious the negative health outcome of non-compliance could be; perceived benefits of compliance to a health action; and perceived barriers or reasons for not engaging in the health action. In later versions of the HBM, self-efficacy was added to the original four factors based on the argument that if one believes a new behaviour is useful (perceived benefit), but does not think that he/she is capable of doing it (perceived barrier), chances are that the action will not be formed (Janz et al., 2002). In this regard, Viseskul, Fongkaew, Settheekul, and Grimes (2013) found that positive sexual self-efficacy (resistive self-efficacy) in adolescents is associated with lower sexual risk taking, while Rostoskyar, Dekhty, Cupp, and Anderman (2008) reported that adolescent males who have higher levels of resistive efficacy and a positive view of themselves as sexual beings, are more likely to have the ability of translating their knowledge of sexual risk into self-confidence-based action in sexual risk situations.

Although the HBM is aimed at encouraging healthy behaviour among individuals (youth) who put themselves at risk of developing negative health (sexual) outcomes, it is clear that the HBM still focuses on avoiding disease (HIV and STIs), rather than on achieving health.

By means of the Information Motivation-Behavioural Skills Model of Sexual and Reproductive Health Behaviour (IMB) of Fisher, Fisher et al. (1996), adolescent males are both intrinsically and extrinsically motivated and equipped with sexual and reproductive health information, as well as behavioural skills which buffer risky sexual behaviour. Such youth are assumed to accurately anticipate the risk of pregnancy and foresee the future consequences of contraceptive neglect.

Concluded from these models, it seems that sexual education programmes for youth should be broad and developmentally-based, encompassing intra- and interpersonal abilities to develop skills and competencies around their sexual identity and concept of personal sexuality as a whole. It would also seem that preceding the education about sexual practices, a programme should ideally include the development of a healthy identity with supportive self

features such as self-esteem, -efficacy and -discipline; cognitive skills such as value and attitude formation, decision making and cognitive restructuring of situations; inter-other strengths such as relationship-building skills, communication and conflict management skills, and behavioural competence in coping, problem solving, assertiveness, and environmental mastery. Thus, as mentioned before, it seems important that programmes should produce reasoning and communication, relating and practicing competencies to ensure sustained meaningful outcomes (Arthur & Carr, 2013; Durlak & Weissberg, 2011).

Although the current focus of this research is on proposing guidelines for a sexual education programme aimed at promoting sexual health and well-being in male youth, such a programme could also be seen as an intervention, even though it is not intended to improve on a problem-laden situation or circumstance. The same considerations given to ensure a meaningful intervention could be applied to this proposed programme.

Lyubomirsky (2007) indicated that interventions aimed at achieving sustainable increases in people's well-being should include engaging participants in mood-enhancing intentional activities that fit with personal values and interests; such activities should be varied. Theron (2015) stated that for an intervention to be meaningful, it should be intensive, interactive, multi-dimensional, relevant and timely (thus, culturally, contextually, developmentally and historically appropriate). According to Masten (2014), there are five requirements for successful change programmes or interventions, namely a mission that pursues positive goals; models that should include positive factors, influences and actions; measures to track the positive and the problematic; methods that prevent, promote and protect; and multi-levels that foster complex and in-depth approaches. Although Masten had resilience interventions in mind, the intervention structure that she proposed could be used in all positive youth development projects. Returning to the views of Lyubomirsky (2008), she cautioned that activities of an intervention may not complement all people. Also, as the HBM discussed above, for an

intervention to succeed, it requires motivation and commitment from the individual to grow and build his/her own well-being (Lyubomirsky, Dickerhoof, Boehm, & Sheldon, 2011). Lyubomirsky and Layous (2013) proposed a positive activity model, suggesting that there are three factors that may have an effect on the outcome of any well-being-enhancing intervention, namely features of activities (type and variety); features of individuals (effort and motivation); and the person-activity fit.

According to Lyubomirsky and Layous (2013), activities that are well-planned as far as their content, dosage, variety and trigger value are concerned, are more effective and social support (e.g. peers, partners, parents or teachers) can enhance the effect of positive activities. Features of the person involved in the activity that may influence its effectiveness are the effort and motivation shown, the emotional mood, individual differences in personality, for example self-esteem, -efficacy, -confidence, introversion/extraversion, social support and some demographic features such as age, gender and culture. Careful consideration should thus be given to designing a programme according to the facets mentioned above and, especially, to the context in which the intervention is used and the personal situatedness of the individual involved (Issa, Schuller, Santacaterina, Shapiro, Wang, Mayer, & DaRosa, 2011).

Lyubomirsky's (2008) caution about the fact that activities may not fit all people, is emphasised by Bonanno, Westphal and Mancini (2011) who stated that general prophylactic interventions are often ineffective and may even be harmful to some. These authors indicated four aspects to be considered in order to prevent unintended side effects from risk management interventions: Can risky behaviour be increased; do participants have the capacity to cope with all aspects (especially cultural and emotional) of the activity; does the activity underestimate the effect of the context; and can the activity or intervention increase stigma (e.g. embarrassment, ridicule or blame)? Roberts, Kitchiner, Kenardy, and Bisson (2009) warned that no psychological intervention can be recommended for routine use, while Stevens, Bond,

Pryce, Roberts, and Platt (2008) found that curriculum-intervention programmes may increase helplessness/hopelessness in youth. It is thus clear that in sexual education for youth, programmes and their activities will have to be custom- or tailor made with carefully planned aims and outcomes, while keeping the contexts and individual situatedness in mind. Based on the above, one wonders about the ethicality and effectiveness of curriculum-based programmes used in South African schools for sexual education of youth.

Inclusion of Social Support

In the above discussion, the value of social support for the effectiveness of an intervention was mentioned. As far as sexual education for youth is concerned, parents and peers have been included in some programmes and the somewhat successful involvement of peers as either facilitators or in supportive roles has been noted by Kim and Free (2008), Visser (2007), and Karnell, Cupp, Zimmerman, Feist-Price, and Bennie (2006).

Parents' involvement could be more complex due to the cultural taboo of open discussion about sexual matters between parents and youth in many African societies (Iyer & Aggleton, 2013; Klein & Breck, 2010). Involving both parents and their adolescent children will have to be done with equal amounts of caution as has been discussed above regarding person-programme fit in order to prevent conflict, tension or emotional discomfort in either parties. However, various programmes involving parents do exist and it was found that where parents are meaningfully involved, the effects could be positive (Terzian & Mbwana, 2009). Derus (2009) reported that family cohesion, family satisfaction, emotional connectedness, and positive and effective communication between parents and adolescents have a powerful impact on the sexual behaviour of adolescents. Similarly, Afifi, Joseph, and Aldeis (2008), and Epstein and Ward (2008) found that when there is open, attentive and friendly communication around sexuality within the family, adolescent males may avoid situations where they receive incorrect and misleading information from their peers and the media.

As far as teachers are concerned, their training for and involvement in curriculum-based sexual education programmes are a given. Educators are often the key to successful curriculum-based sex-education programmes (Boscarino & DiClemente, 1996), as they may increase students' self-esteem, sense of competence and communication and refusal skills to resort to anti-social behaviour because of peer pressure (Kirby, 2002a). Educational researchers further argue that self-esteem of youth could also be influenced by the teacher-learner relationship. Teachers' behaviour in terms of motivation, enthusiasm, planning, organisation and effort may equip learners with the necessary skills to deal with contextual stressors they may encounter in their immediate surroundings (Jong, Mainhard, van Tartwijk, Veldman, Verloop, & Wubbels, 2014). However, research in African communities has found that the taboo mentioned above - about open discussion of sexual aspects between adults and youth - also apply to many teachers (Preston, 2013), who, despite having been trained to facilitate a programme, often do more harm than good due to negative attitudes.

Finally, the basic aim of any intervention to promote the sexual health and well-being of youth should not be imposing by nature and should be presented in partnership with the young people involved. The focus of such programmes should keep in mind that Boyden and de Berry (2004) emphasised that youth are capable of positively shaping their own lives, even amid serious challenges. In similar vein, Sommers (2006) stated that "it is a crucial departure point for youth interventions and programmes, because it casts the youth as the formulators of their own existence" (p. 8).

Conceptual Framework for the Proposed Sexual Education Programme

Empirical background for proposed guidelines

Previous research conducted for this study quantitatively investigated the relationships of sexual values, attitudes, decision making and communication with coping strategies, self-esteem, mental health and well-being of African adolescent males. A sample of $N = 552$

African adolescent males, aged 13–21 years, was used. Participants were learners from four high schools in the Vaal Triangle, Gauteng Province, South Africa. Validated questionnaires, namely the Mathtech Sexuality Questionnaires for Adolescents by Kirby (1984), the Children's Coping Strategies Checklist (CCSC) by Ayers and Sandler (1999), Rosenberg's Self-Esteem Scale (Rosenberg, 1965), and the Mental Health Continuum: Long Form of Keyes (2005) were completed by the youth. The data obtained was statistically analysed using the Mplus 7.31 (Muthén & Muthén, 1998-2014) programme for structural equation modelling.

The results of the preceding quantitative research found that correlational indices between all variables were significant and in line with what would be theoretically expected. Interesting findings were that:

- Amongst the variables of sexual values and attitudes, self-esteem and mental health and well-being (emotional, psychological and social well-being), the strongest correlations were with the psychological well-being component of mental health and well-being. It would seem that psychological wellness has a strong influence on behavioural aspects of youth (Keyes, 2006). As far as values about sexuality are concerned, the strongest correlations were with self-esteem, both positive and negative, which could indicate that self-esteem has a strong influence on having either clarity of personal sexual values, understanding own sexual responses and being satisfied with own sexuality, or of being uncertain and confused about these aspects in relational experiences (Mann, Hosman, Schaalma, & de Vries, 2004).
- Amongst the variables of sexual decision making and communication, coping strategies and mental health and well-being; the strongest correlations were with the coping strategies of problem solving and seeking social support. This seemed to mean that problem-solving abilities and social support (when needed) have enabling influences for youth in dealing with developmental challenges (Aldwin, 2011). Positive problem

solving skills have salutary cognitive, self-related, emotional and psychological effects on youth; and social support has positive relational, affiliative and stress buffering effects (D' Zurilla & Nezu, 2006; Taylor, 2014).

Further findings of the study were that:

- Self-esteem proved to be a mediating variable in the relationships between emotional, psychological and social well-being and sexual values and attitudes of youth, which meant that the effects of mental health and well-being were transferred by self-esteem (positive and negative) to the sexual values and attitudes of the youth in this study. This may indicate that positive self-esteem could have both enhancing and buffering influences, while negative self-esteem could have self-defeating effects on the sexuality of youth (Harper, 2004; Mann et al., 2004).
- Latent class analyses found that as far as their mental health and well-being are concerned, participants in this study belonged to three classes, namely flourishing (28%), moderately mental health (56%) and languishing (16%). Furthermore, problem-solving coping and communicating about sexuality were significant predictors of participants belonging to the three classes of mental health and well-being. This seems to indicate that flourishing youth function better than both moderately well and languishing youth; and that flourishing would lead to developmentally healthy outcomes, especially as far as sexuality is concerned (Keyes, 2006, 2007). The findings also seem to indicate that problem-solving abilities in youth, as well as their skills in communicating about sexual (and perhaps all other) aspects, could promote their mental health and well-being and enable them to flourish (Heppner & Lee, 2009; Kirby, 2002b).

These findings seem to strongly indicate the importance of intervention strategies aimed at developing healthy values and attitudes about sexuality in youth, sexual decision-making and communication skills, problem-solving coping and support-seeking competencies, a sense

of self-worth, as well as building flourishing through emotional, psychological and social wellness in youth. Such interventions have also been called for by prominent researchers in the various fields, such as Keyes (2007) about flourishing in youth; Mann et al. (2004) about self-esteem; Heppner and Lee (2009) regarding problem-solving abilities; Taylor (2014) with regard to social support; and Kirby (2007) about sexuality competencies in youth.

Theoretical background for proposed guidelines

The theoretical constructs investigated in the empirical research for this study could also serve as a theoretical conceptual framework for a psycho-educational programme aimed at promoting healthy sexuality and psychosocial well-being in youth.

As far as *sexuality values and attitudes, decision making and communication* are concerned, there is a recognition of the subjective aspects of adolescent sexuality, but mostly literature has focused on objective indicators of sexual behaviour such as the ages of becoming active, sexual practices and health-related (mostly negative) outcomes of youth sexuality. While this approach gives information about problematic youth sexuality, it fails to consider the intra- and interpersonal processes that influence sexual beliefs (values and attitudes), decisions and choices made, as well as coping with difficulties about their sexuality. According to Crockett, Raffaeli, and Moilanen (2003), understanding such subjective dimensions is imperative towards developing effective interventions aimed at reducing sexual risk behaviour and promoting healthy sexual beliefs, choices and behaviours. Brooks-Gunn and Paikoff (1997) emphasised that it is crucial for any meaningful intervention to understand the meaning young people ascribe to their experiences and the ways in which sexuality is integrated into their identities and intimate relationships.

Crockett et al. (2003) stated that the crucial task of adolescence is to develop a concept of themselves as sexual beings and to integrate their sexual self into their overall identity. Key dimensions of a sexual concept may be sexual self-esteem, -self-efficacy/mastery and beliefs

about their sexual self and abilities. Long before adolescents engage in sexual activities, they have developed a complex set of ideas about sexuality and sexual practices. Such mental representations are known as “scripts” that provide guidelines for sexual interactions (Gagon, 1973, 1990). Such cognitive schemas are likely based on internalised cultural and familial images of sex, loving and relating between genders. The cultural values and attitudes regarding sexuality are distilled through experiences in everyday social contexts, but are powerful background voices against which the developing adolescent must pitch his own identity (Crockett et al., 2003). Furthermore, Crockett et al. stated that cultural proscriptions are often counterbalanced by permissive attitudes reflected in the media and in the actions of many adults.

These opposing perspectives co-mingle, resulting in a situation where adolescents are exposed to sexual issues in their interactions, but given inadequate preparation to behave sensibly in sexual situations. Their feelings of sexual desires and attraction clash with social prescriptions, creating confusion, psychological conflict, tension and behavioural incompetencies. Crockett et al. (2003), emphasised that although fairly little research exists about adolescents’ constructions of sexuality, it would be subjective elements along with situational factors that affect youth’s decision making, have an influence on sexual choices and determine behaviour.

Based on the above, the question arises whether the proposed sexual education programme of this study should keep track with cultural impositions within which many adolescent males were raised, e.g. parent-child open communication taboos, but lenience for male youth to “sow their wild oats”, while keeping in mind that adolescent girls are expected to prize their virginity, but also to show their potential regarding fertility. It would seem that a golden midway could be found in which sexual education programmes follow the approach of the World Health Organization that sexual health is a state of physical, emotional, mental and

social well-being in relation to sexuality. Sexual health requires a positive and respectful approach towards sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence (WHO, as cited in Public Health Agency of Canada, 2008). In line herewith, the Swedish State Commission on Sex Education added that youth should gain knowledge that will equip them to experience sexual life as a source of happiness and joy, in fellowship with other(s) (cited by Crockett et al., 2003).

Concerning *self-esteem* as a mediating variable in this study, research has consistently found that self-esteem is associated (often strongly) with positive outcomes in youth such as positive affectivity (Fredrickson & Joiner, 2002), happiness and life satisfaction (Peterson, 2006), optimism exploratory style (Peterson & Park, 1998), hope (Snyders, 2002) and secure attachment style in adulthood (Brennan, Clark, & Shaver, 1998). Equally, self-esteem has been included as a component of growth in numerous interventions and there are various interventions aimed at producing well-being-related outcomes, that use self-esteem as the sole component (Heppner & Lee, 2009; Hewitt, 2009; Mann et al., 2004).

Two approaches exist toward developing self-esteem in youth, namely interventions that focus on the individual and self-esteem as intra-personal characteristic (Mann et al., 2004; Schiraldi, 2009); and those that view self-esteem as a socially constructed feature of the self (Hewitt, 2009). Schiraldi recommended that the following aspects be included in a self-esteem intervention: Self-acceptance, coping with self-doubt, finding one's core worth, rational thinking, body appreciation, affirming thoughts, creating possibilities, failure inoculation, self-forgiveness, caring self-medication and self-appreciation. Hewitt (2009), on the other hand, included features such as acceptance by others, receiving positive evaluation from others, beliefs that one compares well with others or with one's ideal self and believing that one can initiate healthy action in one's world. Hewitt also emphasised that self-esteem is strongly

related to cultural context and thus, in working with youth from collective cultures such as the African cultures, an intervention should explore these influences keenly, yet carefully.

Coping strategies and especially problem-solving and support-seeking strategies are viewed as adaptive coping behaviour and have proved to be strong variables in this study, but also as strong precursors of well-being on various levels in other research (Folkman, 2010; Park, 2011). Positive outcomes of effective coping strategies are, amongst others, positive emotions (Fredrickson & Joiner, 2002), resilience (Zautra & Reich, 2011), flourishing (Keyes, 2007), meaning (Park, 2011), benefit finding and sense making (Pakenham, 2011), living positively with HIV (Ironson & Kremer, 2011), self-regulation and quality of life (Wrosch, 2011), future-oriented thinking (Aspinwall, 2011), and positive self-related features such as self-esteem and self-efficacy (Harper, 1991; Heppner & Lee, 2009; Mann et al., 2004).

Interventions based on coping theories are, amongst others, coping effectiveness training (Chesney, Chambers, Taylor, Johnson, & Folkam, 2003), in which youth learn to choose specific coping ways for specific aspects of demanding situations; assessment of assets (Dunn & Dougherty, 2005), in which a person's practical and personal resources are explored and applied in coping with stress; solution-focused coping (O'Connell & Palmer, 2003), which focuses on strengths, competence and achievements involved in solution-finding behaviour; and cognitive-behavioural stress management actions (Lopez, Antoni, Penedo, Weiss, Cruess, Segotas, Helder, & Fletcher, 2011), which reduce negative mood states, improve outlook and beliefs, teach coping skills to enhance self-efficacy and obtain social support.

Various constructs from positive psychology have recently been included in interventions aimed at promoting healthy coping behaviour, such as meaning-making coping (Park, 2011), hope-building (Pedrotti, Lopez, & Krieschok, 2000), strengths-finding and utilising (Park & Peterson, 2009), forgiveness (Worthington, 2007), benefit-finding (Pakenham, 2011), self-regulation (Moskowitz, 2010), and pro-active coping (Aspinwall, 2011). A popular and well-

researched positive psychology construct used in coping interventions is positive emotions and its theoretical framework of broaden and build (Fredrickson, 2001; Tugade, 2011). Fredrickson stated that positive emotions are facilitators of adaptive coping and adjustment to stressful circumstances, providing a purpose for positive therapeutic processes. The generation of positive emotions is a common factor in most therapeutic interventions and positive affect serves as a basis for coping self-efficacy- and resilience-building strategies (Fitzpatrick & Stalikas, 2008).

Two approaches toward coping interventions that have a strong focus on a sense of self-efficacy, mastery, control or competence are Heppner and Lee's (2011) problem-solving training interventions, and Zimmer-Gembeck and Skinner's (2011) perceived control and development of coping approach. Heppner and Lee stated that appraising the self as an effective problem solver can be learned, as posited in the social learning theory of Bandura (1977). Effective problem-solving self-appraisal, specific coping skills and problem-solving coping abilities - all aimed at developing problem-solving coping through a strong sense of self-efficacy - are core features of Heppner and Lee's interventions. Zimmer-Gembeck and Skinner saw perceived control as a powerful resource and a crucial part of coping with demands. Perceived control refers to a person's sense of affectance, competence, mastery or control in stressful interactions with the environment. The authors proposed a strong model of adaptive coping with a sense of perceived mastery or control at its core.

As far as *mental health and well-being* are concerned, research abounds that associates the flourishing concept proposed by Keyes (2002) – referring to optimal emotional, psychological and social well-being in most dimensions of life – with adaptive outcomes (Keyes, 2009; King, 2008). Flourishing individuals have reported physical health as few lost workdays, low levels of heart disease, few health limitations to daily activities, few chronic diseases, low health-care use and high levels of good health and zest (Compton & Hoffman,

2013; Keyes, 2009). In terms of psychosocial functioning, flourishing individuals reported low perceived helplessness and a sense of control, high levels of workable goal setting, resilience and relational closeness (Keyes, 2009). Howell (2009) found several positive correlates between flourishing and academic achievement, mastery goal setting, self-control and continued perseverance in youth. Flourishing was aptly defined by Michalec, Keyes, and Nalkur (2009) as “a state of positive mental health; to thrive, to prosper and to fare well in endeavours free of mental illness, filled with emotional vitality and to function positively in private and social realms” (p. 391).

In this study – rather similar to the findings of Keyes (2005) – it was found that only 28% of the adolescent participants were flourishing, while 56% were moderately mentally well and 16% were languishing (respectively 38%, 56% and 6% in Keyes’ study). Keyes (2006) strongly emphasised that flourishing in youth is associated with developmentally desirable outcomes and that interventions towards youth development should all have the promotion of flourishing included. For such purposes, Keyes (2003) proposed a diagnostic framework for flourishing (optimal mental health and well-being), as well as thirteen operational definitions for the enhancement of flourishing which could be practically included in any intervention to promote health and wellness of youth.

Quite an array of interventions or programmes and activities to promote various aspects of mental health and well-being exists, ranging from positive psychotherapy (Magyar-Moe, 2009; Rashid, 2008, 2009), personal growth therapy (Robitschek & Keyes, 2009), well-being therapy (Fava, 1999), and hope therapy (Lopez, Floyd, Ulven, & Snyder, 2000); to strategies such as learned optimism training (Seligman, 2002), self-determination training (Wehmeyer, 1996), emotional intelligence skills training such as the South African emotional intelligence curriculum (Mayer, Salovey, & Caruso, 2004), building character in schools (Ryan & Bohlin, 1999; Seider, 2012), the celebrating strengths approach (Eccles, 2008), resilience development

(Wolin & Wolin, 1993), and also interventions toward increasing positive emotions (Fredrickson, 2009) and happiness (Fordyce, 1981; Lyubomirsky, 2007).

A recent model for an intervention towards personal well-being by Boniwell and Ryan (2012) ties in with the Skills of Well-being Programme in UK schools (Baylis & Morris, 2006) and a USA programme for schools, based on Seligman's (2002) Authentic Happiness approach. The model of Boniwell and Ryan is called 'Personal well-being lessons for secondary schools: Positive psychology in action'. The model encompasses a comprehensive well-being curriculum that targets every known major predictor and correlate of well-being and uses individually tested interventions to enhance learning. The first phase of the project focuses on positive interventions, covering areas that have a solid evidence base such as happiness, positive emotions, flow, resilience, achievement, positive relationships and meaning. The second part focuses on positive education, enabling youth to reflect on and make choices about their well-being and development. The themes covered are positive self, positive body, positive emotions, positive mind set, positive direction and positive relationships (Boniwell & Ryan, 2012).

In the preceding discussion, both empirical and theoretical evidence based on the constructs used in the research for this study were given, on which to base the development of a psycho-educational programme for youth to enhance their sexual and psychosocial health and well-being. For any intervention to be appropriate, the context within which it will be offered must be considered.

Contextual factors for proposed guidelines

As was mentioned before, the effectiveness of any intervention aimed at promoting the psychosocial well-being of youth, is enhanced by the social support given to such youth in their developmental quests. Gumede (2009) described the context as a conducive socio-cultural environment which fosters young people's psychosocial well-being development, while

Richter, Foster, and Sherr (2006) were of the opinion that psychological, social, emotional and physiological growth as determined by the individual's manifested capabilities, are embedded in his/her social and material context. According to Gilborn, Rollock, Vincent, and Ball (2012), the youth's interpersonal, emotional and mental status together with their interpersonal network of relatedness and social functioning constitute the context within which optimal development can occur. The outcome of such a context will be either a person whose emotional state and relationships are positive, healthy and consistently adaptive, or distressful, maladaptive and self-defeating.

As far as the context for the enhancement of sexual health and well-being of South African youth is concerned, factors to be considered are the following:

- The majority of youth develop their sexuality in contexts where there is either a cultural or familial taboo on the discussion of sexual matters between parents and adolescents (Kigozi, 2006). Young people are thus raised with a void in a crucial part of their development, in which normative, cognitive and relational support from their parents or significant adults could shape the quality of their sexual and relational well-being (Louw & Louw, 2014; Mash & Wolfe, 2013).
- Keeping the above in mind, the Children's Act No. 38 of 2005 states that no person may refuse to sell condoms to a child 12 years or older, or refuse to provide such a child with condoms on request where such condoms are distributed free of charge (Han & Bennish, 2009).
- In an attempt to address the above-mentioned risks posed by the social context to the psychosexual well-being of youth, sexuality education is embedded in the Life-Orientation (LO) curriculum of the Department of Education, (2006). However, the curriculum does not encourage a learner-centered approach, in order to inculcate a culture of inquiry among learners for them to express experiences and questions pertaining to

sexuality – without being fearful (Francis & DePalma, 2014). Furthermore, school policies that advocate sexuality education are unknown to key policy players (e.g. principals, educators or learners) (Mcgillivray & Jennings, 2008).

- The peer group context for the African adolescent male is a very powerful one in which conformity to peer norms and activities is non-negotiable and enforced (Morell, 2007; Morell, Jewkes, & Lindegger, 2012). Sexual risk taking and peer group-inspired sexual behaviour with little concern for the individual's wishes, fears and uncertainties are the peer norm. For the African adolescent male, the peer group is also a context in which his masculinity is shaped, approved and reinforced (Adams & Govender, 2008).

The above contextual factors will form the background for any psycho-educational programme, with activities aimed at promoting sexual and mental health and well-being in youth. A challenge for such an intervention would be to identify when to support and when to question the contextual influences; however, in way that are conducive to open discussion and that will not create resistance in participants.

Proposed Guidelines and Strategies: A Sex-education Programme

Guidelines are described as a set of recommendations (initially for the nursing profession), aimed at developing appropriate care processes in the enhancement of health practices and the improvement of intervention outcomes (Shekelle, Woolf, Eccles, & Grimshaw, 1999). The proposed guidelines of this study would aim at the development of young people's skills and competence in both their sexual and psychosocial well-being. By means of their existing and developing strengths and skills of flourishing, coping and self-esteem; features of their sexuality could be explored and enriched, in order to promote their sexual health and well-being integrated with their psychosocial health and well-being. An environment that is conducive towards positive outcomes of such a programme would entail (Melato, 2013):

- Fostering existing strengths, social support and the ability to cope with change;
- Establishing positive helping relationships;
- Maintaining hope and expectations; and
- Using relevant and respectful methods acceptable to young people (Saleeby, 2006).

The proposed programme and activities are intended for use with groups of male adolescents and would aim at the growth of such youth within the context of peers with whom they could identify; and share similar characteristics, challenges, dreams and aspirations, also about their sexuality. Yalom (1975) emphasised that the universality and sense of belonging in such groups are unique to the recovery within a group context, while Walker-Williams (2012) stated that the group context creates an opportunity for members to reflect on their own potential, since the group could be a safe and contained environment in which youth can voice their needs, goals and challenges as well as explore similarities and differences without being judged. According to Ball, Tharp, Valle, Hamburger, and Rosenbluth (2012), group members often become facilitative in steering the growth plan and the direction of the processes, while the strengths of group members are positive tools towards achieving salutary change. The utilisation of group strengths could prevent problems, promote growth and maximise potential (Lopez, 2008); and harnessing the strengths of the group could foster group collaboration and acceptance of the growth programme (Saleeby, 2006).

Eight group sessions are suggested in this proposed programme and each session will last for about four hours, should be flexible in its scheduling, and with a short break in the middle of each session. Each group will comprise ten adolescent participants.

Guideline 1: Proximal programme objectives

Prior to the distribution of questionnaires to the male youth participants during the research conducted previously, the researcher had to introduce himself, explain the purpose of the study, and ensure them that their information would be treated with confidentiality. Thus,

he had to establish a relationship of agreement and set an environment that was safe and free from extraneous distractions in order for them to complete the measurements with ease. The environment and atmosphere in which a sexual education programme will be facilitated, need to be engaging, safe and supporting, whilst simultaneously creating a climate of openness and mutual trust. The facilitator is the instrument for creating an open, honest, comfortable and motivating setting in which the participants can relate, explore and express themselves about sexuality matters. Furthermore, the person-programme fit will have to be explored, the motivation and readiness of youth to engage in such a project and their willingness to commit to the eight sessions of growth, including activities and open discussions about aspects of sexuality, will have to be facilitated. The setting of personal goals relating to their sexual and mental health and well-being will be encouraged.

Strategy: Sexuality: Preparing for our journey towards healthy sexual lives

Aim: To establish a conducive relationship and climate in which adolescent males are able to relax, relate their sexuality views, identify and choose goals and strengths with which to engage in a sensitive, yet stimulating programme, in a safe and supporting environment, without being judged.

Actions

1. Facilitator introduces himself and asks them to do the same. State sexuality (not sex) as the topic of the programme and guide them towards finding a metaphor for human sexual happiness. Facilitate ice-breaking discussion.
2. Involve them in the setting of ground rules to be adhered to during the sessions, so that they can optimally explore and engage with ease and confidence.
3. Give an overview of the programme and begin to gauge person-programme fit, their

readiness and emotional comfort to engage in and grow from the experience and to set personal goals for sexual and overall health and well-being.

4. Introduce the general sexual education context of African youth with positive and negative features. Facilitate discussion of what they bring from their background to the current exploration of their views on sexuality. Which messages can be confirmed and which could be challenged?
5. Since they have now been informed about the aims, content and facilitative style of the sexual education programme, establish their readiness and obtain their written agreement to voluntarily participate. Thereafter, explore their expectations of what to gain from the endeavour, as well as their stated commitment towards their collective growth in health and well-being.

Outcome: The participants will begin to orientate themselves toward the facilitated activities and explore their perceptions with ease and curiosity, set goals and begin to commit to the invitation towards growth.

Discussion of evidence. According to Walker-Williams (2012), to commence with a “get-acquainted exercise”, builds rapport which is crucial for young people, because it contributes towards establishing flexible relationship boundaries and agreements between the facilitator and participants. The above is in line with the suggestion by Agula, Baret, and Tobi (2015) that to build rapport with adolescent males is essential for the development of trust between the facilitator and participants, as specific goals and objectives must be set and achieved in the intervention programme. Lyubomirsky (2008) advised that from the beginning of an intervention, the person’s fit to the programme and the context from where the person comes, should be considered. Thus, the broad aim of this guideline is to encourage them to personally and collectively commit to engagement in this growth-promoting process.

Guideline 2: Sexual attitudes and values

The empirical research found that both clarity of values and attitudes, as well as some unclarity of values and negatives attitudes were experienced toward sexuality by adolescent males. The aim of this guideline is to create awareness of the cognitive and emotional beliefs and mind sets that underpin their sexuality. Tsakani, Davhana-Maselesele, and Obi (2011) explained from the Sexual Health Model, that being '*sex-positive*' means that one's behaviour, values and emotions should be congruent to and integrated within the person's wider personality structure, and consist of well-developed clusters of attributes, abilities and skills regarding sexuality. The aim would further be towards awareness of the socio-cultural and familial messages that created the beliefs that feed their values and attitudes (Wamoyi, Wight, & Remes, 2015). How these factors also shape their sexuality choices and decision making, will be discussed.

Strategy: Sexuality starts in your head and heart: What you think about and want from the sexual you.

Aim: To assist adolescent males in exploring sound sexual attitudes and values by challenging the cultural male stereotypes about women and about male sexuality; to encourage them to take ownership of their sexuality and to articulate their personal values and attitudes toward healthy and caring sexual relatedness; to create awareness of their own choices and decisions regarding the quality of their sexuality and sexual relatedness.

Actions

1. Using sexual values-seeking conversations, for example:
 - What are values and what are attitudes?

- Give examples of positive and negative values and attitudes.
 - Do I know my own values and attitudes toward my sexuality?
 - Am I clear about what is right or wrong for my sexual behaviour?
 - Do I have a good understanding of my own feelings and reactions?
2. The use of attitude-forming discussions, for example: “Why in South Africa is violence against women and girls a problem and what maintains the situation? How does it reflect on me?”
 3. Give a short introduction on the socially constructed nature of values and attitudes and explore: What or who shaped my views of sex, love, men’s needs and women’s needs? Am I sure that my current values and attitudes are good for my sexuality?
 4. Present and discuss a newspaper story, video clip or advertisement depicting stereotyped gender roles. Explore the consequences thereof in relationships.
 5. Make collages of pictures and words depicting respectful and caring couple-relatedness. Discuss: What would I like my relationships to be like and how can I achieve that?
 6. Facilitate the writing of a letter to a partner expressing appreciation for her and for the relationship. It need not be disclosed.

Outcomes: The participants will become aware of their values and attitudes and the quality thereof, as well as the importance of ownership of these aspects in establishing caring relationships and sexuality.

Discussion of evidence: Allport (1966) and Cooper and McGough (1966) explained the relationship between values and attitudes, that both are socially constructed cognitive structures that manifest in behaviour; and that values and attitudes could be learned and adapted. From such an understanding of the subjective nature of values and attitudes, the call by Kalmuss et al.

(2003) is understood, namely that research needs to investigate the broader perspectives that shape the internal sexual, psychological and emotional aspects of adolescent sexuality, more deeply. Their sexual behaviour should be guided along healthy and adaptive routes, especially in the case of African male adolescents where parents' guidance toward youth sexuality is so often lacking (Kigozi, 2006 ; Mturi, 2001).

Guideline 3: Promotion of sexuality and sexual health through correct education on physical aspects thereof

In previous research, some participants reported unclarified values pertaining to sexuality and, according to Kirby (2008), such negative sexual attitudes may manifest in risky sexual behaviours. Therefore, although no direct evidence from the preceding research exists for this guideline, it would make sense to include a presentation on the physiology of sexuality in a sexual education programme. Literature abounds about the lack of knowledge among many adolescents about the physical aspects of healthy sexuality (Louw & Louw, 2014).

Strategy: Sexuality and the language of my body and that of my partner

Aim: To give clear factual information on the physiology of male and female sexual functioning and facilitate discussions about caring and protective love-making.

Actions

1. A presentation by a sexual therapist or counsellor of LoveLife on the differences in female and male anatomic structures, arousal and the four cycles of sexual response (Bancroft & Graham, 2011).
2. The presentation would include love-making styles and mutual approval thereof, as well as the role of oral stimulation.
3. Pregnancy prevention and the nature thereof would be discussed.

4. The prevention and management of STIs and issues pertaining to HIV status will be discussed.

5. Mutual caring, respect, enjoyment and a “feeling-good-about-us” will be encouraged.

Outcomes: *The participants will learn that there are options to choose from pertaining to healthy sexual behaviour and that sexual involvement requires mutual caring and protection.*

Discussion of evidence: Whereas Silva, Ferreira, Agueda, Almeida, Lopez, and Pinto (2012) indicated the lack of sexual knowledge in adolescent males and the negative health outcomes thereof; Uecker, Angotti, and Regnerus (2008) reported on the choices made by informed adolescents about sexuality. Furthermore, research done about the sexual education models of Fisher, Fisher et al. (1996) found that clear and factual information given to adolescents leads to responsible sexual choices and protected sexual behaviour.

Guideline 4: Development of healthy relationships, sexual decision-making and communication skills

Previous research for this study found that decision-making skills of participants had little effect on other variables, but communication about sexuality was a predictor of flourishing in youth. Seeking social support as a coping strategy also had little effect on other variables. The implication seems to be that the youth wish to communicate about sexuality matters, but they are often met by a lack of social support in this regard by parents and other adults in their lives. It would also seem that their ability to make sexuality decisions may suffer as a result. On the contrary, healthy peer communication regarding sexuality was found in research, to such an extent that successful sexual education programmes include peers as co-facilitators and role models (Kim & Free, 2008). Furthermore, communication with sexual partners - about sexual matters and about decisions to be made regarding sexual aspects - was only present in healthy

relationships and where adolescent males showed emotional self-regulation (Aymer, 2008).

These issues will be addressed in this session.

Strategy: Your sexuality relationship context: Talking to parents, peers, and partners

Aim: To encourage communication with significant adults, positive peers and sexual partners. To work towards decision-making skills in sexual matters.

Actions

1. Discussion about the importance of communication about sexual matters and respect in dating or sexual relationships (Uecker et al. 2008). What makes it difficult to talk?
2. Illustrate the scenarios of good communication and bad communication by means of videos. Discuss the enhancement of relational health and well-being through open communication. Teach the minding activities and communication patterns of Gottman (2001) and Gottman and Silver (2000).
3. Probing questions and discussion around culture and traditions with regard to sexual communication. Explore the need for fathers regarding sexuality.
4. Explore the lack of communication about their own sexuality with parents/adults. Discuss what caused them harm and how to grow beyond that.
5. Can good friends help or hinder in sexuality well-being? How can they be of value? Can they assist in making the right decisions about sexual matters?
6. Discussion on decision-making: What are the challenges? What causes indecisiveness and what are the outcomes? What issues must have mutual agreement by both partners?

Outcome: Participants will be aware of communication as a pathway toward healthy sexuality, of the importance of significant adults and peers in this regard and of mutual relational communication with partners.

Discussion of evidence: de Looze, Contantine, Jermame, Vermeulen-Smit, and ter Bogrt (2014) found that communication about sexual matters may transmit sexual values, beliefs, expectations and knowledge from parents to children, while Ferreira, Nelas, Duarte, Albuquerque, Grilo, and Nave (2013) stated that parents and educators should respect and mould the developmental sexuality of adolescents by answering and informing them sincerely pertaining to sex-related matters; thereby enabling them to make well-informed decisions and promote their sexual and reproductive health. It is a known fact that where parental guidance lacks, adolescents turn to peers and social media as a source of sexual information. Peers could either have negative influences (Ali & Dwyer, 2011; Jewkes & Morrell, 2010) or positive and protective roles (Zeman, Cassano, & Adrian, 2012). Furthermore, Widman, Welsh, McNulty, and Little (2006) found that engaging openly in topics such as sexual preferences and concerns, sexual fantasies and sexual behaviour between sexual partners, may result in experiencing sexual satisfaction and mutual consideration.

Guideline 5: Building self-esteem as an enabling personal characteristic

Self-esteem was found to be a mediating variable between the emotional, psychological and social well-being of youth and their sexuality behaviour of decision making and communication in prior research for this study. According to Neff (2011), self-esteem can impact psychological well-being and it also relates to the three basic psychological needs, namely autonomy, competence and relatedness. Mann et al. (2004) were of the opinion that self-esteem is crucial to mental and social well-being, since it influences aspirations, personal goals and interaction with others.

Strategy: Your self-esteem as a building block for healthy sexuality

Aim: To assist adolescent males in developing positive self-esteem.

Actions

1. Explain self-esteem and the foundations thereof. Let participants complete the Rosenberg (1965) self-esteem scale and discuss the results in detail.
2. How do they think their self-esteem can be improved? Use interactive role play. How do they think self-esteem could enhance their sexuality.
3. Encourage them to write a letter to themselves on how to improve their sense of self-value.
4. Introduce self-efficacy and self-esteem as aspects of a healthy self. Discuss how self-efficacy can help in decision making and healthy behaviour.
5. Make a collage of pictures and words depicting feeling good about themselves.

Outcomes: *Participants will become aware that positive self-esteem has an enabling power and could contribute towards their sexual and overall health and well-being.*

Discussion of evidence: According to self-esteem interventions developed by Hewitt (2009), Mann et al. (2004), and Schiraldi (2009), self-esteem is an essential component of mental health promotion. The authors agree that self-esteem is inherent in characteristics such as social and functional competence, mastery and a sense of behavioural control, and as such could serve towards the prevention of an array of physical and mental problems and many of the social ailments challenging society (also see Harter, 1999).

Guideline 6: Problem solving coping and sexual, as well as general health and well-being.

Previous research found that problem-solving coping acts as a predictor of flourishing or mental health and well-being. This supports the extensive work done by Heppner and Lee (2005, 2009) in the field of problem-solving coping. Heppner's opinion that appraising the self as an effective problem solver can be learned was upheld by the social learning theory of Bandura (1997). It will therefore be the motivation for this guideline and strategy towards strengthening the problem-focused coping skills of youth, in favour of their sexual health and general adaptive well-being.

Strategy: Coping and your sexuality and well-being

Aim: To help adolescent males to master problem-focused coping skills.

Actions

1. Present information on coping with stress; focus on problem-focused coping as dealing with the problem directly.
2. Present vignettes of selected stress situations for youth and use role play to demonstrate the problem-focused strategy and skills to be used, also pertaining to sexuality issues.
3. Assist them to identify incidences where they could solve problems and identify the strengths and resources that enabled them. Also look at situations in which they were not able to solve problems and identify what they could have done differently.
4. Assist them to identify their resources – intra- and interpersonal, environment etc.
5. Request that they solve a challenge in the week ahead and report back at the next session.

Outcome: Participants will be aware of the need for them to develop problem-solving skills and to make use of all available resources in their lives.

Discussion of evidence: Positive problem-solving experiences have enhancing cognitive, self-related, emotional and psychological effects (D’Zurilla & Nezu, 2006; Taylor, 2014). Heppner and Lee (2009) succinctly state that a person’s appraisal of his/her problem-solving skills and style is a crucial strength or resource for coping with life’s demands. Furthermore, Heppner, Witty, and Dixon (2004) found that effective problem solvers have more social skills, less social distress and more social support; in general showing better social and psychological adjustment.

Guideline 7: Flourishing or Mental Health and Well-being.

This guideline is based on flourishing; a construct which was developed by Keyes (2002, 2007) and that is seen as complete mental health and has been linked to good physical health. People flourish when they experience mostly positive emotions, happiness and overall satisfaction with their lives; when they are functioning well and are free from recent mental illness (Keyes, 2002, 2005, 2007). Also in line with research by Keyes, the empirical research for this study found that flourishing youth would use problem-solving coping and communication skills in their sexuality encounters, more so than moderately mentally healthy youth or those languishing. In this study, 28% of youth were flourishing, 56% were moderately mentally well and 16% were languishing.

Strategy: Flourishing or overall well-being and your sexuality

Aim: To raise the adolescents’ awareness of their emotional, psychological and social well-being and of how to improve and maintain their flourishing.

Actions

1. Do a presentation on flourishing along the lines of Keyes’ (2009) descriptors. Request them to identify three indicators of their own flourishing.

2. Explain positive emotions and the value thereof for sexual and overall well-being. Encourage the regular use of positive emotions during the coming week and to report back on the effects thereof.
3. Make use of three activities to enhance psychological well-being (these are available on the internet), e.g. a gratitude exercise, a strengths exercise and a humour exercise.
4. Make use of exercises that that would enhance social well-being, such as the gratitude letter, acts of kindness etc.
5. Explore strengths that they see as their own abilities and that they usually apply in life management. Devise ways in which these could be strengthened.

Outcome: The awareness of participants of their mental health challenges and of the importance of being mentally well will be raised and they will know how to enhance aspects of their well-being.

Discussion of evidence: Wissing, Khumalo, Oosthuizen, Nienaber, Kruger, Potgieter, and Temane (2011) reported that flourishing South African youth showed positive affect, coping competence, self-efficacy, ego-resilience, sense of coherence, satisfaction with life, self-regulation and perceived social support, with low levels of depression, negative affect and physical symptoms of stress. This finding and the results of the preceding research for this study strongly support Keyes' (2006) call for building flourishing in youth to empower them psychologically for dealing with life challenges. Keyes also recommended that building flourishing should be a component of any intervention aimed at youth development.

Guideline 8: Closing of the programme and committing to health and well-being, mentally and sexually.

The concluding session of the programme will be to gauge what the participants have learned from the activities, what they can do with what they have learned and experienced, and

what their needs for future development would be. Since the activities were fairly full of content, it may be necessary to revisit some of the themes and that could also be done in this final session. In line with the Health Belief Model (Janz et al., 2002), this session could also ask participants to reflect on what risks with regard to their sexuality they could have encountered that they can now avoid, as well as to commit to the benefits that they gained from the programme and to foresee barriers that they may further encounter.

Strategy: Sexuality: Where are you now and what do you commit to from here?

Aim: To bring them in touch with a deeper awareness that they acquired from attending the programme.

Actions

1. Guide participants to discuss what they have learned from every session and to indicate any aspects that they would like to have revisited.
2. Guide a discussion on risks or problems that they may have encountered in their sexuality (or in general), that they have been made aware of during the programme. Do they perceive themselves as more competent to deal with such issues and also with challenges regarding unwanted pregnancy, HIV and STI, sexual coercion, etc.
3. What do they plan to do with what they learned? Ask each one to write 5 statements of intent based on their learning acquired. Discuss these.
4. Request the group to make a collage about healthy living based on the programme's themes.
5. Write a short letter to themselves, expressing gratitude for attending the programme. They should give 3 aspects for which they are grateful. The letter must end with an undertaking to live healthy and stay well.

Outcome: Participants could conclude the experience of this sexual education programme

and ground it into a future perspective.

Discussion

The purpose of this study was to develop specific guidelines and strategies purported at the development of a sexual education programme towards the promotion of healthy sexual behaviour and psychosocial well-being of African adolescent males. The Health Belief Model (Janz et al., 2002) and the Information Motivation-Behavioural Skills Model of Sexual and Reproductive Health Behaviour (IMB) (Fisher, Fisher et al., 1996) were seen as broad conceptual frameworks. The proposed programme is intended for use towards male youth's healthy sexual behaviour and psychosocial well-being and was based on promoting subjective features of sexuality values and attitudes; sexuality decision-making and communication skills; self-esteem; adaptive coping strategies; and emotional, psychological and social well-being.

A review of relevant theory and literature about sexual education programmes, as well as the constructs of adolescent sexuality - in particular values and attitudes, decision making and communication, self-esteem, adaptive coping strategies and mental health and well-being - provided theoretical evidence in support of the programme guidelines. The statistical results of the quantitative research for this study could serve as evidence towards developing an intervention (sexual education programme) protocol aimed at enhancing healthy sexual behaviour and psychosocial well-being of African adolescent males. Figure 1 below depicts the process of growth toward healthy sexual behaviour and psychosocial well-being for adolescent males, envisioned by the proposed programme built on guidelines and strategies that flowed from relevant literature and research findings in this study.

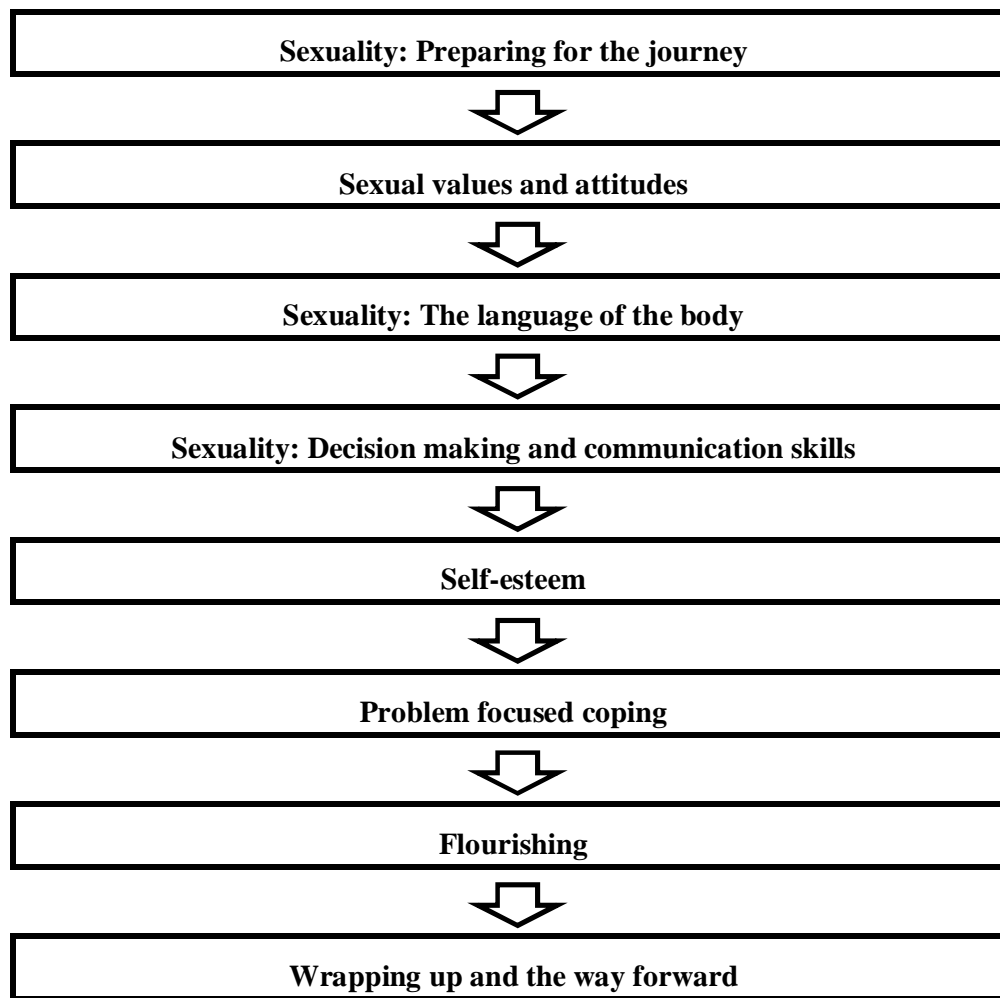


Figure 1: Guidelines and strategies towards healthy sexual behaviour and Psychosocial well-being of adolescent males.

Authors, such as Kalmuss et al. (2003) and Kirby (2002, 2007), studying the psychosexual health of youth, lament the fact that until recently research mainly focused on the self-defeating or problematic sexual functioning of youth. Research has mostly failed to address broader and more subjective aspects of adolescent sexuality that shape the internal sexual, psychological and emotional features that guide youth towards practicing healthy sexual behaviour. Kirby, especially, indicated the lack of research on sexual values and attitudes, decision-making skills and the ease with which youth can communicate about sexuality as factors that either shape a sexually healthy lifestyle or contribute to involvement in risky sexual

practices. The dearth of research on the factors raised by Kirby still exists and for that reason and based on empirical findings pertaining to them, these aspects were included in the guidelines and strategies for a sexual education programme.

Self-esteem has been found as either in correlation with, a predictor of, or a mediating variable for various health and growth-promoting facets in youth (as well as for negative facets), as in this study. Authors such as Hewitt (2009), Mann et al. (2004), and Schiraldi (2009) saw self-esteem as so crucial in the development of youth's identity, based on its enabling and buffering effects, that they advised that all youth development and growth-promoting interventions should include a self-esteem component. Thus, self-esteem enhancement was deemed as important and was included as a guideline for this proposed programme.

Of all adaptive-coping strategies, problem-focused coping has repeatedly been found to be a powerful factor related to the enhancement of health and well-being, as well as to buffering aspects of psychopathology in research (Antonovsky, 1979; Butler & Meichenbaum, 1981; Heppner et al., 2004). In this study, problem-focused coping not only emerged as a strong correlator with aspects of youth sexuality and mental health and well-being, but also proved to be a predictor of flourishing in youth. Heppner and Lee (2009) claimed that appraisal of oneself as an effective problem solver could be learned and advised for the inclusion of the problem-solving coping construct in interventions for youth development. Therefore, problem-solving coping was included as a guideline for this proposed programme.

In the field of positive psychology, the work of Keyes (2002, 2006) on the mental health and well-being of youth is well known and often researched by means of the Mental Health Continuum measurement. Keyes identified the flourishing, moderate mental health and languishing dimensions of youth mental health and described flourishing as a state of optimal mental health, to thrive, to prosper and fare well in all functioning; free of illness symptoms

and filled with emotional vitality to live well in private and social areas (Michalec et al., 2009). Flourishing also has a promoting-effect on other wellness aspects, as well as a buffering effect against illness symptoms and self-defeating behavioural and relational aspects (Wissing et al., 2011). In this study, flourishing was found in 28% of youth and therefore the promotion of flourishing became a guideline, in support of Keyes' call for flourishing to be promoted in all youth to enable their optimal well-being (Keyes, 2006).

Furthermore, all literature guidelines for interventions advise that the context of the participants should be kept in mind. The sexuality context of African adolescent males is often characterised by early sexual debut, but very little sexual guidance from parents (Setswe, Ramlagan, Mbelle, Davids, Zungu, & Pezi, 2014), the absence of a father figure (Holborn & Eddy, 2011), powerful peer influence (Amoateng, Kalule-Sabiti, & Arkaah, 2014), a masculinity-oriented culture (Jewkes & Morrell, 2010), and high levels of sexual abuse of women and girls (Slabbert, Knijn, & de Ridder, 2015). These aspects were included in the strategies of the proposed programme, but only in an explorative way and with the aim of raising the youth's awareness of these matters as challenges to sexual health and wellness. It is recommended that these culture-related factors be more directly addressed in other sexual health-promoting interventions for youth.

The activities in the strategies of the programme attempt to ensure person-activity fit as recommended by Lyubomirsky (2008), and also to contain elements of knowledge, behaviour and socialisation as identified in existing sexual education programmes. The proposed sexual education programme cannot claim to be complete or even to address the most salient issues challenging youth sexuality, since the field is wide and both developmentally and contextually diverse as far as sexuality challenges for youth is concerned. It is, however, one of a few programmes that include sexual values and attitudes, decision making and communication

features, in combination with self-esteem, problem-focused coping and flourishing, based on empirical research findings.

The proposed sexual education programme is not aimed at evading the challenges faced by male youth, but to constructively challenge and look beyond the psychosocial problems that are rife in their lives, in a process of fostering new ways of thinking about their sexual selves, their partners and a healthy and satisfying psychosexual life style. Such a lifestyle could be conceptualised along the lines of the WHO's description of youth sexual health alluded to before, and especially the ideal of the Swedish State Commission on Sex Education that youth should gain knowledge that will equip them to experience their sexual life as a source of happiness and joy, in fellowship with another (cited by Crockett et al., 2003).

Conclusion

In conclusion, the proposed guidelines and strategies could serve the purpose of a sexual education programme aimed at promoting sexual health and psychosocial well-being in youth. Although the aim of this study was achieved by the proposed sexual education programme, it is still a conceptual model that could only become a valid programme (intervention) once it had been applied in practice and had been validated by further research. Such research is recommended and will also be undertaken by this researcher in future.

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CHAPTER THREE

CONCLUSIONS, LIMITATIONS, RECOMMENDATIONS AND CONTRIBUTION OF THE STUDY

The aim of this study was to investigate the relationships of variables of sexual values and attitudes, decision-making skills and ease of communication, with the self-esteem, adaptive coping strategies and mental health and well-being of a group of African adolescent males. In the preceding chapters of this thesis, an overview of relevant literature to this study was given; thereafter two manuscripts reporting on the empirical research done and a manuscript with guidelines and strategies for a proposed sexual education programme for adolescent males were presented. This chapter includes conclusions drawn from the study, limitations of the research, recommendations made and the contribution of the study.

Conclusions from the Literature Overview

Relevant literature was reviewed to investigate adolescent sexuality, the intra- and interpersonal factors, theories, and contextual factors pertaining to the sexuality and psychosocial well-being of African adolescent males. The literature study met the first broad aim of this investigation, namely to study how the constructs used in this research were conceptualised in literature.

African male adolescents' sexuality

From the literature reviewed, it seemed that in South Africa an alarming portion of African adolescent males do not engage in sexually healthy practices such as involvement in monogamous relationships and the consistent use of condoms. In their search for identity and sexual identity in particular, African adolescent males often tend to prematurely experiment in sexual activities without protection and with multiple sexual partners. Such youth, it seems, pay little attention to their emotional, mental and physical health; have little healthy sexual experience; and largely ignore the consequences of premature sexual activity such as early fatherhood that could result in poverty, reduced job opportunities and low self-esteem. They also place themselves at risk of sexually transmitted infectious diseases (STIs) and other psychosocial problems.

While puberty in itself presents developing adolescent males with a range of physical, interpersonal and social dilemmas, their incomplete cognitive development results in their not being able to think hypothetically, perhaps making them less able to make informed decisions about sexual activities and healthy sexuality as a whole. Being psychosocially more immature than adults, adolescent males' judgment is often impaired by peer influences, attitudes towards and perception of sexual risks and an incapacity for self-regulation and -management. According to literature, the strongest reason for most African adolescent males to engage in early sexual activities is to gain acceptance and approval from peers and especially to prove their masculinity; thus for fear of being rejected or ridiculed, adolescent males often conform to peer pressure and may behave irresponsibly and aggressively in sexual practices.

The above mentioned challenges in the developing sexual health and wellness of African male youth are further complicated by the fact that in many black communities in South Africa, parents (especially fathers) continue to avoid discussion of topics which involve sexuality with their adolescent males. They believe talking about sexuality would lead their adolescent males to promiscuity and that it would degrade the status of the parent. This apparent unwillingness of many parents or caregivers to conduct caring and informative sex-related discussions with them may leave many African adolescent males deficient in knowledge concerning the building of healthy sexuality relationships and behaviours, especially safe sex negotiation, how to handle social pressures to engage in sexual activity, and the motivation to practice protected sex. Furthermore, cultural discourses underpinning African male sexuality and maintaining male sexuality practices play a crucial role for male adolescents in the sexual sense of self and of the female partner. The African patriarchal power system, cultural convictions about masculinity, the higher hierarchy of power and status of males, and the resulting rights of men to demand sexual rights have been indicated as the origins of many

abusive and self-defeating behavioural practices of African male youth (for an interesting study see Jewkes et al., 2009).

It could thus be assumed that higher order mental yet socially constructed functions such as belief systems, as well as the values and attitudes pertaining to sexuality that flow from such beliefs, would be wholly shaped by the reigning cultural discourses. Furthermore, the ability and skills with which to make decisions about sexuality matters would originate from the beliefs (values and attitudes) that prevail and that are guided by the cultural masculine discourse. It would further seem that masculine discourse-dominated beliefs about sexuality are very seldom discussed and almost never challenged in the majority of African families. Male youth therefore seem to create their sexual and overall identities and their sexual behaviour patterns in line with and informed by the cultural discourse, irrespective of its harmful consequences and effects on their psychosocial well-being.

Very little research on the above mentioned factors influencing African male youth's sexuality development could be found. Apart from fairly old research by means of the Mathtech Sexuality Questionnaires for Adolescents done mostly in America, there is a dearth of research on the sexual values, attitudes, decision-making skills and ease of communication about sexuality matters of African adolescents. There is even less about the relationships of these factors with aspects pertaining to the psychosocial well-being of African male youth.

It is thus concluded, that although recognition is given in literature to mostly objective indicators of sexual behaviour of African male youth such as the ages of sexual debut, certain - mostly negative - health practices such as risky sexual activities, lack of condom use, multiple partners and aggressive actions in sexual encounters, more subjective dimensions of sexuality development in youth, has received little attention. Such subjective factors would consider the intrapersonal and interpersonal processes that influence sexual beliefs, decisions and choices made, as well as coping with difficulties about sexuality; seeking to understand the meaning

that African male youth ascribe to their sexual experiences and the ways in which sexuality is woven into their identities and intimate relationships. Research into these dimensions of adolescent male sexuality is strongly recommended and the current study attempted to initiate such research interest.

African adolescent males' sexual and psychosocial well-being

For the purpose of this study, psychosocial variables such as self-esteem, adaptive coping strategies and mental health and well-being were used to conceptualise the psychosocial well-being of the adolescent male participants.

Self-esteem: In literature self-esteem or a sense of self-worth has been reported as either a correlate or a predictor of various health- and growth-promoting facets in youth (as well as of negative facets). For example, intrapersonal and interpersonal variables such as subjective well-being, optimism and motivation, anxiety, aggression, and anger are associated with positive and negative self-esteem respectively; also interpersonal variables such as relatedness, social support and teamwork, delinquency, risky behaviour and gang membership.

Initially, self-esteem was deemed as an interpersonal characteristic, although it was based on the internalisation of interpersonal messages about the self. More recently, Hewitt (2009) emphasised that self-esteem as a socially constructed, evaluative and affective characteristic of a person, indicated a sense of security in the social context, cultural competence, being skilled to interact and to balance personal and social expectations.

Despite the different findings pertaining to the relationship of self-esteem with other characteristics of the individual, the most constant finding reports self-esteem as a crucial component of mental and social well-being, since it influences aspirations, personal goals and interaction with others. Self-esteem is repeatedly recommended as an important focus in health promotion. Very little research could be found on self-esteem and healthy aspects of adolescent

sexuality. Such research, especially with sexual values, attitudes, decision making and communication, is recommended.

Adaptive coping strategies: In a nutshell, coping strategies explain the emotional, cognitive and behavioural skills that individuals employ to manage the stress experienced due to internal and external challenges and demands. Adaptive coping strategies refer to the coping activities that are successful in reducing stress and promoting well-being. Adaptive coping has been associated with features of well-being such as self-regulation, hope, happiness and relatedness, but many more research findings focus on negative coping strategies such as denial and avoidance and their association with ill-being features of the adolescent such as depression, aggressiveness, substance abuse etc. The same applies to sexuality aspects of youth, where non-adaptive coping methods have been related to risky sexual practices, partner abuse, sex under the influence of peer pressure, gang activities or substance use.

Thus, the field of research into adaptive coping and health-promoting aspects of youth sexuality is both open and enticing, especially since adolescent males seem to use sex as an often preferred way of coping with stress (see the work of Horton, 2007, in this regard).

Mental health and well-being: Various aspects of mental health have repeatedly been associated with sexual behaviour of adolescents, but mostly viewed from the pathogenic perspective, for example, low self-esteem, depression and aggression in association with risky sexual activities, abuse towards sexual partners and sex under the influence of substances. However, although more salutogenic-oriented research is still scarce, some findings with the three components of mental health and well-being - as conceptualised by Keyes (2002) - have emerged:

- Emotional well-being as emotional vitality, happiness, satisfaction with life and predominantly positive emotional experiences has been associated with aspects of healthy sexual behaviour of youth by Higgins et al. (2011).

- Psychological well-being is described as self-acceptance, autonomy, personal growth, purpose in life, positive relatedness and environmental mastery. Self-acceptance as self-esteem and self-efficacy have been related to either risky or adaptive aspects of youth sexuality; autonomy of youth has been related to sexual health practices and satisfaction; and positive relatedness has been associated with healthy sexual development features and positive partner behaviour (see Higgins et al., 2011 and Mann et al., 2004, in this regard).
- Social well-being - seen as social acceptance, actualisation, contribution, coherence and integration - has been associated with sexual debut, protected sexual activities, mutual respect between sexual partners and positive peer information regarding sexuality (see Crone & Dahl, 2012; Kigozi, 2006; Zeman et al., 2012, in this regard).

Yet, despite the few studies on mental health and well-being and healthy sexuality features of youth that could be found, a paucity of research still exists regarding positive mental health and well-being in relation to healthy, satisfying and self-enhancing sexual practices in youth. This paucity of research may exist because of the natural inclination towards focusing on psychosexual difficulties of adolescents. Also the study of well-being may seem less pressing than the obviously urgent problem-saturated developmental aspects of adolescents, such as violence, sexual risk behaviour and substance abuse. However, the lack of research into psycho-sexual health and well-being of youth limits our understanding of positive sexuality of adolescents and how their well-being in this regard could be facilitated and enhanced (Tweed, Biswas-Diener, & Lehman, 2012). Such research is strongly recommended and this study may make a contribution in that regard.

Conclusions from the Empirical Findings

Broad aims stated for the empirical research of this study were to determine descriptive statistics and the psychometric properties of the measuring instruments used; to identify

correlation and regression relationships between all latent variables by means of factor analysis and structural equation modelling; and to identify from the empirical findings, guidelines and strategies for a proposed sexual education programme for male youth.

In the manuscripts discussed below that reported the research findings, it is evident that the broadly stated aims were all met, albeit through specific aims set for the research stages.

Conclusions from the first quantitative study of the sexual values and attitudes, self-esteem and mental health and well-being of African adolescent males (Manuscript 1).

Three measuring instruments were used in this study for data collection purposes in this study with $N = 552$ African adolescent participants, namely the *Mathtech Sexuality Questionnaires for Adolescents* by Kirby (1984), the *Rosenberg Self-esteem Scale* (Rosenberg, 1965), and the *Mental Health Continuum: Long form* (Keyes, 2002). Data was analysed using SPSS 19 (Gray & Kinnear, 2012), and the Mplus version 7.31 (Muthén & Muthén, 1998-2014). Means and standard deviations as well as reliability indices were compared and found similar to those reported in literature for the same measuring instruments. The correlations between the latent variables of this research showed significant positive correlations between emotional, psychological and social well-being, positive self-esteem, clarity of values and attitudes toward intimacy, and also between self-esteem and sexual values and attitudes.

The expected significant negative correlations with negative self-esteem and unclarity or confusion of sexual values and attitudes, also emerged. These correlational findings were all in line with relevant theory. Strong positive correlations of the psychological well-being dimension with other variables seemed to indicate that the mental well-being features had the strongest influence on sexuality aspects of these youth, perhaps because their emotional wellness may fluctuate and their social wellness is often under pressure. Regarding values towards sexuality, strong correlations with self-esteem seem to indicate the role of self-esteem as a socially constructed characteristic, in either clarity of values and satisfaction with sexuality

of youth or in uncertainty and confusion about these aspects of their lives. The mentioned findings strongly supported numerous research findings reported in literature in this regard.

A statistically best fitting measurement model was identified by Mplus and through path coefficients of the structural model and further bootstrapping methods, it was found that self-esteem transferred the effects of mental health well-being to the sexual values and attitudes of the youth involved; in other words, self-esteem proved to be a mediating variable in the relationship between mental health and wellness and sexuality values and attitudes. This seems to be a fairly unique finding since very little research could be found on the mediating effects of self-esteem and about none on the mediating role of self-esteem in the psychosocial well-being-healthy sexual beliefs relationship.

However, it would seem from these findings as if self-esteem could, as a mediating variable, serve a cognitive function to transfer the effects of mental health and well-being to sexuality values and attitudes, which are also seen as social-normative beliefs that serve as cognitive behavioural determinants (see Ajzen, 1991). Furthermore, the findings seem to support literature indicating a bi-directional relationship between emotional, psychological and social dimensions of mental health and well-being, and self-esteem. Self-esteem could therefore be seen as an important feature in interventions aimed at mental health promotion, as suggested by Mann et al. (2004), and as intended with this study about psychosexual health promotion of youth.

The aims for this study, namely to investigate the relationships and the directions thereof between variables studied, also whether self-esteem mediates the relationships between variables, were successfully achieved.

Conclusions drawn from the second quantitative study of sexual behaviour (decision-making skills and ease of communication), coping strategies and mental health and well-being of African male adolescents (Manuscript 2).

For data collection with $N = 552$ African adolescent male participants, the Mathtech Sexuality Questionnaires for Adolescents: Inventory for Behaviour of Kirby (1984) were used, also Keyes' Mental Health Continuum: Long form (2002) and the Children's Coping Strategies Checklist by Ayers and Sandler (1999).

The descriptive findings indicated that the means and standard deviations as well as reliability indices for these scales were comparable to those found in literature for the same measuring instruments. The significant positive correlations that were found between the coping measures – those of mental health and well-being and those of sexuality decision making and communication – all made theoretical sense. Coping strategies proved to have the strongest correlations with other variables. Strong and significant correlations of coping strategies to solve problems and obtain social support with mental health and well-being and with sexual decision-making behaviour, seemed to indicate that problem-solving abilities and perceiving social support when needed have enabling influences on youth in dealing with their developmental challenges (see amongst others, Aldwin, 2011). Positive problem-solving experiences may have enhancing cognitive, self-related, emotional and psychological effects; and social support has strong relational, affiliative and stress-buffering effects (Taylor, 2011, amongst others). Therefore, the strong recommendation of Heppner and Lee (2009) and Malouff et al. (2007) that problem solving should be included in programmes aimed at building the health and wellness of youth could be supported.

Using Mplus 7.31 of Muthén and Muthén (1998-2014), confirmatory factor analyses were done on the latent variables and a measurement model was specified that proved to have good statistical fit. A statistical best-fitting structural model indicated both direct and indirect effects on all latent variables.

Latent class analyses were used to group participants with similar emotional, psychological and social well-being response patterns, based on the fit indices and three classes

that proved optimum and were named flourishing, moderately mentally healthy, and languishing. The classes comprised 28% of for flourishing, 56% for moderately mentally well and 16% as languishing youth. This corresponded with findings of Keyes (2006) in American youth, and Koen (2012) and Van Schalkwyk (2009) in South African youth, although the levels of flourishing were lower and languishing more in the youth of this study. Flourishing youth, in general, thus have emotional, psychological and social well-being and, in line with the current findings, would use problem-focused coping ways and communication skills to deal with sexuality challenges. Also, the use of problem-focused coping strategies and communication skills about sexuality issues could enhance flourishing in youth. These findings support Keyes' (2006) strong call for flourishing to be developed in youth in order to enhance all their developmental outcomes.

The aims of this study, namely to assess the construct validity and reliability of measures for sexuality behaviour, coping strategies and mental health and well-being of the participants; to test a structural model through estimating regression paths from well-being (emotional, psychological and social) to the respective factors that constitute coping strategies and sexual decision making and communication; and to identify underlying classes not identified through specifying the best fit models, were successfully achieved.

Conclusions drawn from the guidelines for promoting healthy sexual behaviour and psychosocial well-being of African adolescent youth (Manuscript 3).

The general aim of the proposed guidelines and strategies of this study was to develop a sexual education programme aimed at establishing healthy sexual practices and corresponding psychosocial well-being features in adolescent males. The guidelines and strategies were based on empirical findings obtained from prior research into these factors of adolescent development, as well as relevant literature reviewed.

Findings from the first study indicated significant correlational relationships between

sexual values and attitudes, self-esteem and mental health and well-being of youth, specifically, that self-esteem mediated the relationship between mental health and well-being and sexuality aspects of the participating youth. The second study yielded findings of significant correlations between sexual decision-making skills, ease of communication about sexuality, coping strategies and mental health and well-being. Specifically, latent class analysis found three classes, namely flourishing, moderate mental health and languishing respectively, which explained the levels of mental health and well-being of participants.

From these findings, variables that could be included in guidelines and strategies were psychological well-being and self-esteem, flourishing, problem-focused (solving) coping strategies and communication skills about sexuality. Literature reviewed further indicated the inclusion of topics such as African adolescent males' experience of sexual education from cultural perspectives; sexuality and masculinity discourses and manifesting belief systems; the absence of fathers in the development of sexuality of male youth; factual information on physical sexuality; prevention and protection during sexual practices; building of a sexual sense of self integrated with identity formation; building respectful, mutually caring and supportive partner relationships and also self-enhancing relationships with parents and peers; and committing to and maintaining long term healthy, satisfying and mutually growth-promoting couple relationships.

Corresponding with literature about the construction of interventions, the proposed programme will also attend to the person-strategy fit, the socio-cultural context of participants, establishing their motivation and commitment to the aims and outcomes of the programme and for the strategies to include cognitive, interactive and applicable content.

Furthermore, in line with the aims and purpose of the study, the understanding and development of healthy values and attitudes and decision-making abilities will be integrated into all strategies of the proposed programme. Guidelines that were proposed for inclusion in a

sexual education programme were thus sexuality, preparing for the journey, sexual values and attitudes, sexuality, the language of the body, sexuality, decision making and communication skills, self-esteem, problem-focused coping, flourishing, and wrapping up and the way forward.

Finally, the ultimate aim of a proposed psycho-education programme on sexuality – as the one flowing from this study – will be to foster a positive and respectful approach to sexual relationships, as well as to have pleasurable and safe sexual experiences, free from coercion, discrimination and violence. In other words, to provide youth with knowledge that will equip them to experience their sexuality as a source of happiness and joy, in fellowship with a meaningful other (see Crockett et al., 2003).

Limitations and Recommendations of the Study

There were various limitations in this study and some recommendations could be made:

- The measuring instruments used in this study with African youth were in English and were mostly not standardised for use on South African youth. Although English is the language of tuition at the schools where the research had taken place, the researcher is of the opinion that even more valid and richer results could have been obtained with scales in the mother tongue of the youth. Research into the sexuality of South African adolescent males with similar scales such as those in this study is recommended, but with scales presented in the mother tongue of participants.
- The Mattech Sexuality Questionnaires for Adolescents are old scales and although still in use for survey research mainly, factor analyses towards identifying the relevant factors by means of which sexual values, attitudes, decision making and sexuality-related communication could be conceptualised, could not be found. Despite these conceptual and psychometric problems of the MSQA, it is still one of the only existing scales that explore the sexuality of youth along these lines. It is thus recommended that the MSQA be revised, adapted and revalidated for use with South African youth in modern times.

- The Mental Health Continuum's long form questionnaire has not been validated for use in South African research; whereas the questionnaire's short form (MHC: SF) has (Keyes, Wissing, Potgieter, Temane, Kruger, & Van Rooy, 2008). The use of the MHC: SF is thus recommended for future research into the psychosexual well-being of South African youth.
- The Rosenberg Self Esteem Scale has been validated for use in South Africa and has also been used extensively in research with youth. However, one wonders whether the use of a collective self-esteem measurement would not have produced richer results in this study. It is thus recommended that future research investigate the role of collective self-esteem in the sexuality of African youth.
- Self-esteem, flourishing, problem-focused coping and communication about sexuality aspects were found to be strong variables that could influence the healthy sexuality and overall well-being of African adolescent males. Further research along those lines with the view of including these features in interventions aimed at fostering sexual health and well-being in youth, is recommended. This would correspond with literature in which the main theorists in the mentioned fields often indicate the wisdom of including these health and growth promoting aspects in youth development interventions.
- This was a quantitative research study and although valuable results emerged from the study, the question often arose during interpretation of the findings as to what the participants could have disclosed about topics in a qualitative study. Both mixed method approach and qualitative explorations of African youth's sexuality are strongly recommended.
- In a quasi-experimental research design the proposed programme could have been implemented between pre- and post-intervention measurement sessions and a preliminary validation of the programme could have been done. Follow-up research to validate the proposed sexual education programme is strongly recommended.

- Although the conceptualisation of phenomena was alluded to above, there is a lack of understanding as to how aspects such as beliefs, values and attitudes about sexuality are conceptualised by African youth within cultural contexts that are characterised by male-dominated discourse, lack of openness and guidance from parents, absent fatherhood and prominent peer influences, as well as poverty-related environments. Research into the conceptualisation of these and other features of a sense of sexual self by African youth is strongly recommended.
- During debriefing after the administration of the measurements for this study, the large number of participants ($N = 600$) voiced their need for further discussions along the lines of the topics investigated. The principals of the schools where the research was done also requested further sexual education services to the youth; also for similar research to be done with girls. It is thus recommended that similar research be done with female adolescents and that serious attention should be given to the quality of sexual education services in South African schools.
- Finally, the concerns of parents; educators; youth counsellors; and religious, spiritual and cultural leaders in communities about psycho-sexual problems relating to the youth and the physical outcomes of their immature sexual involvement, are often raised. However, limited research could be found that addresses the burning issues; and even less evidence-based interventions to alleviate the risky issues threatening the psycho-sexual well-being of youth in South Africa. It is recommended that a large project be launched by the South African Government through its relevant departments and commissions, and the HSRC, also involving universities towards researching and developing appropriate, applicable and meaningful programmes for South African youth which could guide them towards healthy, caring and joyful sexuality.

Contributions of the Study

A contribution of this study is towards the knowledge base of the fields of positive and developmental psychology, education, gender studies and other fields in psychology as a broad discipline, since it addressed emotional, psychological, and social well-being, self-esteem, problem-solving coping and various aspects of youth sexuality within the South African context. New knowledge is added and existing knowledge is updated by this research.

The findings of this study could raise enthusiasm for and interest in further research about the topics investigated by it, since the limited research done about healthy adolescent sexuality - especially in South Africa - has been alluded to before. The constructs investigated in this research gave a unique conceptualisation of adolescent sexual values, attitudes and aspects of behaviour in relation to their psychosocial well-being. This could contribute toward further theory-building about the psycho-sexual health and well-being of youth. Findings of the study could also contribute toward effective and relevant interventions aimed at the enhancement of sexual values and attitudes, decision making and communication skills, as well as psycho-sexual wellness.

The proposed programme of this study, aimed at promoting healthy sexual behaviour and psychosocial well-being of adolescent males, could be implemented and validated. This would largely contribute to the field of sexual education in which there is a dearth of evidence-based programmes. The programme could be further implemented and researched in diverse contexts with youth, in order to adapt it meaningfully for use by various counsellors, therapists and also youth leaders in the quest of young people's well-being.

Once the manuscripts of the study have been published in relevant scientific journals, the articles could be made available to the departments of Health, Education and Social Development to support motivations for policy writing towards fostering the psycho-sexual

well-being of South African youth. Sexual education curricula could be improved and new programmes developed, based on meaningful, appropriate and applicable policy guidelines.

More specifically, the findings of the study about the potential value of intra- and interpersonal characteristics such as self-esteem, flourishing, problem solving, coping, and ease of communication could be used toward fostering not only salutary sexuality features in youth, but also general mental health and well-being on intra- and interpersonal levels. In other words, separate self-esteem building, flourishing-promoting, problem-solving coping skills activities and communication-promoting exercises could be facilitated in diverse growth- promoting contexts with youth.

Finally, the knowledge generated and the proposed intervention could contribute to the training of psychologists (developmental, counselling and clinical), social workers, youth counsellors and teachers towards an understanding of youth sexuality as an inherent part of their identity formation and well-being in general.

It may be concluded that the aims – general and specific – of this study were reached. By investigating sexual values and attitudes, self-esteem and mental health and well-being of African adolescent male participants, as well as their decision making and communication about sexuality skills, coping strategies and the associations thereof with their mental health and well-being; evidence emerged that could inform guidelines and strategies for youth. The research questions about the relationships between those variables and adolescent sexuality and psychosocial well-being, were answered. Apart from investigating correlational results, the findings of self-esteem as a mediating variable in the sexuality-well-being relationship, and the three classes of flourishing, moderate mental health and languishing in these adolescent participants, could be considered to be unique. The outcome of this study could be of social relevance towards enhancing projects and programmes aimed at improving the health and well-being of South African youth.

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