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EFFECT OF RATIONAL EMOTIVE BEHAVIOUR THERAPY ON HEALTH RISK-TAKING BEHAVIOUR OF IN-SCHOOL ADOLESCENTS IN ABIA STATE

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ABSTRACT

This study explored the effect of rational emotive behaviour therapy on health risk-taking behaviour of in-school adolescents in Abia State. The study adopted a quasi-experimental design. Two research questions and one null hypothesis guided the study. The sample size of the study consisted of 32 in-school adolescents who were purposefully drawn from 778 senior secondary class II students with Health risk-taking behaviours in Abia State. The instrument used for data collection was a 30-item questionnaire titled Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ). The instrument was validated by three experts in order to establish its face validity. The reliability of the instrument was established using Pearson Moment Correlation Coefficient to establish the stability of the instrument which yielded a coefficient of 0.87; while Cronbach Alpha method was used to establish the internal consistency of the instrument, and the result indicated index values of 0.76. Data collected were analysed using mean and standard deviation to answer the research questions, and Analysis of Covariance (ANCOVA) to test the null hypothesis at 0.05 level of significance. The results among others showed that rational emotive behaviour therapy resulted to reduction of health risk-taking behaviour of in-school adolescents in Abia State at both the post-test and follow-up.

Keywords: *Adolescence/Adolescents/in-school Adolescents, Health Risk-Taking Behaviour and Rational Emotive Behaviour Therapy.*

INTRODUCTION

Adolescence as a remarkable period of growth and development in the life-course of anybody, is filled with vulnerabilities and risks as well as incredible opportunities and potentials. Adolescence is defined by Wong, Tung, Chan and Jiang (2021) as a transitional period where the child is no longer considered a child and yet not part of the adult world. Adolescence is therefore a transitional period from childhood into adulthood, while adolescents are young people that are within the adolescence stage of development. Hence, the in-school adolescents are adolescents who are currently in secondary schools. And they undergo profound changes during their adolescent years in their physical, psychological, physiological, emotional, social, intellectual and moral well-being and development.

According to Tull (2014), risk-taking behaviour is the tendency to engage in behaviours that have the potential to be harmful or dangerous. Health risk-taking behaviours constitute the highest social risk problems in societies; and as such, health risk-taking behaviours could erode family values, and pose a tremendous challenge to the overall well-being of the young adults. The manifestation of these behaviours ranges from gangsters, physical fighting, smoking, drinking alcohol, using of drugs, stealing, early unprotected sexual activities, homosexuality and lesbianism. Ugoji (2014) observed that many of these adolescents indulge in these behaviours just for the reason of experimentation and peer influences, due to a wealth of open information they are exposed to, through an intensifying wave of westernization, the Internet and electronic social media. As these social experimentations and participation increase, adolescents' involvement in a variety of dangerous risk activities may also increase. National Centre for Health Statistics (2012), reported that underage drinking, unprotected sex, drug use, smoking and gang involvement are notable risky behaviours that often result in undesirable consequences.

In Nigeria for instance, adolescents were seen as a healthy segment of the population (Ofole & Agokei, 2014). Regrettably, environmental factors have brought additional health risk challenges to them. Ahonsi (2013) posited that adolescents in Nigeria have high burden of health risk problems. This assertion supported earlier surveys conducted on sexual behaviours of Nigerian adolescents by National Demographic Health Survey (2018), National HIV/AIDS and Reproductive Health Survey (2017) and Integrated Biological and Behavioural Surveillance Survey (Ofole & Agokei, 2014); which showed that Nigerian adolescents between fifteen and nineteen years of age (both male and female) have engaged in several risky behaviours. Ofole and Agokei (2014) maintained that several in-school adolescents experience mental health problem,

either temporarily or for a long period of time as a result of health risk-taking behaviour. Some become insane, maladjusted to school situations and eventually drop out of school.

There is no doubt that adolescents' high risk-taking behaviours have serious effects on their health, social, academic and psychological well-being. On health ground, it can lead to sexually transmitted infections/disease (STI/STD), unwanted pregnancies, HIV/AIDs, chronic diseases and early death (Malak, 2015). It may impede their healthy social development leading to delinquency, violence, ritual killings, kidnapping, vandalism, hoodlum, truancy, alcohol drinking, reckless driving, cultism and armed robbery. It may cause academic failure, poor academic performance and school dropout. Psychological conflict such as mental distress, social isolation, and depression could be some of the effects of adolescents' health risk taking behaviour (Okwundu, 2014). It is against this backdrop that the researchers deemed it necessary to embark on a study that will proffer solution that would salvage these adolescents from the impending danger of health risk-taking behaviours. Therefore, the researcher wonders if other methods like Rational Emotive Behaviour Therapy could be explored.

On the other hand, Rational Emotive Behaviour Therapy (REBT) by Ellis is a therapeutic intervention that helps people come out of their self-defeating thought that inhibits general progress in life. According to Mahfar and Senin (2015), REBT claims that people to a large degree consciously and unconsciously construct emotional difficulties such as self-blame, self-pity, clinical anger, hurt, guilt, shame, depression and anxiety behaviours and behaviour tendencies such as procrastination, compulsiveness, avoidance, addiction, and withdrawal by means of their irrational and self-defeating thinking. Even though health risk-taking behaviours cannot be eradicated totally, but the way a student sees it and organizes his thought might go a long way in helping that student make necessary adjustments and continues with his academic pursuit. REBT as a mental restructuring mechanism is often applied as an educational process in which the therapist often actively counsels the client on how to identify irrational and self-defeating beliefs and philosophies. Rational Emotive Behaviour Therapy (REBT) adopts the ABCDEF model in training clients. This model has explained in great details how emotional disturbance or health risk-taking behaviours experienced by an individual is due to irrational belief system and not negative events experienced (Obi & Nicholas, 2020).

In adopting Rational Emotive Behaviour Therapy (REBT) to help in-school adolescents with health risk-taking behaviour, gender is another factor that is assumed to influence the effectiveness of the technique. Gender is the social and psychological aspects of being female or male; it includes

a person's understanding of the meaning to his own life of being a male or a female (Kaj, 2018). Again, evidence abound about the effectiveness of some behavioural intervention techniques like REBT in reducing maladjusted behaviours. For instance, studies by Olatunbosun (2020) which reported that REBT was effective on reducing the test anxiety of underachievers. Another study that was carried out by Muhammad (2020) to reduce the anxiety of victims of bullying by using a rational emotive behaviour therapy (REBT). The study by Awujo and Kennedy (2020) which determined the 'Effects of Rational Emotive Behaviour Therapy in improving poor study habit among students in Obio-Akpor local government area of Rivers State, Nigeria. Tsagem (2020) also reported that rational emotive therapy was effective in remediating proneness to violent behaviour among the students and that though female students benefited the most, it was concluded that RET proved effective for both genders. In the light of the foregoing, the problem of the study therefore is: to find out the relative effectiveness of Rational Emotive Behaviour Therapy (REBT) on health risk-taking behaviours of in-school adolescents in Abia state.

The purpose of this study is to find out the effect of Rational Emotive Behaviour Therapy (REBT) on health-risk taking behaviour of in-school adolescents in Abia state. Specifically, the study sought to:

i) determine the mean score difference in the reduction of health risk-taking behaviours between the Rational Emotive Behaviour Therapy group and control group at post-test.
ii) determine the mean score difference by gender in the reduction of health risk-taking behaviour based on the treatment package at post-test.

RESEARCH QUESTIONS

The following research questions guided the study:

i) What is the mean score difference in the reduction of health risk-taking behaviours between the Rational Emotive Behaviour Therapy group and control group at post-test?
ii) What is the mean score difference by gender in the reduction of health risk-taking behaviour based on the treatment package at post-test?

HYPOTHESIS

This null hypothesis was formulated and tested at 0. 05 level of significance to guide the study.

$H0_1$: There is no significant mean score difference in the reduction of health risk-taking behaviours between the Rational Emotive Behaviour Therapy group and control group at post-test.

METHODOLOGY

The study was delimited to Senior Secondary class two (SSII) students in 2020/2021 academic session in Abia State. These students were screened using Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ). Only students with high tendency of health risk-taking behaviours were selected. Only SSII students were used in the study because they were not taking any external examination and have spent at least one full session as senior students in the school, so as to respond positively to the treatment modalities. Both male and female students participated in the study at the same time. In-school adolescents with moderate and low health risk-taking behaviour were not part of this study.

The focus of this study was on the relative effectiveness of Rational Emotive Behaviour Therapy (REBT) by Albert Ellis in 1955. The present study focused on these five techniques of REBT: Imaginal Disputation, Behavioural Disputation, Emotional Control Card, Confrontation and Encouragement. Rational Emotive Behaviour Therapy is the independent variable and health risk-taking behaviour of in-school adolescents is the dependent variable. Gender is the moderating variable. The study was carried out in Aba and Umuahia education zones in Abia State. This study adopted a quasi-experimental research design employing non-randomized pre-test, post-test and control group using 2x2 factorial matrix. A quasi-experimental research design was chosen for this study because it is an interventional study used to estimate the causal impact of an intervention on target population without random assignment of subjects (Kpolovie, 2016). There are two groups, namely Rational Emotive Behaviour Therapy group and a control group; while the column is represented by gender (male and female) as moderator variable for this study.

The area of the study is Abia State. The interest of the researcher about the area is that it has been discovered that secondary school students in Abia State tend to record unsteady achievement in most core science subjects both in internal and external examinations (WAEC, 2015-2019). This low achievement seems to be attributed to high tendency for health-risk taking behaviours in Abia State (Adeyemi, 2021). Thus, the rationale for choosing Abia State was to find out the extent rational emotive behaviour therapy could help in reduction of health risk- taking behaviours of the in-school adolescents. The population of this study was made up of 778 in-school adolescents in senior secondary two (SSII) in public co-educational secondary schools in Abia State with high

tendency of health risk-taking behaviours. The rationale for the choice of senior secondary class two students was because they were not taking any external examinations such as West African Senior Secondary Examinations (WASSEC), and the students have several months to stay in the school for follow-up assessment period. They are also older adolescents that would be able to respond positively to the treatment modalities.

The sample size of this study comprised 32 (16 males and 16 females) students drawn from two co-educational public senior secondary schools in Abia State. A multi-stage sampling technique involving five stages was used to draw subjects from 148 co-educational public senior secondary schools from two education zones in Abia State for this study. The first stage involved the use of simple random sampling to draw two Education Zones (Aba and Umuahia Education Zones) from the three Education Zones. Simple random sampling technique was also used in the second stage to draw one Local Government Area, each from the two selected Education Zones (Aba South Local Government Area and Umuahia North Local Government Areas). Purposive sampling technique was used in the third stage to select two co-educational public senior secondary schools; each from the two selected Local Government Areas with the highest number of SS II students that had high tendency to health risk-taking behaviours. This was based on the form teachers' and school counsellors' identification and confirmation by the students during the initial survey using the Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ). In the fourth stage, simple random sampling technique was used to assign the two selected schools to the two groups. Group I- REBT group (LST) with 16 subjects and group II- control group with 16 subjects. Stratified sampling technique was used in the fifth stage to draw the male and female students to the two groups to take care of the gender variable in the study.

One instrument was used for the study and titled: The Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ). It was adapted by Odoemelam (1996) Students Sexual Behaviour inventory (S.S.B.I.). It has two major sections – A and B. Section A elicits information on personal data e.g. age, class and gender. Section B has 30 items which elicit information on different adolescents' health risk-taking behaviours. The items of the instrument were designed on a 4-point rating scale of strongly agree (SA), agree (A,) disagreed (D) and strongly disagreed (SD) with weights as 4, 3, 2 and 1 respectively. Any subject that had mean score of 2.50 in each item statement was believed to have high tendency of health risk-taking behaviour, while any score below 2.50 indicated low tendency of health risk-taking behaviour of the students. The Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ) was used

for the preliminary study to identify adolescents with Health Risk-Taking Behaviours, and during pre-test, post-test and follow-up phases.

The Adolescents' Health Risk-Taking Behaviour Identification Questionnaire (AHRTBIQ) was validated by three experts, two from the Department of Psychology and Counselling and one in Measurement and Evaluation from the Department of Science Education, Michael Okpara University of Agriculture, Umudike, Abia State in order to establish its face validity. The research experts were given the purpose of the study, research questions and hypothesis; and were requested to study the items coverage in terms of suitability, language and the relevance of the items to the study. The experts corrected some of the items that were not properly stated. Their corrections and suggestions were effected and reflected in the final copy of the instrument.

The reliability of the instrument (AHRTBIQ) was established using test-re-test method. This is in support of Nwankwo (2016) who pointed out that test-re-test is a method of the most convenient reliability. The instrument was given to 20 students that were not part of the population but shared the same characteristics with the sampled students on two weeks interval. The initial scores and re-test scores were subjected to Pearson Product Moment Coefficient for the stability of the instrument, while Cronbach's Alpha Method reliability test was used in determining the internal consistency of the instrument. Stability value of 0.87 and internal consistency reliability of 0.76 were established, indicating that the instrument was both stable and reliable for the study.

The data collection was carried out in systematic three phases – namely; pre-treatment phase, post-treatment phase and follow-up phase. Phase one was the pre-treatment phase where the researchers administered the instrument to the students in order to establish the base line data for the study. Phase two was the post-treatment phase where the researchers re-administered the instrument to both the treatment (to determine the treatment effects) and control groups. The third and final phase was the follow-up phase which was used to ascertain the maintenance of treatment effects after a period of four weeks. The instrument was administered and collected immediately subjects finished responding to the items on the questionnaire. The data collected from the pre-test and post-test treatments as well as follow-up were statistically analyzed using both descriptive and inferential statistics. The research questions were answered using mean and standard deviation while analysis of covariance (ANCOVA) was used to analyze the hypothesis at 0.05 levels of significance.

Table 1: The Summary of the Counselling process in REBT Treatment Plan

Session	Topic	Activities of researchers	Activities of subjects	Duration (approx.)
1	initial counselling establishment issues and setting of goals	(i)Reviewed of events of the previous pre-treatment phase (ii)set goals (iii)REBT orientation discussion on the concept of REBT model and its efficacy on in-school adolescents with health risk-taking behaviour based on identified problems (iv)Reassured the subjects of living a healthy life style irrespective of the tendency for health risk-taking behaviour (v)Encouraged the subjects to work towards a healthy life style (vi)Gave them assignment to write on areas where they exhibit high tendency for health risk-taking behaviour (vii)Thanked the subjects for active participation.	(i) Exchanged healthy pleasantries (ii)Listened attentively and asked questions where necessary (iii)worked towards changing their irrational thinking (iv)narrated situations that contributed to their tendency for health risk-taking behaviour (v)wrote down tasks and assignments	60 minutes
2	Imaginal Disputation Technique of REBT	(i)reviewed previous session and assignment (ii) Introduced the imaginal technique and assisted the subjects on how to use it in their daily activities. (iii) Asked the subjects to imagine a situation that upset them and write down how they feel with all the self-talk that came to their minds.	(i)Submitted assignment and discussion emanating from last assignment (ii) Listened attentively and asked questions where necessary. (iii) Participated actively in all the activities. (iv)Role-played the learnt skill	

		(iv) The researchers again asked them to imagine the same situation that upset them, and then changed the self-talk leading to a more moderate response. (v)asked them to compare the two results (vi)modelled the learnt skill (vii) Gave task and assignment. (viii) Reinforced and thanked the subjects for active participation.		
3	Behavioural Disputation Technique of REBT	(i)revision of previous assignments and review of previous session (ii)Explained the behavioural disputation technique (iii) Assisted the subjects on how to use the technique in their daily activities. (iv)asked the subjects to mention an upsetting situation (v) Asked them to behave in a way that is opposite to the way they would have responded to the situation. (vi) Modeled this skill. (vii)Task and assignment given (viii)Reinforced and thanked the subjects for active participation.	(i)Submitted the previous assignments, (ii)listened attentively and asked questions where necessary (iii)Participated actively in all the activities (iv)Role-played the technique as modelled by the researchers (v)wrote down the various tasks and assignments	60 minutes
4	Emotional Control Card Technique of REBT	(i)Progress verification. (ii)Previous task and assignment reviewed and discussed	i. Ready for the day's activity and submission of homework ii. Listened attentively and asked questions where necessary	60 minutes

		(iii)Explained the emotional control card technique (iv)asked the subjects to make a list of their rational and irrational thoughts on their cards (v)led the subjects to imagine themselves in a difficult situation (vi)modelled this technique (vii)Task and assignment given (viii) Reinforced and thanked the subjects for active participation.	iii.Watched, rehearsed and role played learned techniques iv. Copied assignments	
5	Confrontation and Encouragement Techniques of REBT	(i)Progress verification. (ii)Previous task and assignment reviewed and discussed (iii)Explained the Confrontation and encouragement techniques (iv)Drilled the subjects on these two techniques (v)modelled this technique (vi)Task and assignment given (vii) Reinforced and thanked the subjects for active participation.	(i)Ready for the day's activity and submission of homework (ii)Listened attentively and asked questions where necessary (iii)Watched, rehearsed and role played learned techniques (iv)Copied assignments	60 minutes
6	Review of activities in all sessions and Post-test	((i)Progress verification, (ii)reviewed the entire sessions using questioning, and summarization (iii) Administered the post test. (iv)modelled all the learnt skills (v)Appreciation, assurance and encouragement.	(i)Summarized individual progress in turn (ii)Listened attentively and observed others as they rehearsed all acquired new behaviour (iii)Promised to keep practicing learnt behaviour (iv)Responded to the post test, gave vote of	60 minutes

	(vi)Termination with a closing prayer	thanks and closing prayers

PRESENTATION OF RESULTS

Research Question 1

What is the mean score difference in the reduction of health risk -taking behaviour between the REBT group and control at post-test?

Table 2: Mean and standard deviation of the mean score difference in the reduction of health risk-taking behaviours of the REBT group and control group at post-test

Source		Pre-test		Post-test		Mean Reduction	Mean Reduction Difference
Groups	**N**	$\bar{X}$	**SD**	$\bar{X}$	**SD**		
REBT	16	67.42	4.62	34.13	4.63	33.29	
							26.57
Control	16	66.33	4.64	59.61	4.82	6.72	

Data in Table 2 showed that the Rational Emotive Behaviour Therapy (REBT) group had a pre-test mean score of 67.42 with a standard deviation of 4.62 and a post-test mean score of 34.13 with a standard deviation of 4.63. Similarly, the control group recorded pre-test mean score of 66.33 with a standard deviation of 4.64 and a post-test mean score of 59.61 with a standard deviation of 4.82. The table further showed that the Rational Emotive Behaviour Therapy (REBT) group had mean reduction difference of 33.29 while their counterparts in the control group had 6.72. The mean reduction difference between the Rational Emotive Behaviour Therapy (REBT) group and the control group is 26.57; which implies that the Rational Emotive Behaviour Therapy (REBT) group had higher mean health risk-taking behaviour reduction than their counterparts in the control group. The standard deviation of the two groups ranged between 4.62 and 4.82; indicating that the respondents were not too far from the mean and from one another in their responses, adding further validity to the mean. The results therefore, indicated that the use of Rational Emotive Behaviour Therapy (REBT) had reduced the health risk-taking behaviours of the in-school adolescents.

Hypothesis 1

There is no significant mean score difference in the reduction of health risk-taking behaviours between the REBT treatment group and control group at post-test.

Table 3: Analysis of covariance (ANCOVA) of the mean score difference in the reduction of health risk-taking behaviours among the REBT group and control group at post-test

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	6978.432[a]	4	1744.608	14.381	.000
Intercept	4461.535	1	4461.535	36.777	.000
Pre-test	2249.359	1	2249.359	18.542	.002
Group	3562.134	1	3562.134	29.363	.000
Error	3275.453	27	121.313		
Total	69934.000	32			
Corrected Total	13953.875	31			

The results in the Table 3 above showed that Rational Emotive Behaviour Therapy (REBT) as a factor in the study has a significant effect in the reduction of health risk-taking behaviours of the subjects. The calculated f-value of 29.363 in respect of the treatment as main effect of Rational Emotive Behaviour Therapy (REBT) on mean rate of reduction of health risk-taking behaviour scores is higher than f-critical value of 1.96 with degree of freedom of 27 at 0.05 level of significance. This implies that exposing subjects with health risk-taking behaviours to Rational Emotive Behaviour Therapy (REBT) significantly reduced their health risk-taking behaviours. Therefore, the null hypothesis of no significant mean score difference in the reduction of health risk-taking behaviours between the Rational Emotive Behaviour Therapy (REBT) group and control group at post-test period was rejected. Thus, there is significant mean score difference in the rate of reduction of health risk-taking behaviours between those in the Rational Emotive Behaviour Therapy (REBT) group and control group at post-test period.

Research Question 2

What is the mean difference by gender in the reduction of health risk-taking behaviour based on the treatment package at post-test?

Table 4: Mean and standard deviation of the mean score difference by gender in the reduction of health risk-taking behaviour based on the two treatment packages at post-test

Source		Pretest		Posttest		Mean Reduction	Mean Reduction Difference
Groups	**N**	$\bar{X}$	**SD**	$\bar{X}$	**SD**		
Males	16	67.25	4.53	46.21	3.64	21.04	
							0.24

Females	16	66.23	4.54	45.43	3.63	20.80

Data in Table 4 showed that the male subjects with health risk-taking behaviour in the treatment package of Rational Emotive Behaviour Therapy group had a pre-test mean score of 67.25 with a standard deviation of 4.53 and a post-test mean score of 46.21 with a standard deviation of 3.64. Similarly, the female subjects in the treatment package of Rational Emotive Behaviour Therapy group recorded pre-test mean score of 66.23 with a standard deviation of 4.54 and a post-test mean score of 45.43 with a standard deviation of 3.63. The table further showed that the male subjects in the treatment package of Rational Emotive Behaviour Therapy group had mean reduction difference of 21.04 while their female counterparts in the treatment package of Rational Emotive Behaviour Therapy group had mean post-test reduction score of 20.80. The mean reduction difference between the male and female subjects in the treatment package of Rational Emotive Behaviour Therapy group is 0.24; which implies that the male subjects in the treatment package of Rational Emotive Behaviour Therapy group had greater mean health risk-taking behaviour reduction than their female counterparts in the same treatment group. The standard deviation of the two groups ranged between 3.63 and 4.54; indicating that the respondents were not too far from the mean and from one another in their responses, adding further validity to the mean. The results therefore, suggests that the use of the treatment package of Rational Emotive Behaviour Therapy had reduced the rate of health risk-taking behaviours of the male in-school adolescents more than the female in-school adolescents having health risk-taking behaviours.

DISCUSSION OF FINDINGS

The findings of this study showed that intervention using rational emotive behaviour therapy significantly reduced the rate of health risk-taking behaviours of in-school adolescents in Abia State. This is evident from the result that showed that in-school adolescents exposed to rational emotive behaviour therapy had higher mean scores of health risk-taking behaviour reduction than those in the control group. The findings of this study are in agreement with the findings of earlier studies by Olatunbosun (2020), Muhammad (2020), Awujo and Kennedy (2020) and Tsagem (2020). Olatunbosun (2020) reported that REBT was effective on reducing the test anxiety of underachievers. Another study that was carried out by Muhammad (2020) to reduce the anxiety of victims of bullying by using a rational emotive behaviour therapy (REBT) counselling approach has the support of this study. The study reported that the counselling programme with the rational emotive behaviour therapy (REBT) approach has proven to be effective and has an effect on reducing anxiety in bullying victims, which is characterized by a decrease in anxiety scores. The findings of this study are in agreement with the findings of the study conducted by

Awujo and Kennedy (2020) which determined the 'Effects of Rational Emotive Behaviour Therapy in improving poor study habit among students in Obio-Akpor local government area of Rivers State, Nigeria. Results revealed that REBT had significant effect in improving poor study habit among students in the experimental group while the placebo had no effect on study habit of students, the control group did not show any improvement when compared to the REBT experimental group. Tsagem (2020) also reported that rational emotive therapy was effective in remediating proneness to violent behaviour among the students and that though female students benefited more, it was concluded that RET proved effective for both genders.

CONCLUSION

This study examined the effect of rational emotive behaviour therapy on health risk-taking behaviour of in-school adolescents in Abia State. Based on the data collected and analysed, the study concluded that Rational Emotive Behaviour Therapy significantly reduced health risk-taking behaviours of in-school adolescents. The treatment gains were also maintained at follow-up period. There was also no gender difference in the effectiveness of the treatment package.

COUNSELLING IMPLICATIONS OF THE FINDINGS

The findings of this study have counselling implications for the students in Abia State, teachers, psychologists, school counsellors, researchers and government. The study has provided empirical evidence in respect of the effect of rational emotive behaviour therapy on health risk-taking behaviour of in-school adolescents in Abia State.

The results showed that intervention using rational emotive behaviour therapy significantly reduced the rate of health risk-taking behaviours of the in-school adolescents in Abia State. This implies that teachers, psychologists, school counsellors who have some identified students/clients with health risk-taking behaviour could effectively reduce it using rational emotive behaviour therapy (REBT).

Hence, both male and female in-school adolescents with health risk-taking behaviours could be exposed to the treatment package of rational emotive behaviour therapy without gender discrimination, as the different gender groups benefited equally and significantly from the treatment both at post-test and follow-up periods.

RECOMMENDATIONS

Based on the findings, conclusion and counselling implications of this study, the following recommendations were made:

1. School counsellors should make adequate use of rational emotive behaviour therapy in reducing health risk-taking behaviours of students that are referred to them.
2. Teachers, psychologists, and School Counsellors should endeavour to use the treatment of rational emotive behaviour therapy which is effective in reducing the health risk-taking behaviours of in-school adolescents.
3. Government and School administrators should organize and sponsor regular workshops, seminars and conferences to educate the teachers, school counsellors and the parents of the students on the effective use of rational emotive behaviour therapy in reducing health risk-taking behaviours of adolescents both in the schools and at home.
4. Researchers and school counsellors should endeavour to carry out more studies to find out other undesirable behaviours among students, which rational emotive behaviour therapy could be effectively used on, so as to ensure effective teaching and learning in schools.

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