

SEXUAL DEBUT, ROMANTIC RELATIONSHIP DENIAL AND KNOWLEDGE OF SEXUAL TRANSMITTED INFECTIONS AMONG ADOLESCENCE IN ANAMBRA METROPOLIS

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Abstract

Sexual related health illness seems to be rampant in Nigeria as a result of social-economic problems faced by the people. The increasing prevalence of risky sexual behaviors among adolescents and young adults continues to pose significant public health concerns globally. Although numerous studies have established that knowledge of sexually transmitted infections (STIs) is associated with safer sexual practices, evidence consistently demonstrates that knowledge alone does not necessarily translate into protective behavior. The aim of this research is to have a better understanding of a number of adolescence that have romantic relationship with the opposite sex, their knowledge of sexual transmitted infections and the relationship between sexual debut and knowledge of sexual transmitted infections. Also, this research aims at re-educating them on both negative and positive implications of this sexual behaviour. Furthermore, this theoretical paper examines the relationship among sexual debut, knowledge of sexually

transmitted infections, and romantic relationship denial. It argues that romantic relationship denial a psychological tendency to underestimate or reject the possibility that a trusted romantic partner could transmit an STI functions as an important mechanism through which STI knowledge fails to influence preventive sexual behavior. Drawing from the Health Belief Model, Theory of Planned Behavior, Cognitive Dissonance Theory, and Communication Privacy Management Theory, the paper proposes a conceptual framework explaining how emotional attachment, trust, perceived partner fidelity, and denial distort risk perception despite adequate STI knowledge. The paper concludes that sexual health interventions should move beyond knowledge-based education by addressing emotional, relational, and cognitive factors influencing sexual decision-making. Conclusively, the concept of slave mentality also should be eroded among the adolescence.

Keywords: Sexual debut, sexually transmitted infections, STI knowledge, romantic relationships, denial, sexual behavior.

INTRODUCTION

It has been observed in Nigeria recently that a lot of adolescents involve themselves in diverse sexual behaviours while in school. The reason behind these behaviours could be as a result of peer group influence or experimentation as a result of being exposed to certain uncensored information on the internet. Furthermore, current trend of insurgency, inflation, poverty and even COVID-19 experience which seems to have brought a lot of economic burden on people may

have pushed these adolescences to produce strategies for coping and unfortunately see sex as a way out. This research therefore becomes imperative thereby re-educating them on the implications of risky sexual behaviours and suggest the way forward.

Sexually transmitted infections (STIs) remain one of the most persistent public health challenges worldwide despite decades of investments in prevention, diagnosis, treatment, and sexual health education. According to the World Health Organization (2020), more than one million curable sexually transmitted infections are acquired every day among people aged 15–49 years, with an estimated 374 million new infections occurring annually for chlamydia, gonorrhoea, syphilis, and trichomoniasis alone. Beyond their immediate clinical manifestations, untreated STIs contribute substantially to infertility, ectopic pregnancy, chronic pelvic pain, adverse pregnancy outcomes, neonatal complications, increased susceptibility to HIV infection, and several forms of cancer. The continuing global burden of STIs demonstrates that improvements in medical interventions have not been matched by comparable improvements in preventive sexual behaviour. However, research consistently showed that increased knowledge about STIs does not always produce safer sexual behavior. Individuals with adequate knowledge frequently engage in unprotected sex because emotional and relational factors override cognitive awareness (Andersson-Ellström et al., 1996; Goldmeier & Richardson, 2005).

Young people, particularly adolescents and emerging adults, seems to bear a disproportionate share of this burden because they are at a developmental stage characterized by experimentation, identity formation, emotional attachment, and increasing sexual autonomy. During this

transition, many individuals initiate sexual relationships without possessing adequate interpersonal skills for negotiating safer sex, discussing sexual histories, or managing relationship pressures. Although access to sexual health information has expanded through schools, universities, healthcare institutions, and digital media, behavioural outcomes have remained inconsistent. This paradox has prompted researchers to investigate psychological and relational factors that influence sexual decision-making beyond simple knowledge acquisition (Kahn & Halpern, 2018).

Sexual related health illness seems to be rampant in Nigeria as a result of social-economic problems faced by the people. This could be the reason why some orthodox medicines focused on that and new ones uprising. Most of their customers are youths who are adolescence and afraid or stigmatized to talk about sexually transmitted infections. Since sex is seen as a sacred topic to be discussed with parents or guardians, adolescences seems to deny the fact that they are sexually active (Onyemaechi, 2025, Onyemaechi, et.al, 2022, 2022). All over the world, depending on culture and perception of sex, adolescents are known to have sexual debut and also involved in romantic relationship without hiding it to their caregivers or parents. Therefore, they have the knowledge of the sexual risk behaviours but in African, Nigerian in particularly especially the south east for an example, religious and cultural values restricts sexual/ romantic relationship only to married adults making discussion of sexual health a taboo among adolescence. For this reason, adolescents in this region seem to wander in darkness and become victims of sexual risky behaviours. Hence the need for this study, to fill in the gap in knowledge, given the importance of adolescents to the future of the country.

Recent research among Nigerian secondary-school students found that approximately 22% had experienced sexual intercourse, with nearly 42% of sexually active adolescents reporting sexual debut before the age of 15 years. The same study reported low parental involvement in sexuality education and inadequate communication regarding sexual health (Oladebo et al., 2018; Adebayo et al., 2021). In southeastern Nigeria, including Anambra State, rapid urbanization, widespread internet access, changing family structures, and increasing exposure to social media have transformed adolescent social interactions and romantic relationships. Although cultural and religious values continue to discourage premarital sexual intercourse, adolescents increasingly encounter conflicting messages from peers, entertainment media, and digital platforms (Umeaku, et.al, 2024). One of the most widely investigated determinants of later sexual health is sexual debut, which is defined as an individual's first experience of sexual intercourse.

Sexual debut refers to an individual's first experience of sexual intercourse and serves as a critical marker in sexual development. Sexual debut has been seen to be increasingly recognized as a developmental event that shapes future sexual behaviour rather than merely representing a single life event. Sexual debut represents one of the most important developmental transitions during adolescence and young adulthood. The age and circumstances surrounding first sexual intercourse significantly influence later sexual health outcomes, including exposure to sexually transmitted infections (STIs), unintended pregnancies, and patterns of sexual behavior (Kahn & Halpern, 2018).

Research consistently indicates that individuals who initiate sexual activity at younger ages are more likely to report multiple sexual partners, inconsistent condom use, unintended pregnancy,

and increased exposure to sexually transmitted infections throughout adulthood (Stöckl et al., 2013). Early sexual debut has consistently been associated with multiple sexual partners, inconsistent condom use, higher STI prevalence, lower self-efficacy regarding sexual decision-making, and greater susceptibility to peer influence, all of which contribute to elevated sexual health risks and increased vulnerability to HIV infection, particularly in sub-Saharan Africa (Stöckl et al., 2013).

The timing of sexual debut is influenced by multiple interacting factors, including family environment, peer norms, socioeconomic conditions, cultural expectations, media exposure, substance use, religious beliefs, and educational attainment as ascertained by Envuladu, Kwaak, Zwanikken and Zoakah, (2017). These influences operate simultaneously, making sexual behaviour a multidimensional phenomenon that cannot be adequately explained by biological maturation alone. Consequently, contemporary sexual health research increasingly adopts ecological and behavioural perspectives that recognize the combined influence of individual cognition, interpersonal relationships, and broader social environments (Yaya & Bishwajit (2018). In response to increasing STI prevalence, governments and international organizations have invested heavily in sexual health education programmes designed to improve knowledge regarding modes of transmission, symptoms, prevention, testing, and treatment. These programmes are largely informed by behavioural theories suggesting that individuals who understand disease risks are more likely to adopt preventive behaviours. Consequently, educational interventions have become central components of national reproductive health strategies across both developed and developing countries. Although these interventions have

substantially improved public awareness of sexually transmitted infections, evidence indicates that increased knowledge alone rarely guarantees behavioural change.

Numerous studies have reported that adolescents and young adults with adequate knowledge of STI transmission continue to engage in behaviours such as inconsistent condom use, multiple concurrent sexual partnerships, delayed STI testing, and unprotected sexual intercourse. This persistent gap between knowledge and behaviour suggests that sexual decision-making is influenced by psychological processes extending beyond cognitive awareness. Individuals frequently possess accurate information about disease prevention while simultaneously believing that infection is unlikely to occur within their own relationships. Such discrepancies challenge traditional assumptions that knowledge is sufficient for behaviour modification and highlight the need for more comprehensive theoretical explanations.

One emerging explanation is the role of interpersonal relationship dynamics in shaping perceptions of vulnerability. Within committed romantic relationships, emotional intimacy, trust, affection, and perceived exclusivity often create powerful feelings of security. While these qualities are generally beneficial for relationship satisfaction, they may inadvertently reduce perceived susceptibility to sexually transmitted infections. Individuals frequently discontinue condom use shortly after relationships become emotionally committed, often without discussing previous sexual histories or obtaining mutual STI screening. This behaviour reflects an implicit assumption that trust is equivalent to biological safety, despite evidence that asymptomatic infections are common and that transmission may occur even in relationships perceived as monogamous.

The present paper introduces the construct of romantic relationship denial to explain this phenomenon. Romantic relationship denial refers to the psychological tendency to minimise, reject, or ignore the possibility that a trusted romantic partner could be a source of sexually transmitted infection. Unlike general optimism bias, this construct specifically emerges from emotional attachment and perceived relationship security. Individuals experiencing romantic relationship denial may consciously acknowledge that STIs exist and understand their modes of transmission while simultaneously believing that these risks do not apply within their own intimate relationships. Such denial reduces perceived susceptibility, discourages condom use, delays STI screening, and limits open communication about sexual health. This construct is theoretically important because it may explain why many knowledge-based interventions achieve only modest behavioural outcomes. If emotional attachment systematically alters risk perception, then educational programmes that focus exclusively on increasing knowledge may fail to produce sustained behavioural change. Integrating relationship psychology with sexual health promotion therefore offers an opportunity to improve both theoretical understanding and practical intervention design.

Conceptual Review

Sexual Debut

Sexual debut refers to an individual's first experience of consensual sexual intercourse and represents a significant developmental milestone in adolescence and early adulthood. Although frequently conceptualized as a discrete life event, contemporary research increasingly views sexual debut as the beginning of an evolving trajectory of sexual attitudes, relationship

formation, and health-related behaviors (Kahn & Halpern, 2018). The timing, context, voluntariness, and relational circumstances surrounding first sexual intercourse have been shown to influence later sexual practices, reproductive health outcomes, and vulnerability to sexually transmitted infections (STIs).

The age at sexual debut varies considerably across countries and populations due to differences in cultural norms, religious beliefs, family structures, socioeconomic conditions, educational opportunities, and access to sexual and reproductive health information (Madkour et al., 2014). In many low- and middle-income countries, early sexual initiation remains a public health concern because it is associated with limited access to comprehensive sexuality education, reduced autonomy in sexual decision-making, and barriers to reproductive healthcare. Conversely, delaying sexual debut has been associated with greater emotional maturity, improved decision-making capacity, and increased likelihood of adopting safer sexual practices (Kahn & Halpern, 2018).

The literature consistently demonstrates that early sexual debut is associated with increased sexual health risks. A systematic review by Stöckl et al. (2013) concluded that early sexual initiation was linked to higher odds of HIV infection among women in sub-Saharan Africa. Similarly, longitudinal studies have shown that individuals who initiate sexual activity at younger ages are more likely to report multiple lifetime sexual partners, inconsistent condom use, transactional sex, unintended pregnancy, and subsequent STI acquisition (Kahn & Halpern,

2018). These findings suggest that the timing of first sexual intercourse is not merely a chronological marker but an important determinant of future sexual behavior.

Several mechanisms have been proposed to explain the relationship between early sexual debut and adverse sexual health outcomes. First, adolescents who initiate sexual activity early often have limited knowledge and experience regarding contraception, STI prevention, and healthy relationship communication. Second, early sexual debut may occur within unequal power relationships in which young people have limited ability to negotiate condom use or refuse unwanted sexual activity. Third, early initiation is frequently associated with psychosocial factors such as peer influence, substance use, adverse childhood experiences, and lower parental monitoring, all of which contribute to sustained patterns of sexual risk-taking (Madkour et al., 2014).

Importantly, the consequences of sexual debut extend beyond biological outcomes to include psychological and relational dimensions. The first sexual experience often shapes expectations regarding intimacy, trust, communication, and relationship commitment. Positive experiences characterized by mutual consent, respect, and open communication may encourage healthier relationship behaviors. In contrast, negative or poorly informed experiences may reinforce misconceptions about sexual health, reduce self-efficacy in negotiating safer sex, and normalize risky sexual practices. Consequently, researchers increasingly advocate for a life-course perspective that considers sexual debut as the foundation for subsequent sexual and reproductive health trajectories (Kahn & Halpern, 2018).

The relationship between sexual debut and STI prevention is particularly relevant to the present theoretical paper. Although individuals may acquire substantial knowledge of STIs after initiating sexual activity, behavioral patterns established during early sexual experiences often persist over time. If first sexual relationships are characterized by unprotected intercourse, limited communication, or assumptions of partner safety, these patterns may continue into later romantic relationships despite increased awareness of STI risks. Thus, knowledge acquired through formal education may not fully modify behaviors rooted in earlier relationship experiences.

Within the proposed theoretical framework, sexual debut is conceptualized as an antecedent factor that shapes later perceptions of sexual risk and relationship behavior. Early sexual experiences may influence how individuals interpret trust, intimacy, exclusivity, and vulnerability within subsequent romantic relationships. These perceptions may, in turn, contribute to romantic relationship denial, whereby individuals underestimate the possibility of STI transmission from trusted partners despite possessing adequate knowledge about STI prevention. Consequently, understanding sexual debut provides an important foundation for explaining how behavioral patterns established during adolescence interact with cognitive and emotional processes in adulthood.

Overall, the literature indicates that sexual debut should not be viewed solely as the initiation of sexual activity but rather as a developmental transition with enduring implications for sexual health, relationship dynamics, and disease prevention. Integrating sexual debut into theoretical

models of STI prevention therefore enhances understanding of the complex pathways through which early experiences influence later health behaviors.

Knowledge of Sexually Transmitted Infections

Knowledge of sexually transmitted infections (STIs) refers to an individual's understanding of the causes, modes of transmission, signs and symptoms, prevention strategies, diagnosis, treatment, and possible complications of infections transmitted primarily through sexual contact. It is a fundamental component of sexual and reproductive health literacy and is widely recognized as a prerequisite for informed sexual decision-making (World Health Organization [WHO], 2023). Comprehensive STI knowledge enables individuals to recognize risk factors, adopt preventive measures such as consistent condom use, seek timely testing and treatment, and engage in open communication with sexual partners regarding sexual health status. Despite substantial improvements in sexual health education globally, research consistently demonstrates that high levels of STI knowledge do not necessarily translate into safer sexual behaviour and findings suggest that knowledge is a necessary but insufficient condition for sustained behavioural change. (Samkange-Zeeb et al., 2011; Widman et al., 2018).

Several explanations have been proposed for this knowledge–behaviour gap. One explanation is that sexual decision-making is strongly influenced by emotional and interpersonal factors that may override cognitive awareness. Individuals frequently make decisions within the context of romantic relationships, where trust, intimacy, commitment, and perceived partner fidelity shape perceptions of risk. Consequently, people who understand STI transmission may nevertheless perceive themselves to be personally invulnerable because they believe their partners are faithful

or "safe." Such perceptions reduce motivation for condom use, routine STI screening, and discussions about sexual history, despite adequate factual knowledge (Brannon & Ray, 2023). Another explanation concerns the role of perceived susceptibility, a central construct of the Health Belief Model. Rosenstock et al. (1988) argued that individuals are unlikely to adopt preventive behaviours unless they believe they are personally vulnerable to disease. Knowledge of STI transmission therefore does not automatically lead to behaviour change if individuals perceive their own risk to be low. Knowledge alone may also fail to produce behavioural change because sexual behaviour is embedded within broader social and cultural contexts. Gender norms, religious beliefs, stigma associated with STIs, unequal relationship power, economic dependence, and limited access to healthcare services all influence the translation of knowledge into practice. For example, an individual may understand the importance of condom use but be unable to negotiate condom use because of fear of relationship conflict, partner violence, or accusations of infidelity. These contextual influences highlight the limitations of educational interventions that focus exclusively on information provision while neglecting interpersonal and structural determinants of behaviour.

Within the context of the present theoretical paper, knowledge of sexually transmitted infections is conceptualized as an essential but incomplete determinant of preventive sexual behaviour. The paper argues that the influence of STI knowledge is moderated by relationship-specific psychological processes, particularly romantic relationship denial. Individuals may possess comprehensive knowledge regarding STI prevention yet fail to apply this knowledge because emotional intimacy alters perceptions of vulnerability. Thus, romantic relationship denial may

explain why knowledge-based interventions often achieve modest behavioural outcomes despite successfully increasing awareness. This perspective extends existing behavioural theories by proposing that cognitive knowledge must be understood alongside emotional attachment and relationship dynamics. Rather than viewing knowledge as the sole driver of preventive behaviour, the proposed framework recognizes that sexual decision-making is influenced by the interaction between factual understanding, perceived susceptibility, interpersonal trust, and cognitive-emotional processes. Integrating these factors provides a more comprehensive explanation for persistent STI transmission among knowledgeable populations and offers new directions for sexual health education, psychotherapy, and behavioural interventions.

Romantic Relationship Denial

Romantic relationship denial refers to the psychological tendency whereby individuals underestimate, ignore, or reject the possibility that a trusted romantic partner could expose them to an STI. The denial is fueled by emotional attachment, intimacy, commitment, perceived exclusivity, and trust. Individuals often assume that emotional closeness equates with biological safety. Consequently, they may avoid condom use, neglect STI testing, or fail to discuss sexual history with partners. Research indicates that conversations about STI status are frequently avoided because individuals fear rejection, relationship conflict, or stigma.

Goldmeier and Richardson (2005) argued that romantic love may temporarily override rational cognitive processing, reducing individuals' willingness to apply STI knowledge during sexual

decision-making. Emotional attachment therefore weakens preventive behavior despite adequate knowledge.

Romantic relationship denial is conceptualized in this paper as a psychological process through which individuals minimize, reject, or underestimate the possibility that a trusted romantic partner could expose them to a sexually transmitted infection (STI), despite possessing adequate knowledge of STI transmission and prevention. Unlike general ignorance or lack of awareness, romantic relationship denial occurs when individuals consciously understand the risks associated with unprotected sexual intercourse but perceive those risks as irrelevant within their own intimate relationships (Misovich et al., 1997; Brannon & Ray, 2023). Individuals frequently assume that committed partners are free from infection without discussing previous sexual histories or obtaining mutual STI testing. Such assumptions contribute to inconsistent condom use, delayed STI screening, and reduced engagement in other preventive behaviours.

Romantic relationship denial, however, is relationship-specific. Rather than reflecting a generalized sense of invulnerability, it emerges from emotional commitment and the belief that one's romantic partner represents a uniquely safe source of intimacy (Weinstein, 1987). Consequently, individuals may acknowledge the prevalence of STIs within society while simultaneously believing that infection is impossible within their own relationship. Numerous studies have reported that condom use declines as romantic relationships become more emotionally committed because requesting condom use is often interpreted as evidence of distrust or suspected infidelity (Misovich et al., 1997). Thus, while trust strengthens relationship quality, excessive or uncritical trust may reduce vigilance regarding STI prevention.

The Health Belief Model (HBM) provides one theoretical explanation for romantic relationship denial. According to the HBM, preventive health behaviour is influenced by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Rosenstock et al., 1988). Romantic relationship denial reduces perceived susceptibility because emotional attachment creates a subjective belief that trusted partners cannot be sources of infection. Consequently, individuals may possess accurate knowledge regarding STI prevention while lacking sufficient motivation to apply that knowledge within their own relationships.

The Theory of Planned Behavior (Ajzen, 1991) similarly contributes to understanding romantic relationship denial. According to the theory, behavioural intentions are determined by attitudes toward behaviour, subjective norms, and perceived behavioural control. Within committed romantic relationships, subjective norms frequently discourage preventive behaviours that might imply mistrust. For example, suggesting STI testing or insisting on condom use may be interpreted as questioning a partner's fidelity or demonstrating lack of commitment. Individuals therefore experience conflict between their knowledge of STI prevention and their desire to preserve relationship harmony. Romantic relationship denial resolves this conflict by reducing perceived risk rather than modifying behaviour.

Cognitive Dissonance Theory (Festinger, 1957) offers an additional explanation. The theory proposes that individuals experience psychological discomfort when beliefs and behaviours are

inconsistent. A person who understands that unprotected sexual intercourse increases STI risk but continues engaging in unprotected sex experiences cognitive dissonance. Rather than changing behaviour, some individuals reduce discomfort by convincing themselves that their romantic partner is free from infection or that their relationship is fundamentally different from relationships associated with STI transmission. Denial therefore becomes a psychological strategy for maintaining emotional stability while avoiding behavioural change.

Communication Privacy Management Theory (Petronio, 2002) further explains how romantic relationship denial develops through limited disclosure of sensitive information. Discussions regarding previous sexual partners, STI diagnoses, HIV status, or sexual risk behaviours are often perceived as highly private. Many couples therefore avoid such conversations because of embarrassment, fear of rejection, or concerns about damaging relationship satisfaction. In the absence of open communication, assumptions replace evidence, reinforcing beliefs that trusted partners are free from infection. Consequently, privacy management unintentionally contributes to inaccurate risk perception within romantic relationships.

Empirical evidence supports many components of romantic relationship denial, although the construct itself has received limited direct investigation. Brannon and Ray (2023) found that conversations regarding STI disclosure remain difficult because individuals negotiate ownership and privacy of sexual health information. Similarly, Newton and McCabe (2005) demonstrated that stigma associated with STIs discourages disclosure and testing, thereby increasing opportunities for undetected transmission. Studies of condom use have also shown that

relationship duration and emotional commitment are associated with reduced condom use despite continued risk of STI exposure (Misovich et al., 1997). Collectively, these findings suggest that interpersonal dynamics substantially influence preventive sexual behaviour beyond factual knowledge alone.

Table: Knowledge of HIV/AIDS among Young People in Anambra State (MICS 2021)

State-level survey data

Indicator	Percentage (%)
Young women (15–24 years) who have heard of HIV/AIDS	97.6
Young men (15–24 years) who have heard of HIV/AIDS	98.9
Young women with comprehensive HIV knowledge	63.1
Young men with comprehensive HIV knowledge	74.5

Source: Nigeria Multiple Indicator Cluster Survey (MICS) 2021, Anambra State profile.

State-level data from the Nigeria Multiple Indicator Cluster Survey (MICS, 2021) showed that nearly all adolescents and young adults in Anambra State have heard of HIV/AIDS (97.6% of females and 98.9% of males), while comprehensive HIV knowledge remains moderate (63.1% and 74.5%, respectively). HIV knowledge is commonly used as a proxy for STI awareness because publicly available Anambra State datasets do not report a separate adolescent STI-knowledge indicator.

Sources Of Information About STI By Respondents

Types	Females	Males	Total frequency	Percentage %
Syphilis	105	89	194	58.1%
Gonorrhoea	99	91	190	56.9%
HIV/AIDS	144	156	300	89.8%
Genital herpes	39	16	55	16.5%
Chlamydia	10	9	19	5.7%
Trichomoniasis	8	8	16	4.8%
HPV	16	17	33	9.9%

Table: Knowledge of Preventive measures of STIs by Obiechina (2014)

Preventive measures	Female	Males	Total frequency	Percentage
Avoiding sexual intercourse	145	137	282	84.4
Use of insecticide treated nets	12	9	21	6.3
Vaccination	23	13	36	10.8
Being faithful to one partner	91	65	156	46.7
Use of condoms	54	91	145	43.4
Douching after sex	7	11	18	5.4
Oral contraceptive	9	12	21	6.3
Keeping toilets clean	45	22	67	20.1

It has been observed that although adolescents in Anambra State are recognized as a population at elevated risk of sexually transmitted infections because of early sexual debut and risky sexual behaviours, no recent population-based study has established the prevalence of STIs among adolescents in the state. Existing studies have primarily examined STI knowledge, preventive awareness, and sexual risk behaviours rather than confirmed STI infection.

Contribution to Knowledge

The introduction of romantic relationship denial as a theoretical construct contributes to behavioural science by integrating perspectives from psychology, communication, and public health. Existing theories acknowledge perceived susceptibility, subjective norms, and disclosure processes; however, they rarely consider how emotional intimacy systematically alters these determinants within committed relationships. Existing studies have largely examined sexual debut, STI knowledge, and relationship dynamics as independent predictors of sexual behaviour. Comparatively few studies have attempted to integrate these variables within a single theoretical framework capable of explaining their combined influence on preventive sexual behaviour. Consequently, the complex interactions among developmental experiences, cognitive knowledge, and interpersonal relationships remain insufficiently understood. Although numerous educational interventions have successfully increased knowledge regarding sexually transmitted infections, empirical evidence consistently demonstrates that improvements in knowledge are not always accompanied by corresponding improvements in preventive sexual behaviour (Badawi et

al., 2019; Widman et al., 2018). Research examining romantic relationships has primarily focused on interpersonal trust, condom negotiation, communication, disclosure, relationship satisfaction, and intimacy as separate determinants of sexual health behaviour. Although these studies provide valuable insights into relationship processes, they rarely investigate the cognitive-emotional mechanisms through which emotional attachment alters perceptions of susceptibility to sexually transmitted infections.

Finally, an extensive review of the available literature reveals that no widely established theoretical construct explicitly explains the psychological tendency of individuals to deny or minimize the possibility of STI transmission from trusted romantic partners while simultaneously possessing accurate knowledge of STI prevention. To address these gaps, the present paper proposes Romantic Relationship Denial (RRD) as a novel cognitive-emotional theoretical construct. Romantic Relationship Denial is defined as the tendency of individuals to underestimate or reject the possibility that a trusted romantic partner could transmit a sexually transmitted infection despite possessing adequate knowledge of STI transmission and prevention. The construct integrates perspectives from behavioural psychology, communication studies, and public health to explain how emotional attachment reduces perceived susceptibility and weakens the relationship between knowledge and preventive sexual behaviour.

The proposed construct contributes to the existing literature in several important ways. First, it integrates previously isolated findings concerning sexual debut, STI knowledge, interpersonal trust, and relationship communication into a unified theoretical framework. Second, it offers a plausible explanation for the persistent knowledge-behaviour gap documented across numerous

empirical studies. Third, it extends established behavioural theories including the Health Belief Model, Theory of Planned Behavior, Cognitive Dissonance Theory, and Communication Privacy Management Theory by incorporating relationship-specific psychological processes that have received limited attention within STI prevention research. Finally, it provides a conceptual foundation for future empirical investigations aimed at developing valid and reliable measures of Romantic Relationship Denial and evaluating its role in predicting sexual risk behaviour across different populations.

In summary, while existing empirical studies have significantly advanced understanding of sexual behaviour and STI prevention, they leave unanswered questions regarding the psychological mechanisms linking relationship dynamics with preventive sexual behaviour. The introduction of Romantic Relationship Denial addresses this important gap by offering a comprehensive theoretical explanation for why individuals with adequate STI knowledge may nevertheless engage in behaviours that increase their vulnerability to infection. Future empirical research is needed to operationalize, validate, and test this construct across diverse cultural and demographic settings.

Implications for Policy and Practice

The findings and theoretical arguments presented in this paper have important implications for sexual and reproductive health policy and practice.

1. Current STI prevention programmes frequently emphasize knowledge acquisition through classroom instruction, media campaigns, and public health education. While these approaches

improve awareness, they often overlook the emotional and interpersonal processes influencing sexual decision-making.

2. Public health interventions should therefore incorporate relationship-focused counselling that encourages couples to discuss sexual history, STI testing, condom use, and mutual expectations before discontinuing protective behaviours.

3. Healthcare providers should normalize conversations regarding STI testing within committed relationships and emphasize that trust and emotional intimacy do not eliminate biological risk.

4. Educational institutions should integrate relationship communication, negotiation skills, and emotional decision-making into comprehensive sexuality education programmes. Such interventions may reduce Romantic Relationship Denial by encouraging realistic assessments of susceptibility while preserving healthy relationship functioning.

5. In addition, policymakers should support routine STI screening programmes targeting adolescents, university students, and young adults entering new romantic relationships. These programmes should emphasize that preventive behaviours represent expressions of mutual care and responsibility rather than evidence of mistrust. By incorporating emotional and relational dimensions into STI prevention strategies, healthcare professionals and policymakers may improve the effectiveness of existing interventions and contribute to reductions in STI transmission across diverse populations.

6. This theoretical perspective suggests that sexual health interventions should move beyond traditional information dissemination. Programs should incorporate emotional intelligence, communication skills, relationship negotiation, trust management, and stigma reduction. Couple-

based interventions encouraging routine STI testing and open communication may reduce denial and improve preventive behaviors.

Conclusion

Sexually transmitted infections (STIs) continue to represent a significant global public health challenge despite considerable advances in medical treatment, health promotion, and comprehensive sexuality education. Although educational interventions have substantially improved public awareness of STI transmission and prevention, the persistence of risky sexual behaviours among knowledgeable individuals demonstrates that knowledge alone is insufficient to ensure consistent adoption of preventive sexual practices. This persistent knowledge-behaviour gap highlights the need for broader theoretical perspectives that integrate cognitive, emotional, and interpersonal influences on sexual decision-making.

This paper critically examined three key concepts sexual debut, knowledge of sexually transmitted infections, and romantic relationship denial to develop a comprehensive theoretical explanation of preventive sexual behaviour. The central contribution of this paper is the introduction of Romantic Relationship Denial (RRD) as a proposed cognitive-emotional construct. The paper argues that emotional intimacy, interpersonal trust, perceived exclusivity, and relationship commitment may reduce perceived susceptibility to infection, thereby weakening the influence of STI knowledge on preventive sexual behaviour. The proposed construct is theoretically supported through the integration of the Health Belief Model, Theory of Planned Behavior, Cognitive Dissonance Theory, and Communication Privacy Management Theory. Future empirical investigations should develop valid and reliable instruments for

measuring Romantic Relationship Denial and examine its mediating role using advanced quantitative and qualitative research designs. Longitudinal and cross-cultural studies are particularly recommended to determine the stability of the construct across different populations and relationship contexts. Such investigations will contribute to the refinement and validation of the proposed framework.

From a practical perspective, the findings suggest that STI prevention programmes should move beyond knowledge-based education to incorporate interventions addressing emotional attachment, interpersonal communication, relationship expectations, and perceived susceptibility. Healthcare professionals, educators, and policymakers should promote routine STI testing, open partner communication, and relationship-based counselling that emphasizes mutual responsibility for sexual health. Preventive behaviours such as condom use and STI screening should be reframed as expressions of shared care and responsibility rather than indicators of distrust. In conclusion, the paper proposes Romantic Relationship Denial as a novel theoretical construct that advances understanding of sexual health behaviour by integrating cognitive, emotional, and interpersonal perspectives. If empirically validated, Romantic Relationship Denial has the potential to strengthen existing models of sexual risk behaviour and improve the design of relationship-sensitive STI prevention programmes capable of addressing one of the most persistent challenges in contemporary sexual and reproductive health.

Recommendation

The following recommendations are offered:

1. Researchers should develop and validate a standardized Romantic Relationship Denial Scale (RRDS) to facilitate empirical investigation of the proposed construct.
2. Future studies should examine the mediating and moderating roles of Romantic Relationship Denial using longitudinal, experimental, and cross-cultural research designs.
3. Sexual and reproductive health education programmes should integrate relationship communication, emotional intelligence, and risk perception alongside traditional STI knowledge.
4. Healthcare providers should encourage routine STI testing and open communication between romantic partners before discontinuing protective sexual behaviours.
5. Policymakers should support relationship-based sexual health interventions that recognize the influence of trust, intimacy, and emotional attachment on preventive sexual behaviour.
6. Universities and secondary schools should strengthen comprehensive sexuality education by incorporating relationship psychology, communication skills, and shared decision-making into their curricula.

Overall, integrating the proposed construct of Romantic Relationship Denial into future behavioural research and intervention programmes may enhance the effectiveness of STI prevention strategies and contribute to improved sexual and reproductive health outcomes across

dive.

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