Emotional Intelligence In Modifying Signs And Symptoms Of Sexual Anxiety Among Fresh University Students In South-Western Nigeria

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Abstract

The study examined effects of emotional intelligence training in reducing signs and symptoms of sexual anxiety among fresh university students in South Western Nigeria. 450 fresh university students who were randomly selected from the three randomly selected universities in South-western Nigeria constituted the experimental and the control group. Results indicated significant mean difference by gender between participants. There was also significant difference between the experimental and control group following emotional intelligence intervention. So also treatment was found to be more effective with the arts students than the science students. The observations were also comprehensively discussed. It was recommended that emotional intelligence training should be used as an adjunct intervention strategy to curb sexual anxiety problems among adolescents and young adults.

Introduction

It is assumed that most university students in Nigeria are adolescents and young adults between the ages of 17 – 30 years. Being in their late adolescent and early adulthood, many problems confront them which include the management of their sexuality in a sexually ignorant environment, that is also characterized by socio-cultural beliefs and practices that inhibit sexual expression especially in these days of sexually transmitted infections and forceful sexual gratification.

Sex refers to "the sum of biological characteristics that define the spectrum of humans as males and females". Adolescents of today seem to value sexual activities more than their counterparts of the past years. At the close of the 1970s, Conger, (1979) observed that of all the developmental events of adolescents the most dramatic is the increased sexual drive and the new and often mysterious feelings and thoughts that accompany it. A major hurdle for the adolescent at this stage is the successful integration of sexual activities with other aspects of the emerging sense of self without having to undergo too much conflict and anxiety. Berman and Berman, (2004) thus believes that

sexual adjustment is an important developmental task of adolescents quite difficult to cope with when societies are both permissive and prohibitive to sexual activities.

The traditional values among Nigerians for sanctity of sex and sex procreation, sexual involvement have been overthrown in favour of liberal sexual attitudes. There is evidence of high rate of youth coital sex and premature sexual adolescents (Onwuama, 1992). Infact justifiable concern is being expressed within the adult society about a steady rise in the rate of sexual activities and a decrease in age of which today's youths have their first sexual experience (UNAIDS, 2000). The tragedy of youth sexual behaviour is that young people engage in sexual activities with limited knowledge of what is involved (UNAIDS, 2000) in a society like Nigeria where sex education is not organized in a formal system and sex counseling is not provided or is provided by untrained advisers. Young people therefore rely on untested information obtained from peers and magazines as a guide. In a recent national HIV zero prevalence sentinel survey (FMH 2004) young people (aged 15-24) constituted a large proportion of those with incidence of HIV. This study therefore intends to use emotional intelligence programme to curb sexual anxiety among university fresh students in South-Western Nigeria.

Anxiety and Stress

Anxiety refers to psycho physiological state of arousal characterized by increased mobilization of the body to action such as accelerated heart beat, sweating and shivering of the hands, breathlessness, tension, headache, dryness of mouth e.t.c In some cases, it affects voice temper and tone. It is an emotional condition in which there is fear and uncertainty about the future (Hornby, Corie and Gianson 1974). According to Busari (2005) anxiety is a mediating experiential phenomena, related to perception of impending threat or over-stimulation, accompanied by discharge in sympathetic nervous system. It is an emotional condition in which there is fear and uncertainty about the future Veeraraghaven and Singh (2000) defined anxiety as often a diffused, unpleasant and uncomfortable feeling of apprehension, accompanied by one or more bodily sensations that characteristically recur in the same manner in the person. They further defined it from essentially physiological perspective as "the chronic feeling of discomfort due to repeated stimuli that activate the egotropic, autonomic nervous system and create an excessive discharge in the visceral and motor system".

Fear can be synonymous with anxiety in that both bring about some type of physiological and behavioral manifestations. However, fear is distinguished from anxiety in that the threatening object is known and identifiable, but the threatening object is unidentifiable in case of anxiety. According to Veerarghavan and Singh (2000) anxiety is distinguished from fear in that no conflict is involved and the threat is known. Stress on the other hand is related to anxiety in manifestation in many ways depending on its severity and could easily precipitate illness when not properly handled. Minimum dosage of anxiety, fear and stress can energize an individual towards achieving a goal and thus may have positive effect. On the other hand, when anxiety, fear or stress is severe or frequent in an individual to the extent that they cannot cope emotionally, it results in psychologically illness.

Sexual Anxiety

Sexual anxiety can be defined as a pathological state in which sex related anxiety inhibits maximal pleasurable sexual performance. This may result in interrupted or insufficient desire, arousal, erectile, orgasmic (e.g anorgasmia) or pain disorder. It is a mood (excitation) based sexual disorder in which sexual relationship is associated with

unusual anxiety, fear or stress with the result that sexual performance is depressed leading to poor or no sexual satisfaction, discomfort, frustration and therefore a potential source of conflict especially in marital relationship.

In situations where religious beliefs and practices forced couples into sexual fidelity, sexual anxiety could be a salient source of discord and dissatisfaction especially in socially inhibited partners where motivation to seek help could be low, reinforced by the usual societal prohibitive attitude towards sex related issues. Sexual anxiety may be individual experience specific, and may relate to personality characteristics of the couple, perception of previous sexual experience, sexual attitude and orientation, previous exposure to venereal infection as well as sexual appeal and acceptance of sexual partner, propaganda etc. Closely related to sexual anxiety is sexual dysfunction. Sexual dysfunction may be described as a persistent impairment of the normal patterns of sexual interest or response. It refers to the situation where an individual cannot experience maximal sexual performance and pleasure due to some intervening variables. Sexual dysfunction varies between the sexes in terms of nature and manifestation.

Sexual Dysfunction in Male.

Sexual Dysfunction in Males (sexual anxiety inclusive) embraces but is not limited to erectile dysfunction which involves inability to achieve erection or lack of sufficient erection rigid enough to sustain a meaningful sexual relationship and ejaculation. Other types of sexual dysfunction include premature or rapid ejaculation (ejaculation praecox) which refers to a subjective feeling of insufficient duration of coital relationship before ejaculation. This subjectivity could be largely influenced by experiential factors as sexual deprivation, posture, partner, excitement and situational factors, priapism named after the Greek and roman God of procreation. This has to do with abnormally sustained penile erection for as much as 4-6 hours in the absence of sexual arousment (Zonagen sexual dysfunction programme). In males, sexual dysfunction may increase with age and may be associated with certain lifestyles such as smoking, lack of exercise, anti-hypertensive medications, over-weight, alcoholism as well as psychopathological factors, such as anxiety and panic disorders (Figeuira, Possidente, Marques and Hayes, 2001)

Sexual Dysfunction in Female.

Sexual Dysfunction in Females includes but is not restricted to arousal, desire and sexual pain disorder (Virginismus and Dyspareunia, Phillip 2000). Recently organismic disorder has been included to the definition of female sexual dysfunction. (Berman and Berman, 1991, 2000, 2001, 2003, 2004) Arousal Disorders, may be related to insufficient sexual stimulation or experience, postmenopausal period associated with reduced estrogen production and heightened irritability, sex organ related surgery such as removal of uterus or breast, trauma etc. that could result in sexual pain or discomfort with consequent distress. Virginismus on the other hand refers to the persistent involuntary spasm (closure) of the virginal muscles (outer third layer of the vigina) on sexual stimulation in order to prevent penile penetration (Berman and Berman, 1999, 2000, 2001, 2003, 2004).

Emotional Intelligence

The term emotional intelligence is an elusive one, which can not be pinned down to just a definition. Various authors defines it from different perspectives. According to Mayer and Salovey (1997) emotional intelligence is the ability to perceive emotions, to

access and generate emotions so as to assist thought, to understand emotions , and emotional knowledge , and to reflectively regulate emotion so as to promote emotional and intellectual growth. Again Salovey and Mayer (2001) defined emotional intelligence as the ability to monitor one's own and others feelings, to discriminate among them and to use this information to guide one's thinking and actions.
Goleman (1998) in his explanation defined emotional intelligence as:

- Knowing one's emotions
- Managing emotions
- Motivating oneself
- Recognizing emotions in others
- Handling relationships.

Research Hypotheses

This study was based on the following null hypotheses; formulated and tested at 0.05 level of significant.

1. There will be no significant difference between the subjects in the experimental and control group on reporting signs and symptoms of sexual anxiety.
2. There will be no significant difference between male and female subjects exposed to emotional intelligence training in reporting sexual anxiety.
3. There will be no significant difference between Science fresh students and Arts fresh students in their response to emotional intelligence training in reporting sexual anxiety.

Methodology

Design and Sample

The study adopted pre-post experimental design. The population of this study consists of all fresh students in South Western Nigeria. From the six states in the South Western part of Nigeria, three universities from three states namely, Oyo, Osun and Kwara were randomly selected through the use of number random sampling technique. A total of 450 fresh students, randomly drawn from Universities of Ibadan, (150, 33.3%) Obafemi Awolowo University, (150, 33.3%) and University of Ilorin (150, 33.3%) participated in the study. From the selected sample 325 (72.2%) were males while 125 (27.8%) were females. Further breakdown of the demographic information also shows that 285 (63.2%) were studying Arts based courses while 165(36.2%) were in sciences.

Instrument

The instrument used in this study was the Sexual Anxiety Inventory (SAI). This instrument is a 28 item questionnaire developed by Hoon & Chambles (1986) to measure clinical anxiety associated with sexual relationship and indication of sexual dysfunction. The inventory is in two forms namely Sexual Arousability Inventory (SAI) which keeps account of behaviours and practices believed by an individual to be sexually arousing and Sexual Arousability Inventory Expanded (SAI-E) designed to measure sexual activities which an individual finds to be anxiety producing. The authors of the test provided the norms for American subjects where the test was developed. However, Nwobi (1998) adopted the Sexual Arousability Inventory Expanded (SAI-E) in Nigeria by providing norms for Nigeria subsequently renamed Sexual Anxiety Inventory.

Validation

Hoon and Chambless (1986) reported a split half reliability coefficient of 0.94 while Nwobi (1998) obtained concurrent validity coefficient of -.20, .16, .13, and .24 by correlating SAI with index of sexual dysfunction. (Hudson, 1982), State – trait Anxiety Inventory forms Y.1 and Y.2 (Speilberger Grosuch and Lustere, 1983) and the anxiety scale of Scl – 90 (Denegatis, Lipman & Covi 1977) respectively.

Scoring

All positive scores were added, less negative scores to arrive at the final score of the subject.

Norms

Nwobi (1998) found the following norms for Nigerian samples
1. Teenage male and female (N=40) 22.28
2. Young adult male and female (N= 40) 44.45
3. Middle age male and female (N=40) 48.38
4. Males only (N=90) 46.09
5. Females only (N=90) 33.11

For the purpose of this study, 22.28 was used as the norm since the subjects were in their early and late adolescents

Data Analysis

Paired t-test was the main statistical tool to measure the effectiveness of the treatment programme. Results were also treated with the mean and standard deviation.

Procedure and Treatment

Subjects of this study participated in eight, 1- hour sessions which held once a week, for eight weeks consecutively. The programme consists of certain basic components such as presentation of conceptual framework, identification of pathological state in which sex related anxiety inhibits maximal pleasurable sexual performance, recognition of reported signs and symptoms of anxiety inhibiting sexual performance, identification of social prohibitive attitude towards sex related issues that is generating anxiety. Developing and testing new skills to reduce reported signs and symptoms of sexual anxiety, application and practice of new acquired skills to reduce signs and symptoms of sexual anxiety and review of previous session's activities and administration of post test instrument. During the first session, participants introduced themselves to each other, and definitions of emotional intelligence, sexual anxiety and signs and symptoms of sexual anxiety were discussed. The pre-test instrument was administered. Each participant was then asked to identify specific signs and symptoms of sexual anxiety they experience. Signs and symptoms identified include profuse sweating in the presence of opposite sex, shaking of the voice , unnecessary sexual arousal, inability to complete sentences or words, accelerated heart beat when in contact with opposite sex, shivering of the hands, and breathlessness. Participants were also informed about the coping skills to be taught during the next session.

The second session focused on identification of pathological state in which sex related anxiety inhibits performance. The therapist and the subjects discussed personal problems, negative and irrelevant thoughts that are likely to result in signs and symptoms of sexual anxiety. The third session dealt with recognition of signs and symptoms of sexual anxiety. The therapist and the subjects discussed anxiety management techniques. Subjects were taught that anxiety inhibits effective performance of any tasks. They were trained on how to express their sexual desires. During the fourth session identification of

social prohibitive attitudes toward sex related issues that are generating anxiety was discussed. Sexually transmitted infections including HIV/AIDS were discussed. They were encouraged not to allow anxiety to push them away towards sexual gratification. The fifth session focused ontraining in sex education. Many of the subjects when asked about sex education reported they never received any. They were engaged in comprehensive study of human body anatomy and various sex organs of the body with their functions. In the sixth session the subjects were trained in the relaxation procedures to reduce sexual anxiety. They were taught to replace irrational and negative thoughts with positive ones. They were also trained in:

- Self regulation techniques
- Self awareness
- Self understanding
- Emotional competences skills.

During the seventh session, the focus was on developing and testing new things to reduce signs and symptoms of sexual anxiety. The therapist and the subjects discussed how to develop and test new things to do, to think on how to reduce signs and symptoms of sexual anxiety. The eighth sessions witnessed the rehearsal and application of treatment conditions. Participants were trained to identify their thoughts feelings and behaviours to help them reduce signs and symptoms of sexual anxiety. The reactions were then rehearsed through role-playing and imagery. The post-test instrument was then administered to the subjects. The control group did not receive any treatment, however, pre and post test instrument was administered on them.

Results.

In order to evaluate changes during treatment on sexual anxiety measure, Paired t-test was the main statistical tool used.

Hypothesis 1 :

There will be no significant difference between the subjects in the experimental and control group on reporting signs and symptoms of sexual anxiety.

Table 1

Post treatment comparism of subjects exposed to emotional intelligence training and the control group using t-test analysis.

Group	N	X	SD	DF	Cal t	Critical t	P
Experimental	300	135.46	27.08				
Control	150	182.45	51.89	498	-3	1.96	S

0.05 level of significance

The comparison of subjects in table 1 indicates 135.46 and 182.45 as mean ratings for subjects in the experimental and control groups respectively. While the experimental group has standard deviation of 27.08, the control group has 51.89. On this premise the calculated t-value (3.49) was found to be greater than the critical value t-value (1.96). The outcome failed to confirm the null hypothesis, hence its rejection. There is therefore a significant difference between the experimental and the control group in the reduction of signs and symptoms of sexual anxiety.

Hypothesis 2

There will be no significant difference between male and female exposed to emotional intelligence training in reporting signs and symptoms of sexual anxiety.

Table 2: Post treatment comparism of male and female subjects exposed to emotional intelligence training using t-test.

Group	N	X	SD	DF	Cal t	Critical t	P
Male	325	108.09	22.17				
Female	125	123.31	30.08	448	3.22	1.96	S

0.05 level of significance

The analysis on table 2 presents male and female subjects characteristics. Male subjects had higher mean of (108.09 ± 22.17) than the female subjects (123.31± 30.08). This resulted into a calculated t-value of 3.22 which is greater than the critical value of 1.96 at alpha level of 0.05; hence the null hypothesis is rejected. There existed therefore significant difference in the reported signs and symptoms of sexual anxiety between male and female subjects.

Hypothesis 3

There will be no significant difference between Fresh Arts students and fresh science students in the signs and symptoms of sexual anxiety reported.

Table 3: Post treatment comparism of Fresh Arts students and science students exposed to emotional intelligence training using t-test.

Group	N	X	SD	DF	Cal t	Critical t	P
Arts Students	285	15.72	22.47				
Science Students	165	41.92	35.12	448	3.23	1.96	S

0.05 level of significance

Table 3 above shows that the calculated t value is greater than the table value (p< 0.05), therefore, we reject the null hypothesis which implies that there is no significant difference between fresh Arts(15.72±22.47) and science student (41.92± 35.12) in the reduction of signs and symptoms of sexual anxiety following emotional intelligence training.

Discussion of Results

The first finding of this study is the fact that there was significant difference between experimental and the control group in their reported signs and symptoms of sexual anxiety inventory, following emotional intelligence training. This result could obviously be due to the fact that subjects in the experimental group were subjected to treatment while the control group subjects were not. Another major outcome of the present work is the demonstration that there was significant difference between male and female subjects in their reported signs and symptoms of sexual anxiety. Male subjects responded to treatment better than the female subjects. The comparative low response of female to treatment could suggest evidence of sexual permissiveness among female subjects possibly consequent upon early exposure to sexual life. In Nigeria, it is a common thing that female gender gets early exposure to sexual life and marriage than their male counterparts. The third observation in the study is the fact that Arts students responded to treatment better than Science students.

The Science students' responses might be affected by the fact that they are sufficiently exposed to human body system and functions with the result that prejudice, negative attitude, fear, fear of discomfort may be reported thus generating sexual anxiety. Signs and symptoms of sexual anxiety may be reduced in Arts students because of the impact of the treatment received couple with increased media publicity of sexually transmitted infections including Human Immuno Deficiency Syndrome (HIV), given the believe that they are likely to take such information more seriously and adhere to it, since it is not the focus of their regular academic study. The last observation in this study is that emotional intelligence training is an effective method of reducing signs and symptoms of sexual anxiety in individuals.

Conclusion

The need to curb negative sexual anxiety traits among Nigerian university adolescents and young adults using emotional intelligence training programme was the focus of this study. From the results, it was revealed that emotional intelligence training had significant positive influence on the signs and symptoms of sexual anxiety reported by subjects. Also, the study concluded that male subjects had a higher rate of reduced signs and symptoms of sexual anxiety following emotional intelligence training than their female colleagues, and that arts students reported lower signs and symptoms of sexual anxiety than their science counterparts following emotional intelligence training. The study therefore recommends emotional intelligence training programme as an intervention strategy in curbing sexual anxiety problems among adolescents and young adults.

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