The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 2, April- June, 2023
DIP: 18.01.169.20231102, DOI: 10.25215/1102.169
https://www.ijip.in

The International Journal of INDIAN PSYCHOLOGY

Research Paper

A Study on Dysfunctional Attitudes, Social Physique Anxiety and Self-Handicapping Tendencies Among Young Adults

Sophia Sherin[1]*

ABSTRACT

Dysfunctional attitudes refers to the cognitive vulnerability to depression because in the presence of specific stressor, dysfunctional attitudes lead to broad patterns of negative, self-referent thinking. Dysfunctional attitudes are beliefs and attitudes that induce negative thoughts about the self, others, and the future, leading to depression. Social physique anxiety refers to the anxious and uncomfortable affective reaction experienced as a result of anticipating negative social evaluations of one's own body. Thus, social physique anxiety does not merely reflect a negative cognitive self- evaluation of the body but the inability to generate favourable public impressions on the basis of one's own physical attributes. Self-handicapping refers to any action or choice of performance setting that enhances the opportunity to externalize (or excuse) failure and to internalize (reasonable accept credit for) success. Self-handicapping behavior is likely adopted to provide an ego-protecting excuse for poor performance at achievement tasks. By creating an external attribution for poor performance, one minimizes perceived lack of ability as the cause of failure. The current research adopts a between groups design to determine whether there are any gender differences with respect to the dysfunctional attitudes, social physique anxiety and self-handicapping tendencies that individuals may have. A correlational design was used to determine associations between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scale among males and females. Non-probability convenience sampling technique was used to select a sample of 331 participants from a population of young adults. The sample consisted of 167 males and 164 females. The findings of the study revealed that women were higher in social physique anxiety and self-handicapping when compared to males. It was also revealed that there exists a correlation between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales amongst male and female participants.

Keywords: *Dysfunctional Attitudes; Social Physique Anxiety; Self-handicapping; Young Adults; Between Groups; Correlational.*

[1]Student
*Corresponding Author

Received: April 04, 2023; Revision Received: May 31, 2023; Accepted: June 4, 2023

© 2023, Sherin, S.; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (www.creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Emerging adulthood is a period of life between adolescence and adulthood, characterized by relative independence and exploration of possible life directions. This period is marked by many changes, such as increased autonomy from parents and other caregivers, entering into romantic relationships, forming one's identity, and greater involvement in the larger world. During this time, emerging adults may question their existing beliefs and values and explore a variety of possible life paths, leading to the development of a sense of self.

These explorations can help to pave the way for a fulfilling, meaningful adult life. Emerging adulthood is a time of life when many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course. (Macmilan, 2006)

The age that falls under young adulthood ranges from 20-25 years of age according to Erikson’s psychosocial theory. At this age individuals face a lot of changes in their lives with respect to their social lives, intrapersonal and interpersonal as well. Erik Erikson's psychosocial theory proposed that adults face a series of challenges as they progress through adulthood, including the need to find a sense of identity and purpose, achieve intimacy in relationships, and develop a sense of generativity (caring for future generations). These challenges must be successfully navigated in order for an individual to experience a sense of fulfillment and well-being. If a person fails to navigate a particular stage successfully, it can lead to psychological issues such as depression, anxiety, low self-esteem, and relationship difficulties. His theory also highlights According to Erikson’s psychosocial theory, Intimacy is one of the terms he throws light on where an individual requires being able to share parts of yourself with others, as well as the ability to listen to and support other people. These relationships are reciprocal—sharing parts of yourself, and others are sharing with you. When this happens successfully, gaining the support, intimacy, and companionship of another person. But sometimes things don't go so smoothly. There a chances of experiencing rejection or other responses that cause withdrawal. It might harm an individual’s self-confidence and self-esteem, making them warier of putting themselves out there again in the future. Erikson seems to have distinguished--without naming--a period that is in some ways adolescence and in some ways young adulthood yet not strictly either one, a period in which adult commitments and responsibilities are delayed while the role experimentation that began in adolescence continues and in fact intensifies(Arnett and Jeffrey,2000). Keniston (1971) also conceptualized youth as a period of continued role experimentation between adolescence and young adulthood.

Being a young adult has got to be one of the most difficult times in a person’s life. It’s a stage where one does’nt feel like a child anymore and neither are they feel ready to take up all the responsibilities that adulthood brings with it. At this base juncture of turning into an adult and being able to take care of yourself, there are several and varied issues that can plague a young adult. These issues and problems span over a diverse field and affect all aspects of their life. It is these problems that we will be talking about. The term problems of young adults is very broad and can span over several areas. It can be related to their social circle, self-esteem, body physique and many more. Emerging adulthood is distinguished by relative independence from social roles and from normative expectations. Having left the dependency of childhood and adolescence, and having not yet entered the enduring responsibilities that are normative in adulthood, emerging adults often explore a variety of

possible life directions in love, work, and worldviews. Emerging adulthood is a time of life when many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course. (Arnett and Jeffrey, 2000)

At this stage individuals also face rapid changes and have to adapt to new roles in their lives which leads the individual to face many challenges and these changes can cause stress in individuals. Due to these changes, individuals tend to adapt to certain self- handicapping tendencies and often have certain dysfunctional attitudes that often are exhibited.

Dysfunctional attitudes can develop and persist throughout a person's life, but research suggests that young adults in the age range of 20-25 may be particularly vulnerable to developing dysfunctional attitudes. During this period of life, young adults are often experiencing significant transitions and changes, such as completing their education, beginning their careers, forming new relationships, and establishing their identity and values. These transitions can be stressful and challenging, and may contribute to the development of negative thought patterns and beliefs about oneself and the world. Additionally, young adults in this age range may be particularly susceptible to social comparison and negative self- evaluation, which can contribute to the development of dysfunctional attitudes such as perfectionism, fear of failure, and negative self-talk.

One study found that young adults in their early 20s were more likely to exhibit dysfunctional attitudes such as perfectionism, need for approval, and emotional inhibition compared to older adults. This suggests that this period of life may be a critical time for identifying and addressing dysfunctional attitudes before they become entrenched and harder to change.(Yiğitoğlu et al., 2019) It is important for young adults in this age range to be aware of the potential impact of negative thought patterns and beliefs on their mental health and well-being, and to seek support and treatment as needed.

The term depression refers to a broad clinical spectrum involving symptoms such as sadness, self-deprecation and hopelessness (Derogatis, 2000). Currently, depression is one of the leading causes of disability and economic disease burden worldwide (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015; Vos et al., 2017). With rates up to 10% (Mojtabai, Olfson, & Han, 2016), young adults (i.e., 18–25 years old; Van Kim, Larson, & Laska, 2012) have been identified as one of the age groups with the highest prevalence of depression (Sutin et al., 2013).

Dysfunctional attitudes are considered a cognitive vulnerability to depression because in the presence of specific stressor, dysfunctional attitudes lead to broad patterns of negative, self-referent thinking (Beck, 1967; Weissman and Beck, 1978). According to Beck’s cognitive model, depression results from an interaction of negative thinking styles and stressful events (1). These negative thinking styles are typically conceptualized as dysfunctional attitudes, which are rigid and maladaptive beliefs about oneself, the world, and the future. Previous studies have shown that dysfunctional attitudes play a central role in the development and prognosis of depression (2). Specifically, subjects with dysfunctional attitudes are associated with higher risk and poorer prognosis of major depressive disorder (MDD) (3), including more severedepression (4), poorer response to antidepressant treatment (5), shorter time to (6–8), and higher risk of (6) relapse and/or recurrence. (Qin et al., 2020) Dysfunctional

attitudes are associated with higher levels of anxiety and depression in young adults. A study by Robert et al., found that young adults with higher levels of dysfunctional attitudes were more likely to experience symptoms of anxiety and depression. Dysfunctional attitudes may be influenced by parenting styles.

A study conducted in 2009 by Lee et al., found that young adults who had experienced controlling parenting were more likely to hold dysfunctional attitudes.

Dysfunctional attitudes are beliefs and attitudes that induce negative thoughts about the self, others, and the future, leading to depression. Perfectionistic dysfunctional attitudes are beliefs and attitudes about achievement and excessive fear of failure, while dependent dysfunctional attitudes are beliefs and attitudes about dependency on, and approval from, others. (horiuchu,Aoki et al 2017) . The findings of a study suggest that targeting low parental care and negative core beliefs for females and negative core beliefs for males may help prevent their dysfunctional attitudes and the resultant depression. (Kuroda, 2017).

Dysfunctional attitudes regarding achievement and autonomy, and to a lesser extent approval and acceptance, were related to perceived problematic interpersonal behaviors was what a study conducted by whisman& friedman in 1998 revealed. Findings from these two studies conducted by Kuiper, olinger et al, 1988 were discussed in terms of the role of dysfunctional attitudes in stress appraisals, and negative emotions such as anxiety and dysphoria. Nevertheless dysfunctional attitudes predict symptoms of depression, thus supporting Beck‘s model but the level of dysfunctional attitudes assessed after positive mood priming predicted symptoms of depression in a negative linear direction pointing to differences in findings and questioning the universality of the cognitive model of depression across cultures. (Kerqeli,Kelpi et al, 2013). Results of a study also show that social support weakens dysfunctional attitudes and it's association with depression. (Liu, Y.L. (2002) Dysfunctional attitudes are related to cognitive biases. A study found that young adults with dysfunctional attitudes were more likely to exhibit cognitive biases such as overgeneralization and selective abstraction. (Henriques et al.,2002) Cognitive-behavioral therapy can be effective in reducing dysfunctional attitudes in young adults. A study found that cognitive-behavioral therapy was an effective treatment for reducing dysfunctional attitudes and symptoms of depression in young adults. (Reinecke et al., 1998)

Social physique anxiety is a subtype of social anxiety that involves anxiety and self-consciousness related to one's physical appearance and body image in social situations. It can impact young adults in the age range of 20-25, as this is a period of life when many individuals are still developing their identity, establishing relationships, and navigating societal pressures around appearance and body image.

Research suggests that young adults in this age range may be particularly vulnerable to social physique anxiety. A study published found that young adults aged 18-25 reported higher levels of social physique anxiety compared to older adults.(He et al., 2021) Factors that may contribute to social physique anxiety in young adults include the emphasis on physical appearance in popular culture and social media, as well as the pressure to conform to societal norms and expectations around body size and shape.

Social physique anxiety can have a significant impact on young adults' mental health and well-being, contributing to anxiety, depression, and other mental health problems. It can also impact social relationships, academic and career performance, and overall quality of life.

Social physique anxiety refers to the anxious and uncomfortable affective reaction experienced as a result of anticipating negative social evaluations of one's own body (Hart et al., 1989). Thus, Social physique anxiety does not merely reflect a negative cognitive self-evaluation of the body but the inability to generate favourable public impressions on the basis of one's own physical attributes (Leary & Jongman-Sereno, 2014). Results revealed that the body image, social anxiety and dysfunctional attitudes in real world lovemaking group compared to virtual lovemaking and without lovemaking is significantly different and has a lower level. Body image, social anxiety, and dysfunctional attitudes in virtual lovemaking were also significantly different and had a lower level (Aslani, Mohammadi et al,2016). It is a kind of distress that people experience with the perceived evaluation of their physiques, and the anxiety becomes the standard response to appearance-related appraisals and feedback (Sabiston et al., 2007). A study provides evidence supporting Social physique anxiety as a potential risk factor for experiencing increased depressive symptomatology during young adulthood for both men and women (Ilbanez & sicilia, 2020)

People with higher social physique anxiety exhibited more total self-handicapping in physical education classes. (Rezasoltani, Hojjati et al). Numerous studies (Berglas & Jones,1978; Harris & Snyder, 1986; Hirt et al., 1991; Kimble, Kimble, & Croy,1998; Rhodewalt & Davison, 1986; Shepperd & Arkin, 1989) have demonstrated that males are more likely to self-handicap than are women, although these gender differences appear to emerge only with regard to behavioral self-handicapping. Relative to women, men’s tendency to engage in self-handicapping and related behaviors remains stable and high across conditions and women are less likely to self-handicap in group situations and respond negatively when led to believe that their potential failure would be attributable to a lack of effort (Eblin, 2009)

Self-handicapping refers to the tendency to create barriers or excuses for oneself in order to avoid taking responsibility for failure or to protect one's self-esteem. This behavior can be particularly relevant for young adults in the age range of 20-25 who are facing various challenges and transitions.

Research suggests that self-handicapping tendencies may be particularly prevalent among young adults, as they are often navigating new and unfamiliar situations and facing a high degree of uncertainty and pressure. Research found that young adults aged 18-25 were more likely to engage in self-handicapping behaviors compared to older adults. (Charara et al., 2022)

Factors that may contribute to self-handicapping tendencies in young adults include the fear of failure, the desire to protect one's self-esteem, and the pressure to succeed in academic and career pursuits. Young adults may also engage in self-handicapping behaviors as a way of coping with stress and anxiety.

Self-handicapping behaviors can have negative consequences for young adults, including reduced academic and career success, decreased self-esteem, and increased stress and anxiety.

Berglas and Jones (1978) defined self-handicapping as "any action or choice of performance setting that enhances the opportunity to externalize (or excuse) failure and to internalize (reasonable accept credit for) success. Self-handicapping behavior is likely adopted to provide an ego-protecting excuse for poor performance at achievement tasks. By creating an external attribution for poor performance, one minimizes perceived lack of ability as the cause of failure. Early research in self-handicapping indicated that individuals who score highly on the self-handicapping scale have an inclination to employ self-handicapping strategies to protect self-esteem when confronted with achievement tasks (Rhodewalt, 1991). Results of a study conducted by Chorba & Was, 2012 indicate that adolescent and young adults who have a developed sense of academic identity are less likely to adopt self-handicapping skills in academic settings, whereas students with a less well-developed academic identity, in particular those who have not made a commitment to academic goals and values, are likely to adopt self-handicapping strategies. A study has highlighted the importance of considering both self- esteem and self-eficacy when predicting self-handicapping in physical achievement contexts. Not only do general feelings about the self-elicit self-handicapping, but situation-specic beliefs about the self (e.g., self-eficacy beliefs) are also important determinants of self-handicapping (Martin et al, 2002). A study conducted by Varma & Singh revealed that females scored higher in self-handicapping and simultaneously scored lower in self-esteem as compared to males. Underachievers seem to apply more of self-handicapping strategies than learned helpessness was the finding of a research by Nurmi, Onatsu et al. (1995)

From the existing literature, it can be seen that limited research has been done collectively on Dysfunctional attitudes, social physique anxiety and self-handicapping tendencies among young adults. Through this study, the researcher seeks to gain a better insight of the gender differences and associations that may exist in respect to Dysfunctional attitudes, social physique anxiety and self-handicapping tendencies among men and women and taking into consideration an individual's satisfaction with their friend circle, company of others, usage of social media platform and how they perceive themselves in respect to their achievements. The Research questions, objectives and hypotheses of the present study are outlined below.

Research Questions

1. Are there any differences in gender in respect to Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scale?
2. Is there a relationship between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales among males?
3. Is there a relationship between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales among females?

Research Objectives

1. To observe whether there are differences in gender in respect to Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social

physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scale.
2. To observe whether there is a relationship between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales among males.
3. To observe whether there is a relationship between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales among females.

Research Hypothesis

H1-

There will be gender differences among young adults in (A) Dysfunctional attitudes and it's dimensions (Ai) functional attitudes, (Aii) Dysfunctional attitudes, (B) Social physique anxiety and its dimensions (Bi) negative evaluation (Bii) positive evaluation, (C) self-handicapping tendencies among young adults.

H2-

There will be an association among young adults in (A) Dysfunctional attitudes and it's dimensions (Ai) functional attitudes, (Aii) Dysfunctional attitudes, (B) Social physique anxiety and its dimensions (Bi) negative evaluation (Bii) positive evaluation, (C) self-handicapping tendencies among male young adults.

H3-

There will be an association among young adults in (A) Dysfunctional attitudes and it's dimensions (Ai) functional attitudes, (Aii) Dysfunctional attitudes, (B) Social physique anxiety and its dimensions (Bi) negative evaluation (Bii) positive evaluation, (C) self-handicapping tendencies among female young adults.

METHODOLOGY

Research Design

The present study adopts a between groups design to determine whether there are any gender differences with respect to the dysfunctional attitudes, social physique anxiety and self-handicapping tendencies that individuals may have. These variables are measured based on how certain dimensions like functional or dysfunctional attitudes have an association with an individual's social physique anxiety in respect to their negative and positive self-evaluation and how prone they are to self- handicapping tendencies.

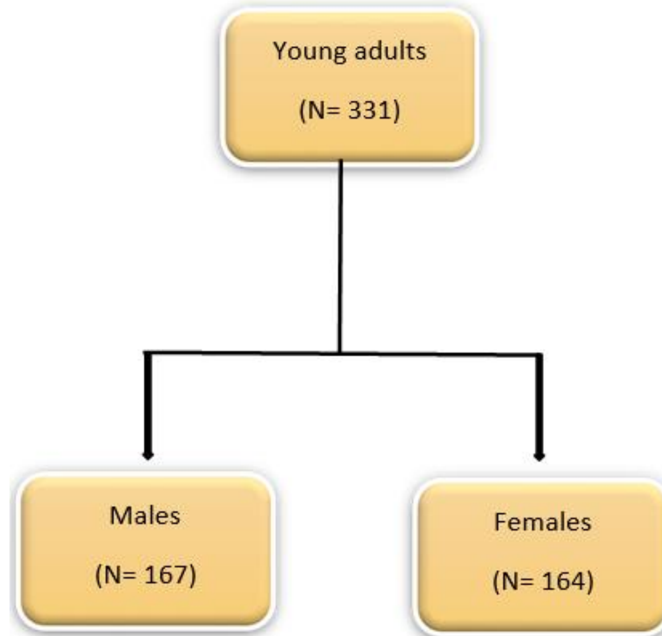
The study also aims to understand if there is an association between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scale among males and females.

Sample

For the present study, non-probability convenience sampling technique was used to select a sample of 331 participants from a population of young adults. All participants were young adults belonging to the age group of 20-25 years. The selected participants were from India

in the cities i.e., Hyderabad and Mumbai. Out of the 331 participants, 167 of them were males and the remaining 164 were females.

Figure 1: Sample division



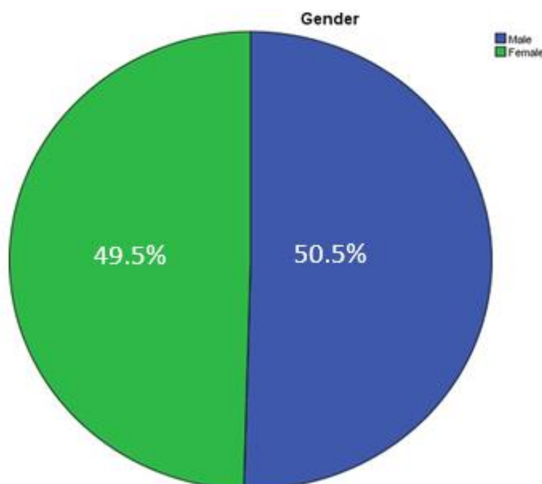
Inclusion Criteria

- Individuals belonging to the age group of 20-25 i.e., young adults.
- Young adults who were from India.
- Young adults who are currently pursuing or have completed their Bachelor's or Master's.

Exclusion criteria

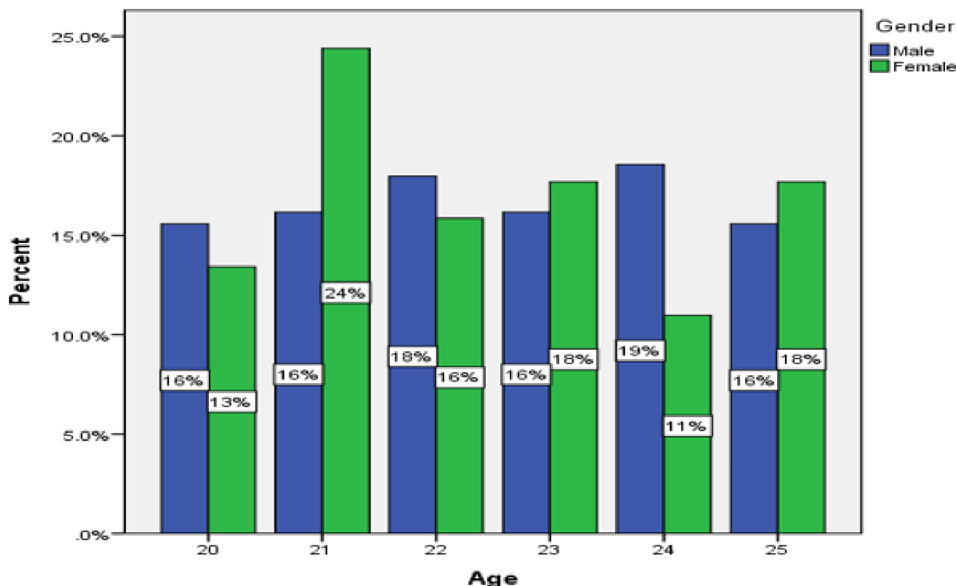
- Young adults who are not from India.
- Young adults who lack proficiency in English.

Figure 2: Pie chart showing the percentage of male and female participants.



From the above figure it is evident that 50.5% males (167) and 49.5% females (164) had participated in the current study.

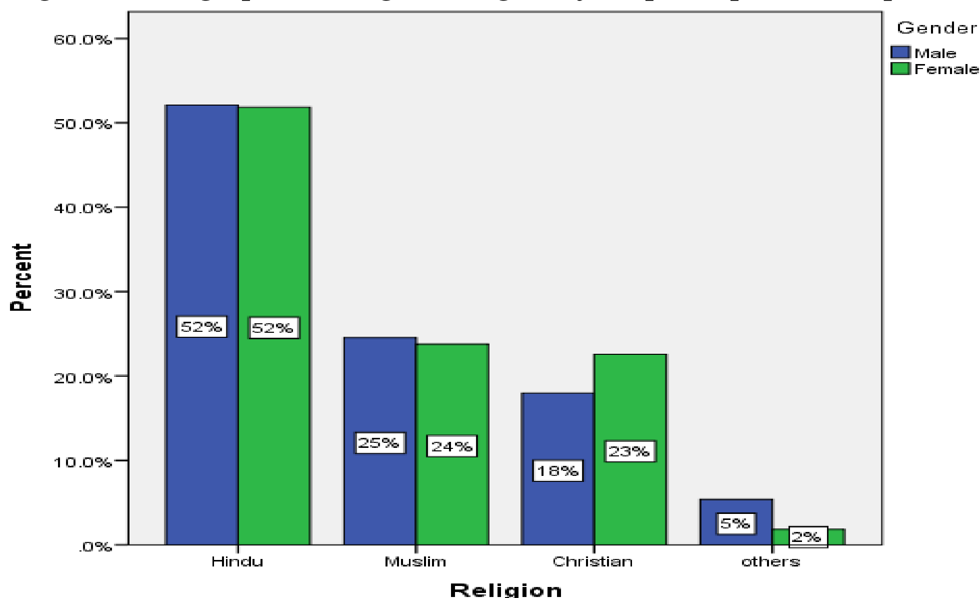
Figure 3: Bar graph showing the age of male and female participants.



From the above figure, we see that under the age of 20, 16% of the participants were male and13% were female. Under the age of 21, 16% were male and 24% were female.

Under the age of 22, 18% were male and 16% were female. under the age of 23,24 and 25, the male participants were 16%, 19% and 16% respectively, whereas female participants were 18%, 11% and 18% respectively.

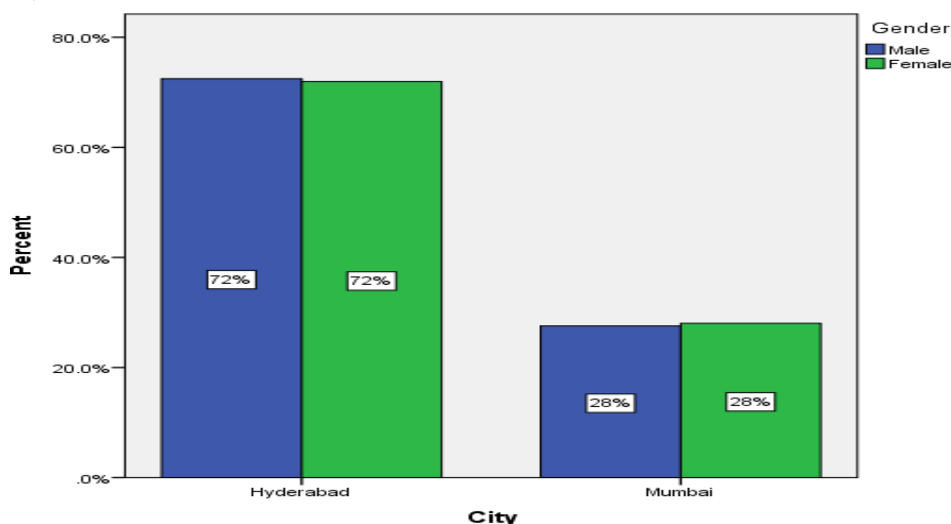
Figure 4: Bar graph showing the religion of the participants in respect to their gender.



From the above figure, 52% of the male participants and 52% of the female participants were Hindu, 25% of the male participants and 24% of the female participants were Muslims,

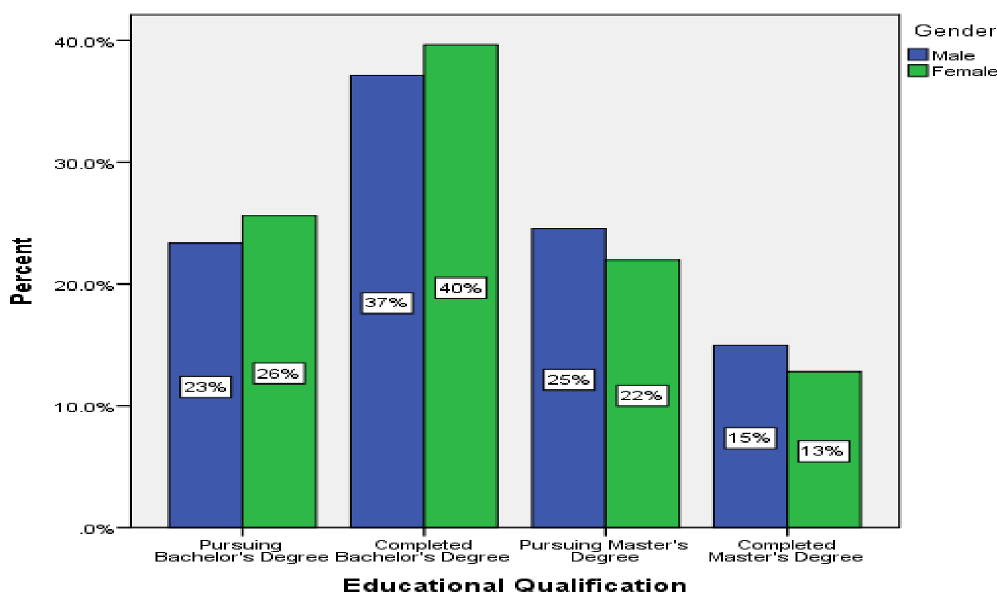
18% of the male participants and 23% of the female population were Christians and the rest 5% of the male participants and 2% of the female population follow other religions.

Figure 5: Bar graph showing how many male and female participants were from Hyderabad and Mumbai.



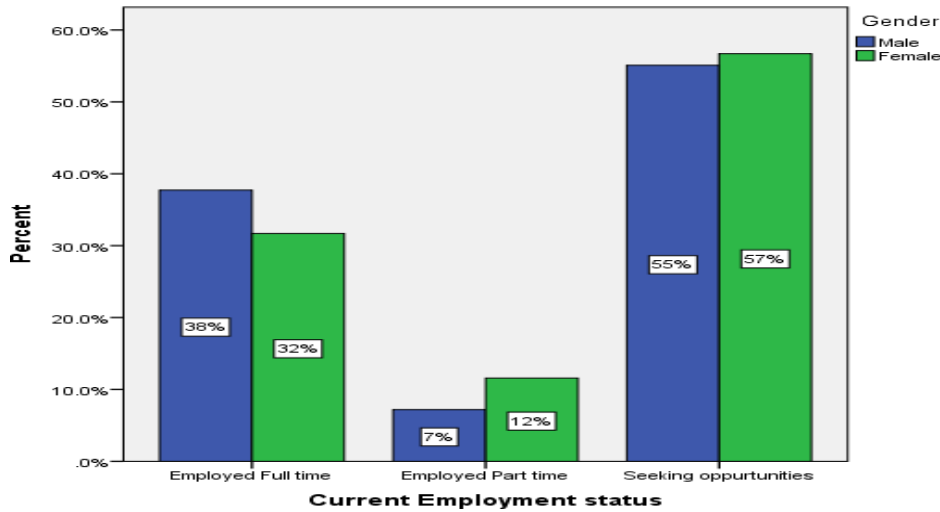
From the graph above, it is seen that the male and female participants who are in Hyderabad were around 72% each. On the other hand, 28% of the male and female participants were from Mumbai.

Figure 6: Bar graph showing percentages of male and female participants who are pursuing or have completed their Bachelor's and Master's degree.



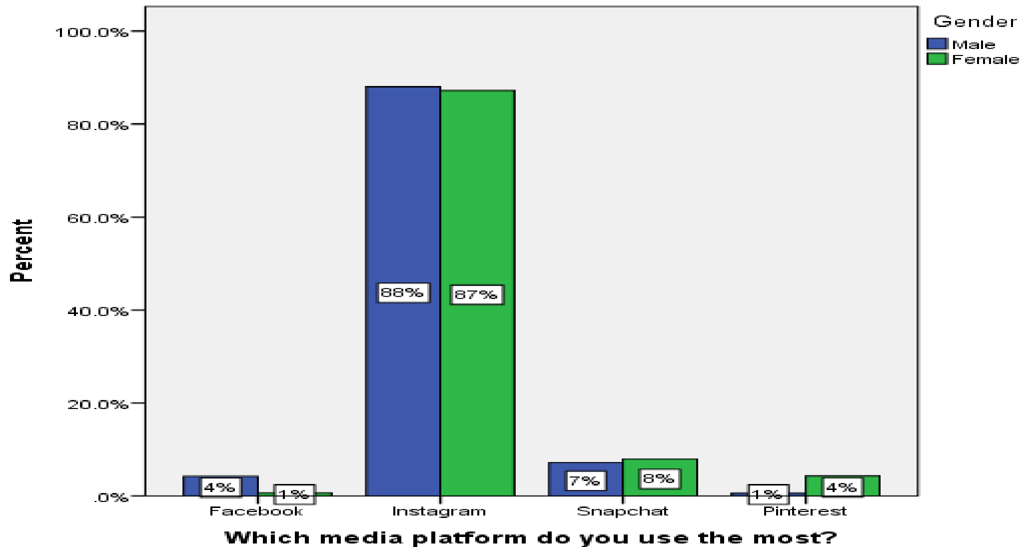
The above figure shows that 23% of the male participants and 26% of the female participants were pursuing bachelor's degree, 37% of the male participants and 40% of the female participants have completed their Bachelor's degree, 25% of the male participants and 22% of the female participants are pursuing master's degree and the rest 15% of the male participants and 13% of the female participants have completed their Master's degree.

Figure 7: Bar graph showing the current employment status of male and female participants.



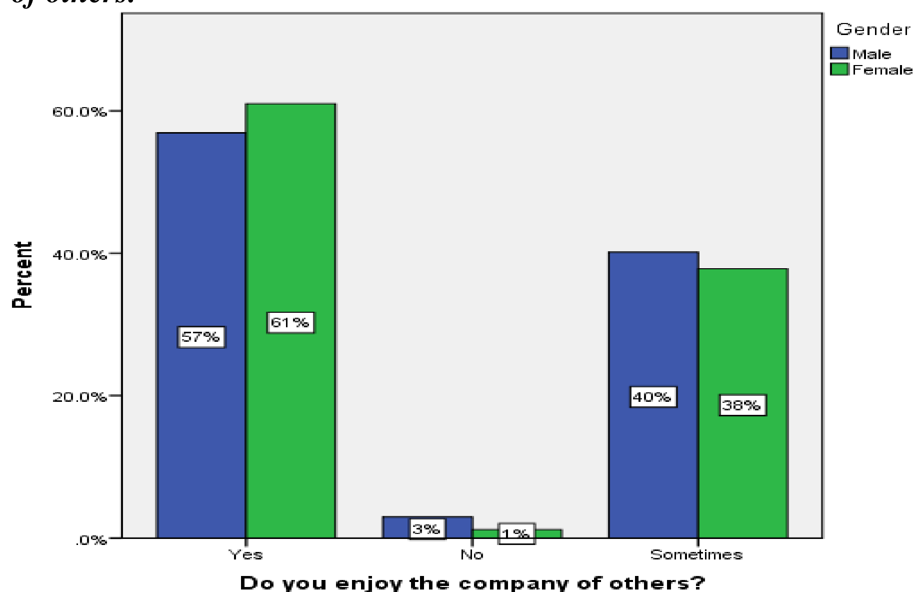
From the above figure, we see that 38% of the male participants and 32% of the female participants were employed full time, 7% of the male participants and 12% of the female population were employed part time, the rest 55% of the male population and 57% of the female population were seeking opportunities.

Figure 8: Bar graph showing which social media platform do male and female participants respectively used the most.



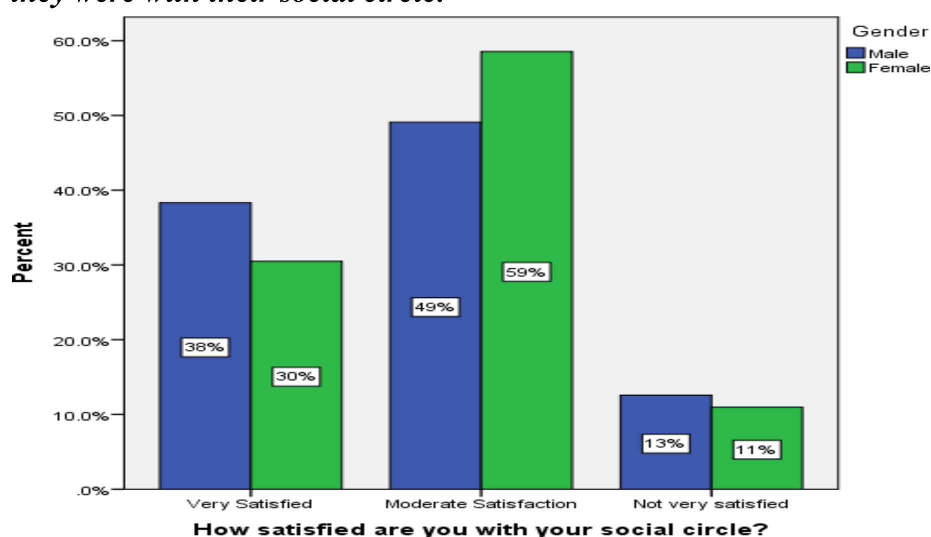
From the above figure, 4% of the male and 1% of the female population use Facebook, 88% of the male and 87% of the female participants use Instagram, 7% of the male and 8% of the female participants use snapchat and the rest 1% male and 4% female participants use Pinterest.

Figure 9: Bar graph showing how many male and female respondents enjoy the company of others.



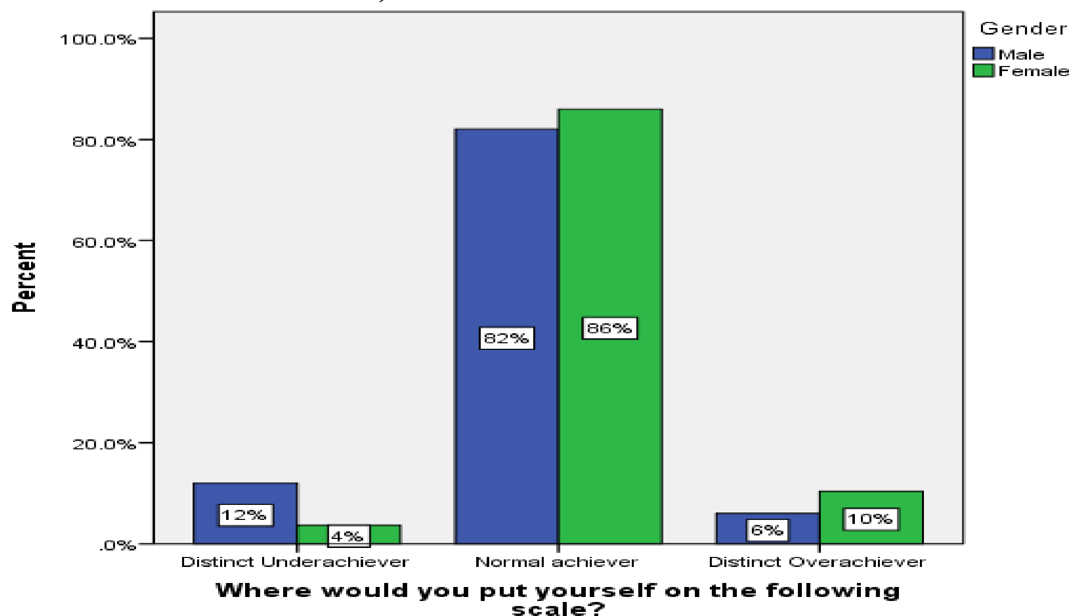
The above figure depicts that 57% of the male population and 61% oof the female population enjoy other's company, 3% of the male and 1% of the female participants do not enjoy other's company and the remaining 40% of male and 38% of females enjoy other's company sometime.

Figure 10: Bar graph showing the male and female participants response to how satisfied they were with their social circle.



The above graph shows that 38% male and 30% female participants are very satisfied with their social circle, 49% male and 59% female participants are moderately satisfied with their social circle, the remaining 13% male and 11 female participants were not very satisfied with their social circle.

Figure 11: Bar graph showing the male and female participant's response to whether they are distinct underachiever's, Normal achiever's and distinct overachievers.



From the figure above, around 12% male and 4% female participants perceive themselves as distinct underachiever's, 82% male and 86% female participants perceive themselves as normal achiever's, 6% male and 10% female participants perceive themselves as distinct overachievers.

Instruments used

Information Schedule:

Participants were asked to provide certain personal details such as age, gender, educational qualification etc. They were also asked what kind of social media platform they use the most and if they perceive themselves to be a normal achiever.

Dysfunctional Attitude Scale (DAS): Dysfunctional Attitude Scale (DAS) was developed by Arlene Weissman in 1978.

The Dysfunctional Attitude Scale form A (DAS-A) is a self-report scale designed to measure the presence and intensity of dysfunctional attitudes. The DAS-A consists of 40 items and each item consists of a statement and a 7-point Likert scale (7 = fully agree; 1 = fully disagree). Ten items are reversely coded (2, 6, 12, 17, 24, 29, 30, 35, 37 and 40), which taps into the functional attitudes of an individual, it is the functional subscale of this questionnaire. The other items come under the dysfunctional subscale of this questionnaire which taps into the dysfunctional attitudes of an individual. The total score is the sum of the 40-items with a range of 40–280. The higher the score, the more dysfunctional attitudes an individual possesses, and lower scores represent more adaptive beliefs and fewer cognitive distortions. Practitioners can also examine other areas where respondents may be emotionally vulnerable or strong as indicated by their responses to other specific items. Treatment can then be targeted to those areas. (Weissman and Beck 1978). The DAS is reported to have very good internal consistency, with alphas ranging from .84 to .92. The DAS also has excellent stability, with test-retest correlations over 8 weeks of .80 to .84. Has excellent concurrent validity, significantly correlating with several other measures of depression, including the Beck Depression Inventory (BDI). The DAS also significantly

distinguishes between groups diagnosed as depressed or not depressed on the BDI. The DAS was also found to be sensitive to change following clinical intervention with depressed outpatients. This scale has been used in the Indian population and the most recent study using this scale was conducted in the year 2022. (Liang et al., 2022)

Social Physique Anxiety (SPA):
It is a 12-item self-report scale which was originally proposed by Hart, Leary in 1989 to assess the degree to which people become anxious when others observe or evaluate their physiques. The Social Physique Anxiety Scale (SPAS) demonstrated both high internal and test-retest reliability. It also correlated appropriately with concerns regarding others' evaluations and with feelings about one's body. Validity data showed that women who scored high on the SPAS were heavier and had a higher percentage of body fat than those who scored lower. In addition, high scorers reported significantly greater anxiety during a real evaluation of their physiques, further supporting the validity of the scale. It is on a 5-point Likert scale (1- not at all characteristics of me to 5- extremely characteristic of me.)

To score, items 1, 2,5,8 and 11 are reverse coded, which indicates a positive self- evaluation, which is the positive subscale. The item scores are then added up for each dimension, higher the scores, higher the type of evaluation (negative/positive). All items correlated at least .50 with the sum of all other items, and Cronbach's alpha coefficient was .90, indicating high inter item reliability. Eight-week test-retest reliability was .82. This scale has been used on Indian population (Panjrath et al., 2022)

Self-handicapping scale (SHS):
The Self-handicapping Scale developed by Jones and Rhodewalt in 1982. The 25- item SHS is the most widely used self-report measure of self-handicapping in psychological research. It was constructed to identify self-handicapping tendencies as a general trait by Rhodewalt, in 1990. In every item, participants are questioned to show their agreement level on a Likert scale of 6-point varied from disagree very strongly (0) to agree very much (5).

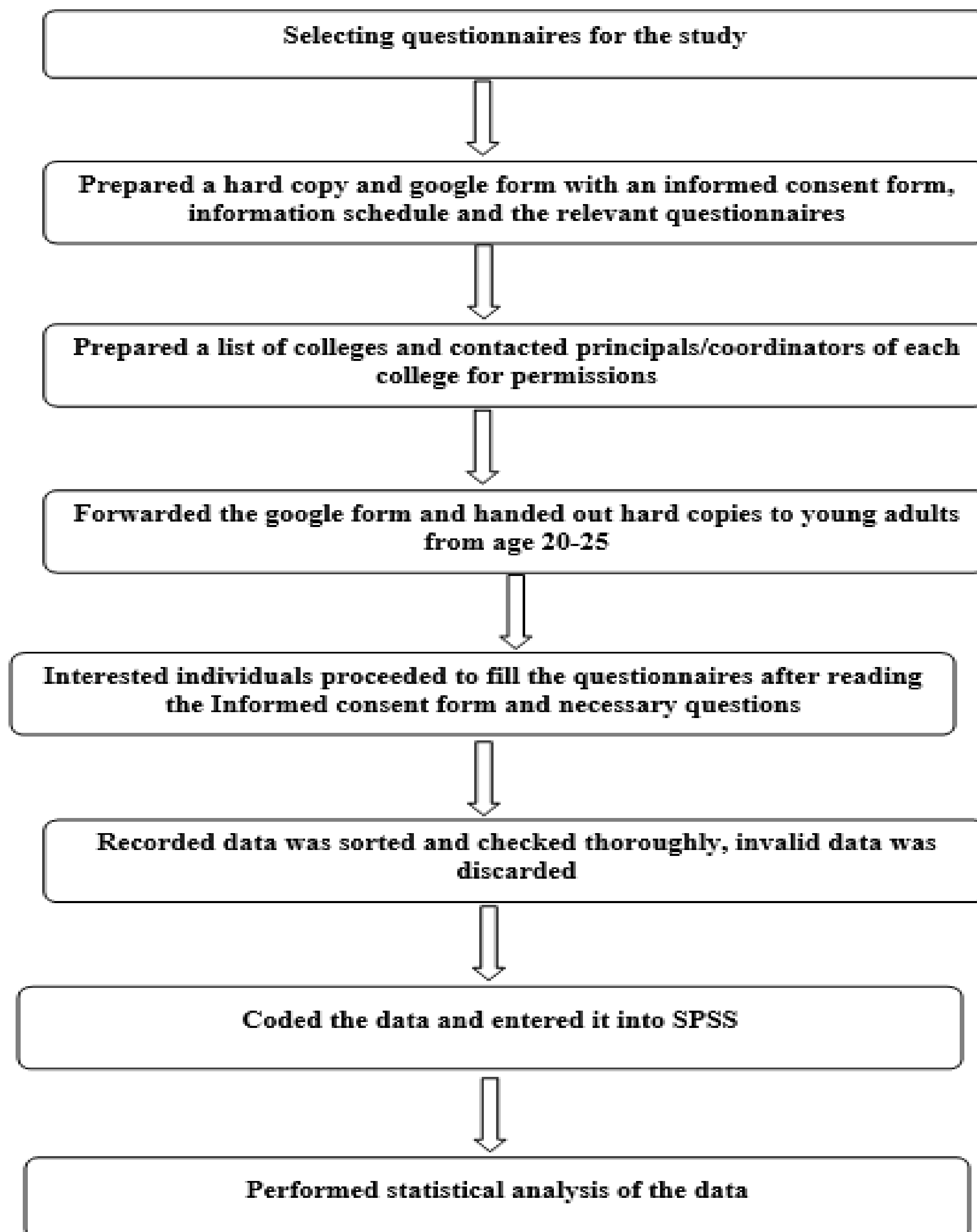
The questionnaire has a sustainable test retest reliability ($r = .74$ after one month) and internal consistency ($\alpha = .79$) (Rhodewalt, 1990). Items 3, 5, 6, 10, 13, 20, 22, and 23 are reversely coded. Scores range from 0 to 125, the higher the score, the higher the self-handicapping tendencies. Median is usually around 60. This scale was developed and validated in the Indian context. (Kaur et al., 2022)

Procedure
Relevant standardized questionnaires for each of the variables were selected. A Google Form along with a hard copy of the questionnaires were made with an informed consent form, information schedule and the relevant questionnaires. On the Google Form as well as the hard copy, the questionnaires along with the informed consent form and the information schedule were self-administered by the researcher to look for any difficulties in understanding the instructions or content and to estimate the approximate time that will be taken to fill it.

A comprehensive list of colleges in the city of Hyderabad was made and the researcher then contacted principals/coordinators of each college for permissions. Online forms were circulated on social media platforms and individuals from Mumbai were contacted to fill the online form.

After reading through the Informed Consent Form, those who agreed to participate in the study were directed to fill in the next section, the Information Schedule. Next, each section had specific instructions for each questionnaire for the students. The responses of those who did not meet the inclusion criteria were discarded and the valid responses were coded, entered in SPSS and statistically analysed. The procedure that was followed is presented in the form of a flowchart.

Figure 12: A flow chart showing the Data Collection Procedure



Data Analysis

Total scores for Dysfunctional attitudes scale and its subscales (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its subscales (viz, negative evaluation and positive evaluation) and self-handicapping scales scores were computed.

The data was then analysed using Descriptive Statistics, Independent Samples t-Test and bivariate correlation. The independent samples t-test was used to determine if there are any gender differences with respect to Dysfunctional attitudes scale and its subscales (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its subscales (viz, negative evaluation and positive evaluation) and self-handicapping tendencies.

Correlation was used to determine if there exists a correlation between the three variables i.e., Dysfunctional attitudes scale and its subscales (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its subscales (viz, negative evaluation and positive evaluation) and self-handicapping scales among males and females.

RESULTS

The gathered data of this study were analysed using the independent sample t- test and Pearson product moment correlation using the Statistical Package for Social Sciences (SPSS) version20.0.

Independent sample t-test was used to analyse gender differences in Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self- handicapping scale.

Pearson product moment correlation was done to determine whether there is a relationship in Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales among males and females.

Figure 13: Showing the mean scores of males and females with respect Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping

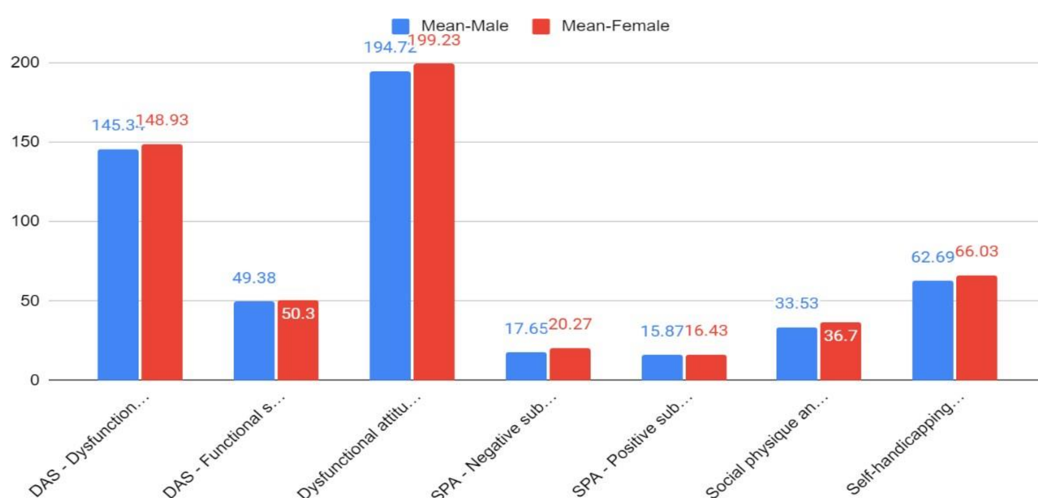


Table 1: Mean, Standard deviation and t-values for Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales between males and females.

Variables	Male (N=167)		Female (N=164)		*t*
	Mean	SD	Mean	SD	
DAS - Dysfunctional subscale	145.34	29.826	148.93	28.957	-1.109
DAS - Functional subscale	49.38	8.705	50.30	8.774	-.953
Dysfunctional attitude	194.72	31.476	199.23	33.814	-1.254
SPA - Negative subscale	17.65	6.841	20.27	6.192	**-3.645***
SPA - Positive subscale	15.87	4.330	16.43	4.361	-1.157
Social physique anxiety	33.53	8.832	36.70	8.568	**-3.312***
Self-handicapping	62.69	10.425	66.03	10.821	**-2.862****

Note:*p≤0.05, **p≤0.01

Table- 1 indicates that there are no gender differences in Dysfunctional attitudes scale and its dimensions (viz, functional attitudes and dysfunctional attitudes). **Thus, hypothesis H1 (A), H1(Ai) and H1(Aii) has been rejected.**

The above table also indicates there are gender differences in social physique anxiety negative subscale (t=-3.645**, p<0.01), social physique anxiety total scores (t= -3.312**, **p<0.01). The mean scores revealed that females scored higher in both social physique anxiety negative subscale (M=20.27) and social physique anxiety total scores (M=36.70) when compared to males in social physique anxiety negative subscale (M=17.65) and social physique anxiety total scores (M=33.53). **Thus, hypothesis H1(B) and H1(Bi) has been accepted.**

On the other hand, there aren't any gender differences in the social physique anxiety positive subscale, **Thus, hypothesis H1(Bii) has been rejected.**

Lastly gender difference was observed in self-handicapping scale total (t= -2.862*, *p<0.05). The mean scores show that females scored higher (M=66.03) than males (M=62.69) in the self-handicapping scale total. **Thus, hypothesis H1(C) has been accepted.**

Correlation:
This section describes the findings of the data collected for the study. The results were computed using SPSS version 20.0. The statistics used to analyse the data descriptive statistics (Mean, Standard deviation) and Inferential statistics Pearson's Product Moment Correlation (r) as well as for the sample (N = 316)

Table 2: Correlation between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales amongst male participants.

Variables	DAS - Dysfunctional subscale	DAS - Functional subscale	Dysfunctional attitudes	SPA - Negative subscale	SPA - Positive subscale	Social physique anxiety	Self-handicapping
DAS - Dysfunctional subscale							
DAS - Functional subscale	.049						
Dysfunctional attitudes	.961**	.323**					
SPA - Negative subscale	.041	**-.183***	**-.162***				
SPA - Positive subscale	-.079	.149	-.117	.210**			
Social physique anxiety	.042	**-.181***	**-.183***	.878**	.653**		
Self-handicapping	.091	**-.265****	**-.226****	**.436****	**-.153***	.413**	

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
a. Gender = Male
b. Cannot be computed because at least one of the variables is constant.

In this table we see that for men there exists a negative correlation between self - handicapping scale and the functional subscale and total score of the dysfunctional attitudes scale. **Thus, hypothesis H2 (c) with (Ai) has been accepted but with (Aii) has been rejected.**

There exists a positive correlation between social physique anxiety negative subscale and a negative correlation of the negative subscale with the self-handicapping scale among men. **Thus, hypothesis H2 (C) with (Bi) and (Bii) have been accepted.**

The functional subscale of the dysfunctional attitudes scale has a negative correlation with the negative subscale of the social physique anxiety and total scores but no correlation with the positive subscale. **Thus, hypothesis H2 (B) has been accepted with (Ai) and (Aii) has been rejected.**

Whereas the dysfunctional subscale of the dysfunctional attitudes scale has no correlation with the subscales of the social physique anxiety scale. **Thus, rejecting hypothesis H2 (B) with (Aii).**

Table 3: Correlation between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales amongst female participants.

Variables	DAS - Dysfunctional subscale	DAS - Functional subscale	Dysfunctional attitudes	SPA - Negative subscale	SPA - Positive subscale	Social physique anxiety	Self-handicapping
DAS - Dysfunctional subscale							
DAS - Functional subscale	.448**						
Dysfunctional attitudes	.973**	.644**					
SPA - Negative subscale	**.286****	**-.187***	**.293****				
SPA - Positive subscale	**-.200***	**.207****	**-.225****	.297**			
Social physique anxiety	**.308****	**-.240****	**.327****	.874**	.724**		
Self-handicapping	**.266****	-.120	**.259****	**.372****	.018	.278**	

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
a. Gender = Female
b. Cannot be computed because at least one of the variables is constant.

From this table we see that for women there exists a exists a positive relationship between self -handicapping scale and the dysfunctional subscale and total score of the dysfunctional attitudes scale. **Thus, hypothesis H3 (C) with (Aii) has been accepted and hypothesis H3 (Ai) has been rejected.**

This table also shows that there exists a positive relationship between self- handicapping scale and the negative subscale of the social physique anxiety but no correlation with the positive subscale of the same. **Thus, hypothesis H3 (C) with (Bi) has been accepted and (Bii) has been rejected.**

The table also reveals that there is negative relationship between the functional subscale of the dysfunctional attitudes and social physique anxiety's negative subscale and total, and a positive relationship with the positive subscale of social physique anxiety. There also exists a positive relationship between the dysfunctional subscale of the dysfunctional attitudes with social physique anxiety's negative subscale and total and negative relationship with positive subscale of the same. **Thus, Hypothesis H3 (B) with (Ai) and H3 (A) with (Bi) (Bii) has been accepted.**

Summary of results
In the following section, the obtained results have been summarized. The findings of the present study revealed that:

- The study reveals gender differences in the following:
- Negative dimension of social physique anxiety
- Social physique anxiety
- Self-handicapping

The results of correlational analysis revealed:

- **Negative correlations between:**
- Functional dimension of dysfunctional attitudes scale and the negative subscale of the social physique anxiety scale among male participants.
- Functional dimension of dysfunctional attitudes scale and the social physique anxiety scale among male participants.
- Functional dimension of dysfunctional attitudes scale and self-handicapping among male participants.
- Dysfunctional attitudes and social physique anxiety among male participants.
- Dysfunctional attitudes and self-handicapping among male participants.
- Self-handicapping and the positive subscale of social physique anxiety among male participants.
- Dysfunctional subscale of Dysfunctional attitudes scale and positive subscale of social physique anxiety among female participants.
- Functional subscale of Dysfunctional attitudes scale and negative subscale of social physique anxiety among female participants.
- Functional subscale of Dysfunctional attitudes scale and total scores of social physique anxiety among female participants.

- **Positive correlations between:**
- Self-handicapping and negative subscale of social physique anxiety among male participants.
- Dysfunctional subscale of dysfunctional attitudes scale and social physique anxiety's negative subscale among female participants.
- Dysfunctional subscale of dysfunctional attitudes scale and self-handicapping among female participants.
- Functional subscale of dysfunctional attitudes scale and positive subscale of social physique anxiety among female participants.
- Self-handicapping and dysfunctional attitudes among female participants.
- Self-handicapping and the negative subscale of social physique anxiety scale among female participants.

DISCUSSION

The purpose of the study was to observe whether there are gender differences in dimensions of Dysfunctional attitudes and its dimensions (viz, functional attitudes and dysfunctional attitudes), social physique anxiety and its dimension (viz, negative evaluation and positive evaluation) and self-handicapping tendencies among young adults.

The findings from Table 1 indicates that there are no gender differences in Dysfunctional attitudes and its dimensions (viz, functional attitudes and dysfunctional attitudes) and in the social physique anxiety positive subscale. Recent research has suggested that there is no difference between genders when it comes to dysfunctional attitudes. It found that both males and females have the same levels of dysfunctional attitudes when it comes to things such as emotions, thoughts, and behaviors. While it is true that both males and females can have the same levels of dysfunctional attitudes, the causes and motivations behind them may differ. In some cases, males may have higher levels of dysfunctional attitudes due to social pressures to perform or conform to certain gender roles and expectations. On the other hand, females often have higher levels of dysfunctional attitudes due to their battle with body image issues, as well as their insecurity about their physical appearance. Additionally, females may also have higher levels of dysfunctional attitudes due to past negative experiences or cultural and societal constructs that promote beauty and perfection. Therefore, while males and females may have the same levels of dysfunctional attitudes, the causes behind them may vary (Ogden et.al 2019)

The table also indicated that there are gender differences in social physique anxiety negative subscale, social physique anxiety total scores. The mean scores revealed that females scored higher in both social physique anxiety negative subscale and social physique anxiety total scores when compared to males in social physique anxiety negative subscale and social physique anxiety total scores. Gender difference was observed in self-handicapping scale total. The mean scores show that females scored higher than males in the self- handicapping scale total. Studies have shown that females show more social physique anxiety and higher self-handicapping tendencies as compared to males. A study done by Hagger and Stevenson (2010) show that females had consistently higher levels of social physique anxiety and lower levels of physical self-esteem when compared males. This discrepancy can be attributed to a variety of gender differences, such as the higher value placed on physical appearance among women and gender roles that emphasize physical appearance as a measure of success. In one study, women reported higher levels of self-objectification, a psychological process in which a person internalizes societal ideals of physical appearance and beauty, than men.

Additionally, the pressure to conform to gender roles, such as being feminine and attractive, was found to be a powerful contributor to social physique anxiety among women. (Harper & Tiggemann, 2007). Another study conducted by Varma & Singh (2016) further revealed that females scored higher in self-handicapping and simultaneously scored lower in self-esteem as compared to males. This phenomenon occurs when individuals put up psychological or physical barriers to their own success, which can be seen through procrastination, self-doubt, and other behaviors.

Self-handicapping is more common among females due to a variety of factors.
Women may be more likely to experience self-doubt related to their own capabilities and achievements, which can lead them to try and protect themselves from potential failure. Additionally, traditional gender roles can contribute to self-handicapping, as women may feel more pressure to conform to certain stereotypes and expectations in order to be successful. (Clarke & MacCann, 2016)

The effects of self-handicapping can be detrimental to both genders, but it is particularly problematic for women. By creating obstacles to their own success, women are hindering

their own development and potential. It is important for both genders to be aware of this phenomenon and to actively work towards overcoming it. (Rucks & Arkin, 2006)

Young adults today face a variety of stressors that can impact their mental and physical health. Some common stressors that young adults may face include academic and career pressures where many young adults are pursuing higher education or beginning their careers, which can be a significant source of stress. The pressure to perform well and the uncertainty and competitiveness of the job market, can contribute to anxiety, depression, and burnout. Financial stress where young adults may also experience financial stress, including student loan debt, high living expenses, and limited job opportunities. Financial stress can lead to anxiety, depression, and difficulties with relationships and daily functioning. Social pressures can also be a significant source of stress for young adults. This may include pressure to conform to societal expectations, peer pressure, or relationship stress. Technology and social media, while technology and social media can be beneficial in many ways, they can also contribute to stress and anxiety in young adults. Social media use can contribute to feelings of inadequacy, loneliness, and FOMO (fear of missing out), while the constant connectivity and information overload can contribute to feelings of overwhelm and burnout. Health concerns, young adults may also experience stress related to their physical health, including chronic illnesses, chronic pain, or concerns about their appearance and body image.

The study did consider the above factors into consideration and found that majority of the responses in the present study showed that individuals did enjoy the company of others which could be one of the reasons why there is no relationship between dysfunctional attitudes and self-handicapping behaviours it is that when individuals are surrounded by people who love and encourage them, it can lead to them having fewer cognitive distortions.

At the same time, it is important to consider that the social environment may not always be a factor in self-handicapping behaviour, as other environmental and personal factors could also be at play.

This study also shows that people with higher levels of Social physique anxiety tend to feel more comfortable in social environments and have an increased sense of belonging. People with higher Social physique anxiety scores also report feeling more connected to their peers, which can lead to more meaningful relationships. (Cox et al., 2011). This correlation could help to explain why some people with high Social physique anxiety scores may enjoy being around others and crave social interaction. They may also be more likely to take risks and take part in social events, as they feel more confident and secure in their own skin.

This study's majority of the respondents showed that they were moderately satisfied with their social circle, they may have lower levels of dysfunctional attitudes. Results of a recent study show that social support weakens dysfunctional attitudes and it's association with depression. It found that individuals who have strong social support networks and positive relationships with others tend to have lower levels of depression and fewer dysfunctional attitudes. This is thought to be due to the fact that having a supportive network of people can make it easier to cope with life's challenges and provide a sense of stability and security. (Liu, Y.L. (2002))

It is true that moderate satisfaction with social circle can lead to a certain amount of dissatisfaction as well, which can be a contributing factor to why individuals experience more social physique anxiety and self-handicapping tendencies in the current population. (Martin, 1998) This could be due to a lack of confidence in their abilities, and a need to protect themselves from potentially negative outcomes.

A study conducted in 2020, by Bhalla and Singh shows a significant relationship between social networking usage (SNU) and Social physique anxiety. It showed that media usage, including the use of technology, has a positive correlation with social physique anxiety (SPA). This is often due to an individual's need to measure up to the idealized body image they are exposed to through the use of social media, television, and other forms of media. The amount of time spent using media, increases the likelihood of developing social physique anxiety. This is due to the constant bombardment of idealized body images which can lead to feelings of inadequacy and a fear of being judged by others. (McColgan & paradis, 2022)

The most used media platform reported in the study was Instagram. Instagram is one of the most popular social media platforms, with two billion active users.(Bernhardt,2022) With its popularity continuing to grow, Instagram is widely considered to be the most widely used platform at the moment. Instagram's popularity and user base presents a unique challenge when it comes to social physique anxiety. Since users are able to post pictures of themselves and access pictures of others, this can lead to comparing one’s own body to the bodies of others. It can also cultivate a sense of perfectionism, as users are constantly presented with seemingly perfect pictures. This can lead to a negative self-evaluation and cause social physique anxiety to worsen. (LaMarre & Rice, 2017)

Normal achievers often have a lower level of functional attitudes compared to their peers due to their lack of recognition and acknowledgement. This can cause them to feel less confident and less motivated towards achieving their goals, leading to a lesser level of functional attitudes. Additionally, they may lack the resources, such as access to mentors and coaches, that other achievers have. This further reinforces the idea that normal achievers have more difficulties when it comes to achieving their goals and thus, have a lower level of functional attitudes. Underachievers seem to apply more of self-handicapping strategies than learned helpessness. Nurmi, Onatsu et al. (1995) Self-handicapping strategies are commonly observed in underachievers, who may be attempting to protect their self-esteem. By attributing their underachievement to external causes, such as bad luck or illness, individuals are able to distance themselves from the actual cause of their underachievement and preserve their self-esteem. Individuals may also engage in self-handicapping by procrastinating or deliberately sabotaging their own efforts. This may be done in order to reduce the pressure and stress associated with the task, and to provide an excuse if they fail. Normal achievers as well have been observed to often employ self-handicapping strategies in order to protect their self-esteem by externalizing the blame for their failures. By doing this, normal achievers can maintain their self-esteem and avoid taking responsibility for their failures. Additionally, self- handicapping strategies can also be used to enhance one's performance, by tricking oneself into working harder or by using stress or other obstacles as a form of motivation (Clarke & MacCann, 2016) The findings of this study could also have been influenced with factors including an individuals satisfaction with their social circle along with the media platform usage.

There was a correlation between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales amongst male participants. The findings of Table 2 shows that there exists a negative correlation between self - handicapping scale and the functional subscale and total score of the dysfunctional attitudes scale. As functional attitudes decrease, individuals are more likely to rely on self-handicapping strategies, as these can help to protect their self-esteem and deflect the blame for their failures. (Rhodewalt et al., 1984). This Indicates that men who are more negative in their attitude toward themselves or others are less likely to experience social physique anxiety. This suggests that having a positive attitude toward oneself and others can help

reduce anxiety levels. Studies have shown that men who score higher on the DAS tend to engage in self-handicapping behaviors more often than those who score lower on the scale. (Chen & Kao, 2018) These findings suggest that individuals with high levels of dysfunctional attitudes are more likely to self-handicap in order to protect their self-esteem and individuals with high levels of functional attitudes score lower in self-handicapping.

The dysfunctional attitudes' functional subscale has a negative correlation with the negative subscale of the social physique anxiety and total scores. Lower levels of functional attitudes may be associated with higher levels of social physique anxiety in men. This is because men with lower levels of functional attitudes may be more likely to think negatively about themselves and their physical appearance, and this may lead to increased levels of anxiety. Additionally, men with lower levels of functional attitudes may be more likely to engage in self-defeating behaviours, such as self-handicapping, which can further increase their levels of social physique anxiety. Therefore, it is clear that lower levels of functional attitudes can lead to an increase in social physique anxiety in men. (Gruchy, 2018)

There exists a positive correlation between social physique anxiety's positive subscale and a negative correlation between the negative subscale of the social physique anxiety scale with the self-handicapping scale among men. Social physique anxiety and self-handicapping showed a positive correlation in men indicating that as social physique anxiety increased, self-handicapping was more likely to occur. The findings of this study suggest that there is a link between social physique anxiety and self-handicapping in men. Men with higher social physique anxiety are more likely to exhibit self-handicapping behavior in physical education classes. (Hojjati et.al,2013) Self-handicapping is a strategy to protect self-esteem in the face of failure. Men with higher levels of social physique anxiety have been found to exercise more for self-presentational reasons than men with lower levels of social physique anxiety. (Frederick et.al, 2008) It has also been noted that social physique anxiety is linked to physical self-presentation, which can lead to feelings of resentment and low self-esteem in physical activity settings. (Yang,2002) Thus, social physique anxiety can lead to self-handicapping in men, as it inhibits them from participating in physical activities which could lead to success.

There exists a correlation between Dysfunctional attitudes scale (viz, functional attitudes and dysfunctional attitudes) with social physique anxiety and its dimensions (viz, negative evaluation and positive evaluation) and self-handicapping scales amongst female participants.

Findings of this study showed that there exists a positve correlation between self - handicapping scale and dysfunctional attitudes dysfunctional subscale and a positive correlation between both the dysfunctional attitudes and its dimension with the social physique anxiety total scores and its dimensions. The higher the self-handicapping behavior, the higher the level of dysfunctional attitude. There is some evidence to suggest that there may be a relationship between dysfunctional attitudes and self-handicapping in women.

Dysfunctional attitudes are beliefs or thought patterns that are rigid, extreme, and unhelpful, and they can contribute to a range of psychological problems. Self-handicapping, on the other hand, is a behavioral tendency to sabotage one's own performance or efforts in order to create an excuse for failure or to protect one's self-esteem.

Research suggests that individuals who hold dysfunctional attitudes are more likely to engage in self-handicapping behaviors. For example, a person who believes that they must always perform perfectly may be more likely to procrastinate or to avoid practicing or studying, as a way of protecting themselves from the possibility of failure. This behavior can become a self-fulfilling prophecy, as the individual's performance is likely to suffer as a result of their self-handicapping behaviors.

Studies have also found that women may be more likely than men to engage in self-handicapping behaviors, particularly in academic settings. It is possible that this gender difference is related to cultural factors, such as the pressure on women to succeed while also conforming to traditional gender roles. (Torok et al., 2022) Research suggests that there may be a relationship between the menstrual cycle and dysfunctional attitudes and self-handicapping in women. The menstrual cycle is the hormonal process that occurs in the female body each month, and it can impact mood, behavior, and cognition.

Studies have found that women may experience greater psychological distress, including negative mood states and increased anxiety, during certain phases of the menstrual cycle. These changes in mood and cognition may contribute to dysfunctional attitudes and self-handicapping behaviors. (Williams et al., 2019)

For example, during the premenstrual phase, some women may experience increased anxiety, irritability, and negative thoughts. These symptoms can exacerbate pre-existing dysfunctional attitudes, such as perfectionism or negative self-talk. Additionally, these negative mood states may contribute to self-handicapping behaviors, such as procrastination or avoidance of challenging tasks.

However, it is important to note that not all women experience negative mood changes during the menstrual cycle, and not all women who experience negative mood changes engage in dysfunctional attitudes or self-handicapping behaviors. Additionally, research in this area is still ongoing, and there is much to learn about the complex interplay between hormones, mood, cognition, and behavior.

Overall, it is important for women to be aware of the potential impact of the menstrual cycle on their mood and behavior, and to seek support and treatment as needed to manage any negative symptoms or psychological distress. Therapeutic interventions such as cognitive behavioral therapy or medication can be helpful in addressing dysfunctional attitudes and self-handicapping behaviors in women, regardless of their menstrual cycle.

However, it is important to note that not all women with dysfunctional attitudes will engage in self-handicapping, and not all individuals who engage in self-handicapping have dysfunctional attitudes. Psychological factors such as self-esteem, anxiety, and motivation can also play a role in self-handicapping behaviors. Additionally, research in this area is ongoing and there is still much to learn about the complex interplay between attitudes, behavior, and gender.

Self-handicapping can protect individuals from feeling the anxiety of potential failure, while a dysfunctional attitude can lead to disengagement and avoidance of the task. Thus, it is possible that the two are opposite ends of the same spectrum, and that individuals who engage in self-handicapping behaviors will have lower levels of dysfunctional attitude. (Schroevers et al. 2020)

Research has shown that women with higher levels of dysfunctional attitudes often have a negative body image when in social settings. This is because women with higher levels of dysfunctional attitudes often think negatively about themselves and their physical appearance, which can lead to increased levels of anxiety when in social settings.

Furthermore, women with higher levels of dysfunctional attitudes may also be more likely to be at risk of developing eating disorders due to the negative thoughts and emotions they experience. Therefore, it is clear that there is a strong link between dysfunctional attitudes and body image in social settings among women. (Liu et.al 2017)

The current study also found that there exists a positive relationship between self-handicapping scale and the negative subscale of the social physique anxiety but no correlation with the positive subscale of the same. This suggests that women who experience high levels of social physique anxiety are more likely to engage in self-handicapping behaviours, such as procrastination, avoidance, and making excuses. The findings of this research can help us better understand the psychological impact of social physique anxiety on women, as well as provide insights into how to best address the issue. Self-handicapping tendencies, for example, can be addressed by providing support and resources, such as cognitive-behavioural therapy, to help women become more confident in their physical appearance. Furthermore, it is important to raise awareness of the issue and educate people on the importance of body positivity and self-acceptance.

Although the study was carried out carefully and meticulously, there were some limitations to this study. Firstly, the current sample was limited due to certain forms not being filled properly and thoroughly. An increased sample size can help to generalize the findings of the study the current population. Future studies may be conducted on large samples for drawing generalization and to get more reliable results. Another factor would be that cultural differences, age differences, family environments were not taken into consideration in the present study. The scales used for the study were self-report measures.

The responses may be exaggerated or the respondents may be too embarrassed to reveal private details or the respondents may not be able to assess themselves accurately. Various biases may also affect the responses, like social desirability bias. Self-report questions are inherently biased by the person's feelings at the time they filled out the questionnaire. Keeping this in consideration the future course of these variable can be that research can focus on the populations family upbringing, attachment styles, age differences and cultural

differences as well which may help gain a clear understanding of these variables. This study helps to a gain a better understanding of the variables in a way which enables

professionals of different fields in psychology as well as other sciences to use the study as a basis to make assumptions. This study can help in certain areas like (i) Career Success, dysfunctional attitudes, such as perfectionism and rigid thinking, can drive young adults to strive for excellence in their careers, leading to success. However, if these attitudes become extreme, they can also lead to burnout and anxiety. (ii) Relationship Issues, dysfunctional attitudes can also affect young adults' relationships with others. For example, if a person has a belief that they must always be perfect, they may struggle to accept others' flaws or be overly critical in their relationships. (iii) Body Image and Self-Esteem, social physique anxiety, or the fear of negative evaluation based on one's physical appearance, can impact young adults' body image and self-esteem. This can lead to behaviors such as excessive exercise or unhealthy dieting. (iv) Academic Performance, self-handicapping tendencies, or intentionally sabotaging one's academic performance to avoid potential failure, can impact young adults' academic success. This behavior may involve procrastination, not studying enough, or not taking tests seriously. This study can also contribute in the field of anthropology, clinical, social psychology and also in the studies related to eating disorders as well.

Overall, it's important for young adults to be aware of these attitudes and tendencies and work to manage them to lead a fulfilling and successful life. Therapy or counseling can be helpful in addressing these issues and developing healthy coping mechanisms. Educational psychologists, clinical psychologists as well as counsellors can use these findings to better understand the relevance of these phenomena in the current population. Adding to this the study can be a base point to employ cognitive behaviour therapy and rational emotive behavioural therapy in this population as the variables tap into dysfunctional attitudes and cognitive distortions. Cognitive Behavioral Therapy (CBT) and Rational Emotive Behavior Therapy (REBT) are two forms of psychotherapy that can be helpful in addressing dysfunctional attitudes, social physique anxiety, and self-handicapping tendencies.

CBT focuses on identifying and changing negative thought patterns and beliefs that contribute to these issues. The therapist works with the client to challenge irrational beliefs and replace them with more realistic and helpful ones. For example, a therapist might help a client with perfectionistic tendencies to recognize the negative impact of their rigid thinking and replace it with more flexible and self-compassionate thinking.

REBT is similar to CBT but emphasizes the role of irrational beliefs in causing emotional distress. The therapist helps the client identify their irrational beliefs and challenge them through logical analysis and evidence-based reasoning. For example, a therapist might help a client with social physique anxiety to recognize that their fear of negative evaluation based on their appearance is unfounded and irrational.

Both CBT and REBT can be effective in helping individuals with dysfunctional attitudes, social physique anxiety, and self-handicapping tendencies. These therapies can provide clients with practical strategies and tools to manage their thoughts and emotions in a healthier and more adaptive way. Additionally, these therapies can help individuals develop a greater sense of self-awareness and self-compassion, which can promote overall well-being and resilience.

REFERENCES

Alcaraz-Ibanez, M., & Sicilia, A. (2020). Analysis of the dynamic relationship between social physique anxiety and depressive symptoms in young adults. *Journal of Applied Developmental Psychology*, *66*, 101085.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American psychologist*, *55*(5), 469.

Aslani, K., Mohammadi, A., & Rezaee Nia, Z. (2016). Social anxiety, dysfunctional attitudes and body image in lovemaking of the real and virtual world among students of Shahid Chamran University, Ahvaz. *Jorjani Biomedicine Journal*, *4*(1), 42-55.

Beck, A. T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Harper and Row.

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J.E. Barrett (Eds.), Treatment of depression: Old controversies and new approaches (pp. 265–290). New York: Raven Press

Berglas, S., & Jones, E. E. (1978). Drug choice as a self-handicapping strategy in response to noncontingent success. Journal of Personality and Social Psychology, 36, 405-417.

Charara, M., & Saneh, A. (2022). Anxiety and self-handicapping behavior: a correlational analysis amongst college students.

Chorba, K., Was, C. A., & Isaacson, R. M. (2012). Individual Differences in Academic Identity and Self-Handicapping in Undergraduate College Students. *Individual Differences Research*, *10*(2).

Derogatis, L. R. (1975). Brief symptom inventory. *European Journal of Psychological Assessment*.

Eblin, J. (2009). *Gender differences in claimed self-handicapping: The role of group status and effort prime* (Doctoral dissertation, The Ohio State University).

esteem. *Journal of personality and social psychology*, *70*(2), 310.

Greenberg, P. E., Fournier, A.-A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). The Journal of Clinical Psychiatry, 76, 155–162. https://doi.org/10.4088/JCP.14m09298.

Gruchy, A. (2018). *Body image in men: the impact of drive for muscularity and drive for thinness on depression, social physique anxiety, self-esteem, and behavioural factors in male health and fitness trainees* (Doctoral dissertation, Memorial University of Newfoundland).

Hagger, M. S., & Stevenson, A. (2010). Social physique anxiety and physical self-esteem: Gender and age effects. *Psychology and Health*, *25*(1), 89-110.

Harmon, J., & Rudd, N. A. (2013). Body size anxiety: Appearance management behaviors, social physique anxiety, appearance evaluation, and appearance orientation in larger size women. https://doi.org/10.31274/itaa_proceedings-180814-804

Harris, R. N., & Snyder, C. R. (1986). The role of uncertain self-esteem in self-handicapping. Journal of Personality and Social Psychology, 51, 451-458.

Hart, E. A., Leary, M. R., & Rejeski, W. J. (1989). Tie measurement of social physique anxiety. *Journal of Sport and exercise Psychology*, *11*(1), 94-104.

He, Z. H., Li, M. D., Liu, C. J., & Ma, X. Y. (2021). Relationship between body image, anxiety, food- specific inhibitory control, and emotional eating in young women with abdominal obesity: A comparative cross-sectional study. *Archives of Public Health*, *79*, 1-10.

Heine, A., Tamm, S., De Smedt, B., Schneider, M., Thaler, V., Torbeyns, J., ... & Jacobs, A. (2010). The numerical stroop effect in primary school children: a comparison of low, normal, and high achievers. *Child Neuropsychology*, *16*(5), 461-477.

Henriques, G., & Leitenberg, H. (2002). An experimental analysis of the role of cognitive errors in the development of depressed mood following negative social feedback. *Cognitive Therapy and Research*, *26*(2), 245-260.

Hirt, E. R., Deppe, R. K., & Gordon, L. J. (1991). Self-reported versus behavioral self-handicapping: Empirical evidence for a theoretical distinction. Journal of Personality and Social Psychology, 61, 981-991.

Horiuchi, S., Aoki, S., Takagaki, K., & Shoji, F. (2017). Association of perfectionistic and dependent dysfunctional attitudes with subthreshold depression. *Psychology research and behavior management*, 271-275.

Jones, E. E., & Rhodewalt, F. (1982). Self-handicapping scale. *Journal of Personality and Social Psychology*.

Kaur, M. M., & Raji, N. S. (2022). The Self-Handicapping Scale: Development And Validation In Indian Context. *Journal of Positive School Psychology*, *6*(9), 234-243.

Kërqeli, A., Kelpi, M., & Tsigilis, N. (2013). Dysfunctional attitudes and their effect on depression. *Procedia-Social and Behavioral Sciences*, *84*, 196-204.

Kimble, C. E., Kimble, E. A., & Croy, N. A. (1998). Development of self-handicapping tendencies. Journal of Social Psychology, 138, 524-534.

Kuiper, N. A., Olinger, L. J., & Martin, R. A. (1988). Dysfunctional attitudes, stress, and negative emotions. *Cognitive Therapy and Research*, *12*, 533-547.

Kuroda, Y. (2017). The Relationship Between Perceived Parenting, Negative Core Beliefs, and Dysfunctional Attitudes Among Young Adults. *The Journal of Psychology*, *151*(8), 739-751.

Leary, M. R., & Jongman-Sereno, K. P. (2014). Social anxiety as an early warning system: A refinement and extension of the theory of social anxiety. In S. G. Hofmann, & P. M. DiBartolo (Eds.). Social anxiety (pp. 579–597). (3rd ed.). Amsterdam: Elsevier Inc. https://doi.org/10.1016/B978-0-12-394427-6/00020-0

Lee, A., & Hankin, B. L. (2009). Insecure attachment, dysfunctional attitudes, and low self-esteem predicting prospective symptoms of depression and anxiety during adolescence. *Journal of clinical child & Adolescent Psychology*, *38*(2), 219-231.

Liang, T., Xu, Y., Xiang, W., Li, Y., Zhang, W., Feng, Z., ... & Xiao, J. (2022). Moderating role of overgeneral autobiographical memory in the relationship between dysfunctional attitudes and state anxiety. *Stress and Brain*, *2*(1-2), 5-16.

Liu, J., Peh, C. X., & Mahendran, R. (2017). Body image and emotional distress in newly diagnosed cancer patients: The mediating role of dysfunctional attitudes and rumination. *Body image*, *20*, 58-64.

Liu, Y. L. (2002). The role of perceived social support and dysfunctional attitudes in predicting Taiwanese adolescents' depressive tendency. *Adolescence*, *37*(148), 823.

Macmillan, R. (2006). 'Constructing adulthood': Agency and subjectivity in the transition to adulthood. *Advances in Life Course Research*, *11*, 3-29.

Martin, K. A., & Brawley, L. R. (2002). Self-handicapping in physical achievement settings: The contributions of self-esteem and self-efficacy. *Self and Identity*, *1*(4), 337-351.

Mojtabai, R., Olfson, M., & Han, B. (2016). National trends in the prevalence and treatment of depression in adolescents and young adults. Pediatrics, 138(6), e20161878. https://doi.org/10.1542/peds.2016-1878.

Nurmi, J. E., Onatsu, T., & Haavisto, T. (1995). Underachievers′ Cognitive and Behavioural Strategies-Self-Handicapping at School. *Contemporary Educational Psychology*, *20*(2), 188-200.

Panjrath, Y., & Pathak, V. N. (2022). A systematic review on the impact of surya namaskar and loving kindness meditation in treating social body anxiety and body dissatisfaction in women with polycystic ovarian syndrome. *Journal of Pharmaceutical Negative Results*, 10146-10151.

Qin, X., Sun, J., Wang, M., Lu, X., Dong, Q., Zhang, L., ... & Li, L. (2020). Gender differences in dysfunctional attitudes in major depressive disorder. *Frontiers in Psychiatry*, *11*, 86.

Reinecke, M. A., Ryan, N. E., & DuBOIS, D. L. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*(1), 26-34.

Rezasoltani, N., Hojjati, A., Hamzeh, K., & Asgar, S. A. G. Social Physique Anxiety and Self-Handicapping in Students.

Rhodewalt, F., & Davison, J., Jr. (1986). Self-handicapping and subsequent performance: Role of outcome valence and attributional certainty. Basic and Applied Social Psychology, 7, 307-322

Rhodewalt, F., Morf, C., Hazlett, S., & Fairfield, M. (1991). Self-handicapping: The role of discounting and augmentation in the preservation of self-esteem. Journal of Personality and Social Psychology, 61, 122-131.

Rhodewalt, F., Saltzman, A. T., & Wittmer, J. (1984). Self-handicapping among competitive athletes: The role of practice in self-esteem protection. *Basic and Applied Social Psychology*, *5*(3), 197-209.

Roberts, J. E., Gotlib, I. H., & Kassel, J. D. (1996). Adult attachment security and symptoms of depression: the mediating roles of dysfunctional attitudes and low self-

Sabiston, C. M., Sedgwick, W. A., Crocker, P. R. E., Kowalski, K. C., & Mack, D. E. (2007). Social physique anxiety in adolescence: An exploration of influences, coping strategies, and health behaviors. *Journal of Adolescent Research*, *22*(1), 78-101.

Shepperd, J. A., & Arkin, R. M. (1989). Self-handicapping: The moderating role of public selfconsciousness and task importance. Personality and Social Psychology Bulletin, 15, 252-265.

Singh, M., & Varma, B. (2016). Self-handicapping and self-esteem: A study of gender differences among individual sports personnel.

Sutin, A. R., Terracciano, A., Milaneschi, Y., An, Y., Ferrucci, L., & Zonderman, A. B. (2013). The trajectory of depressive symptoms across the adult life span. JAMA Psychiatry, 70, 803–811. https://doi.org/10.1001/jamapsychiatry.2013.193

Török, L., Szabó, Z. P., & Orosz, G. (2022). Promoting a growth mindset decreases behavioral self- handicapping among students who are on the fixed side of the mindset continuum. *Scientific Reports*, *12*(1), 7454.

Van Kim, N. A., Larson, N., & Laska, M. N. (2012). Emerging adulthood: a critical age for preventing excess weight gain?. *Adolescent medicine: state of the art reviews*, *23*(3), 571-588.

Weissman, A. N., & Beck, A. T. (1978). Development and validation of the Dysfunctional Attitude Scale: A preliminary investigation.

Whisman, M. A., & Friedman, M. A. (1998). Interpersonal problem behaviors associated with dysfunctional attitudes. Cognitive Therapy and Research, 22, 149 –160.

Williams, N. I., Mallinson, R. J., & De Souza, M. J. (2019). Rationale and study design of an intervention of increased energy intake in women with exercise-associated menstrual disturbances to improve menstrual function and bone health: The REFUEL study. *Contemporary clinical trials communications*, *14*, 100325.

Yiğitoğlu, G. T., & Keskin, G. (2019). Relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients: A sample of Turkey. *Indian Journal of Psychiatry*, *61*(5), 508.

Zhu, L., Wang, J., Liu, S., Xie, H., Hu, Y., Yao, J., ... & Fleer, J. (2020). Self-compassion and symptoms of depression and anxiety in Chinese cancer patients: The mediating role of illness perceptions. *Mindfulness*, *11*, 2386-2396.

Acknowledgement
The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Sherin, S. (2023). A Study on Dysfunctional Attitudes, Social Physique Anxiety and Self-Handicapping Tendencies Among Young Adults. *International Journal of Indian Psychology*, *11(2),* 1606-1636. DIP:18.01.169.20231102, DOI:10.25215/1102.169