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Self-Handicapping the paradox that isn't

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CHAPTER 3

SELF-HANDICAPPERS

INDIVIDUAL DIFFERENCES IN THE PREFERENCE FOR ANTICIPATORY, SELF-PROTECTIVE ACTS

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INTRODUCTION TO INDIVIDUAL DIFFERENCES IN SELF-HANDICAPPING

In 1984, at a point that many felt was the twilight of his golf career, Lee Trevino found himself leading the PGA Championship after the first round. Trevino had not won a tournament since 1981. At the age of 44, he was leading one of the premier events in his sport, a tournament that he would win three days later. When asked to explain his resurgence he replied that he had quit practicing, at his doctor's orders. Trevino, who had been suffering from chronic back problems, was instructed by his physician to give up his career-long habit of hitting 600 practice shots a day. Trevino cited an unanticipated benefit of his new regimen that was adding to the enjoyment he found in golf; "if I have a bad round, I say, 'What the hell, my doctor won't let me practice'" (Fowler, 1984, p. D1).

Jones and Berglas (1978) suggested that, "self-handicappers are legion in the sports world, from the tennis player who externalizes a bad

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shot by adjusting his racket strings, to the avid golfer who systematically avoids taking lessons or even practicing on the driving range" (p. 201). Lee Trevino's comments provide vivid documentation of this observation. At his doctor's suggestion, Trevino forwent practice, when that very practice is usually thought to contribute to a good athletic performance. In so doing, Trevino reaped the benefits of the attributional principles of augmentation and discounting (Kelley, 1972). In the face of defeat, it was difficult to question Trevino's golf ability because of the equally plausible performance-inhibiting cause of lack of practice. We (and Trevino) are willing to *discount* the extent to which we infer that a lack of golf ability caused the poor play because of the presence of an inhibitory cause—lack of practice. Had we tuned in on the Sunday after Trevino won the tournament, it is possible that we could have witnessed the flip side of a process that is inherent in self-handicapping. That is, we (and possibly Trevino) would have *augmented* the attribution of the victory to Trevino's great golf ability, because it occurred in spite of the fact that he had neglected to practice. Win or lose, Lee Trevino's self-esteem was protected by the self-handicap.

Almost a decade of research now supports and elaborates upon Jones and Berglas's (1978) original self-handicapping formulation. Anticipated threats to self-esteem (Snyder & Smith, 1982) or, more specifically, uncertainty about one's ability (Berglas & Jones, 1978) appear to motivate the enactment of self-handicapping strategies. Self-handicapping can also occur in the service of self-presentational concerns (Kolditz & Arkin, 1982). Moreover, a wide range of self-handicapping strategies have been demonstrated. For example, the self-handicapping functions of drug and alcohol consumption (Berglas & Jones, 1978; Higgins & Harris, 1988a, 1988b; Tucker, Vuchinich, & Sobell, 1981), lack of practice (Rhodewalt, Saltzman, & Wittmer, 1984), reduced effort (Pyszczynski & Greenberg, 1983), unfavorable performance settings (Rhodewalt & Davison, 1986), test anxiety (Smith, Snyder, & Handelsman, 1982), and symptom reports (Smith, Snyder, & Perkins, 1983), among others, have been documented. In fact, the list of potential self-handicaps is so vast that Arkin and Baumgardner (1985) have proposed a self-handicapping taxonomy with which to organize this research. They suggest that self-handicaps may be acquired (e.g., consumption of alcohol) or claimed (e.g., reports of symptoms; see also Leary & Shepperd, 1986; Snyder & Smith, 1982). Furthermore, self-handicaps may also be internal (e.g., withdrawal of effort) or external (e.g., choice of nondiagnostic performance settings). Finally, there is evidence that self-handicaps are used attributionally by the self-handicapper in a self-protective fashion (Mayerson & Rhodewalt, 1988).

In sum, the conceptual underpinnings of self-handicapping appear to be fairly well documented, and demonstrations of the phenomenon are commonplace. It is with this background that I turn to the central issue of this chapter: Given that people in general employ self-handicapping strategies in order to protect self-esteem, are there individual differences in people's tendencies to choose this strategy? I will approach this question from several perspectives. First, I will examine individuals' proclivities to rely on what will be termed domain–strategy-specific self-handicaps. Next, I will describe attempts to assess more general and pervasive individual differences in self-handicapping tendencies. After surveying this work I will turn to an examination of other individual differences that are relevant to different self-handicapping motivations, such as self-esteem protection and self-presentational concerns. Consideration then will be given to the subject of sex differences in self-handicapping behavior. Finally, I will conclude by outlining future research directions and by drawing the implications of the individual difference findings for self-handicapping theory.

PREFERENCES FOR DOMAIN–STRATEGY-SPECIFIC SELF-HANDICAPPING

Lee Trevino's use of lack of practice as a self-handicapping strategy exemplifies one way in which individual differences in self-handicapping can be manifested. On his doctor's recommendation he dropped his extensive practice routine. One would assume that Trevino learned of the self-handicapping benefits of this prescription only after suspending practice to cure his aching back. There are many such circumstances in which people initially engage in a behavior for motives other than self-esteem protection. For example, one may consume alcohol to reduce stress, or delay in preparing for a task as a consequence of other, more pressing demands. However, by serendipity or otherwise, people may come to appreciate the self-handicapping function of a behavior or characteristic and continue to use it in a self-protective role in future settings. In this way, behaviors may be maintained or even expanded because of their self-handicapping utility.

Domain–strategy-specific handicaps may be limited to circumscribed evaluative situations or may be broader and reduce the diagnosticity of potential self-evaluative feedback across a range of performance and social settings. An example of the former would be continually foregoing practice prior to a skill-dependent performance, while an example of the latter would be continually acting out the "sick role"

associated with a chronic but nondebilitating illness or injury. Jones and Berglas (1978; Berglas, 1986) suggest that alcoholism and underachievement are just such handicaps. The alcoholic and the chronic underachiever have grasped the notion that drinking or lack of effort spares them from confronting the more self-damaging implications of failure feedback.

Symptoms as Domain–Strategy-Specific Self-Handicaps

Claims of psychological distress or physical symptoms are good examples of domain–strategy-specific self-handicaps. In fact, Snyder and Smith (1982) argued for such a conclusion when they updated the self-handicapping concept by incorporating the Adlerian notion of the self-protective, strategic use of symptoms (see Chapter 1, this volume, for discussion of this perspective). In this formulation, individuals cite, and may well experience, physical and psychological afflictions in the service of self-esteem protection. The laborer who injures his back on the job may come to learn that the lingering back pain shields his fragile athletic ego when he plays third base on the company softball team. Indeed, in a recent investigation, Mayerson and Rhodewalt (1988) demonstrated that pain reports could be used in such a self-handicapping fashion. Under the guise of studying a measure of intelligence that was relatively unaffected by distraction, we administered two analogy tests to subjects. They took the first test while listening to distracting noise and the second while experiencing painful stimulation (one hand immersed in ice water). After the first test, subjects received either response-contingent or noncontingent success feedback. In other words, all subjects performed well under trying circumstances, but only half were uncertain about their ability to perform well again.

Prior to taking the second test, subjects provided baseline ratings of the painfulness of the ice water. They were informed that, although test performance was relatively unaffected by pain distraction, this was only true up to moderate levels of pain. If the individual found the ice water too painful it would, in fact, reduce the validity of the test results. Subjects were asked to provide the baseline pain ratings to help us interpret their performance on the upcoming test. Subjects then took the second test with their nondominant hand immersed in the ice water and learned that they were either successful or unsuccessful on this test. The findings clearly indicate that pain reports can be used as a self-handicap. Noncontingent success subjects were more likely to offer baseline pain ratings that would reduce the diagnosticity of feedback on the second test. This interpretation is corroborated by the self-attributions offered

by self-handicappers and non-self-handicappers after they learned that they had succeeded or failed on the second test. Specifically, in the failure feedback condition, self-handicappers reported that their poor performance did not reflect low ability, and non-self-handicappers indicated that their poor performance was attributable to lack of ability. Failing self-handicappers also claimed that the pain interfered with their performance, while non-self-handicappers did not.

Thus, we have clear experimental evidence that individuals who anticipate a potential threat to self-esteem will use symptom reports in a strategic, self-protective fashion (see also Smith *et al.*, 1982; Smith *et al.*, 1983; Snyder, Smith, Augelli, & Ingram, 1985). Although as yet untested, an underlying interest in this research is the generalizability of our findings to chronic pain patients. Such patients suffer from the persistent and often debilitating experience of pain. Very often it is difficult to identify the organic cause of the symptoms. Moreover, although the pain is fairly constant, pain patients typically report wide variation in the intensity of symptoms. Although at present highly speculative, we suggest that one source of variation in the symptom reports of chronic pain patients is the level of potential self-esteem threat they encounter from day to day.

Individual Differences in the Strategic Use of Symptom Reports

The above conjectures about self-handicapping and chronic pain patients gain plausibility when considered in the context of a series of studies conducted by Smith, Snyder, and their colleagues (Smith *et al.*, 1982; Smith *et al.*, 1983; Snyder *et al.*, 1985). Overall, this work supports the proposition that individuals vary in their employment of "trait"- or "state"-specific self-handicaps. For example, individuals who are characteristically high in social shyness, test anxiety, or hypochondriasis appear to be more prone than individuals who are low on those characteristics to modulate their symptom reports as a function of self-esteem threat.

In the Smith and Snyder paradigm, subjects who are characteristically high or low in the propensity to report specific psychological or physical symptoms are told that the symptom is not a viable excuse for poor performance on an ego-relevant task. For example, Smith *et al.* (1982) preselected subjects on the basis of their responses to the Test Anxiety Questionnaire (Sarason, 1980). High and low test-anxious individuals were led to believe that they were taking a two-part test that was either to provide local norms for a standardized intelligence test (high

evaluative threat) or to provide pilot data for experimental materials (low evaluative threat). Crosscutting the evaluative threat manipulation was information subjects were given about the effects of anxiety on test performance. Subjects were informed that the test either was or was not adversely influenced by anxiety, or they were provided no information. Measures of state anxiety obtained after subjects completed the first test indicated that test-anxious subjects reported elevated levels of anxiety only if they were confronted with a threat to self-esteem *and* if anxiety was a reasonable excuse for failure. The experimental manipulations had no effect on the anxiety reports of low test-anxious individuals. Interestingly, high test-anxious individuals who believed they were taking an important test that was unaffected by anxiety reported that they were expending reduced effort compared to other subjects. This finding suggests that high test-anxious individuals' appreciation for self-handicapping extends beyond their strategic use of anxiety reports—a point to which I will return in the next section.

Summary

In sum, the research by Smith, Snyder, and colleagues provides consistent evidence that an individual difference variable (test anxiety, social shyness, or hypochondriasis) predicts the strategic use of self-handicapping in response to potential threats to self-esteem. Consistent with the analysis of symptom reports as self-handicaps, Baumeister and Kahn (1982) suggest that obesity might also serve a self-handicapping function in some overweight individuals.

Test anxiety, shyness, and hypochondriasis are similar in that they all rely on reports of debilitating physical or psychological conditions. However, they differ in terms of the ranges of situations they may affect. The subjective experience and public reports of test anxiety are limited to ability-relevant assessments. In the same way, shyness as a self-handicap is applicable to a limited number of socially evaluative situations. In contrast, the chronic health complaints of the hypochondriac or obese individual may serve self-protective functions across many different domains of self-esteem threat. A possible implication of this distinction is that attempts to treat or modify such "maladaptive behavior" will be more successful to the extent that the self-handicapping function is recognized and the range of contexts in which the handicap is employed is identified.

It is up to future research to elaborate the contribution of self-handicapping processes in the maintenance of a variety of seemingly self-limiting or self-defeating conditions. Of particular interest are the individual and situational preconditions that transform a transient condition into an enduring mode of self-handicapping (see Higgins & Snyder, 1989, for a related discussion of these issues).

GENERALIZED PREFERENCES FOR SELF-HANDICAPPING BEHAVIOR

The use of symptom reports as self-handicaps provides evidence that some individuals will chronically employ a circumscribed mode of self-handicapping. Another way of approaching the individual difference question is to ask if individuals reliably differ in their appreciation for and employment of a variety of self-handicapping strategies. That is, are there characteristic differences among people in the extent to which they enact a mixture of self-handicaps across a wide range of evaluative situations. Rather than being wedded to one handicapping strategy, perhaps deployed in a particular evaluative setting, it may be that certain individuals seek the opportunity to perform in nondiagnostic contexts whenever and wherever self-evaluative threat is anticipated. These individuals are flexible in that they will call upon any plausible claim or available impediment to performance. Again, Lee Trevino's comments at the 1984 PGA Tournament are illustrative. Recall that he reduced his practice time to cure a chronically aching back. Perhaps Trevino's readiness to appreciate the self-handicapping implications of lack of practice are related to his prior experience with the self-protective benefits of the back ailment.

Is there such a person as the chronic self-handicapper? In the late 1970s, Edward E. Jones and several of his students attempted to provide an answer to this question by devising a questionnaire that directly probed individuals about their self-handicapping behaviors and motivations. Our initial work with this scale indicated that it correlated substantially with low self-esteem (*r*'s .30 to .50), a circumstance that appeared to be theoretically interesting but psychometrically problematic. We designed the Self-Handicapping Scale (SHS) to assess preferences for the use of self-handicapping behavior. Because we sought to demonstrate that the SHS was tapping more than a subject's willingness to confess unflattering or inappropriate behavior (i.e., low self-esteem), we attempted to reduce the overlap of the SHS with self-esteem. Over the next several years Jones and I modified the wording of items on the scale in order to reduce its negative correlation with self-esteem. In addition, we added items that we thought assessed domains of self-handicapping not previously tapped in earlier versions of the scale. The SHS employed

in current research, and displayed in Figure 1, has remained unchanged since 1982.

This brief historical sketch of the early development of the SHS is provided as a backdrop against which to appreciate subsequent research with the scale. Our intent was to devise a face-valid "in house" instrument that assessed the extent to which people reported (admitted) engaging in self-handicapping behavior. Our training and interest are not in psychometric methodologies and concerns but rather in investigating theoretical issues that can often best be examined using the person-by-situation approach. Nonetheless, the SHS has demonstrated adequate validity and reliability. Admittedly, however, the SHS could benefit by refinement, an issue I will address momentarily. With this caveat stated, we can now turn to research using the SHS.

The SHS (Jones & Rhodewalt, 1982) is a questionnaire that asks respondents to indicate the extent to which they agree with the applicability of 25 self-descriptive statements. The scale probes respondents' tendencies to use such self-handicapping behaviors as lack of effort, illness, procrastination, or emotional upsettedness in conjunction with evaluative performances. The scale also includes items designed to assess concerns about achievement. Eight of the items, such as "I hate to be in any condition but my best," are worded in the direction of low self-handicapping. Respondents indicate their agreement with each statement on 6-point scales bounded by the endpoints, *agree very much* to *disagree very much*.

Reliability and Validity of the Self-Handicapping Scale

The SHS has been administered in large group-testing sessions and has exhibited acceptable internal consistency (Cronbach's alpha, $r(503) = .79$) and stability (test–retest reliability at one month, $r(90) = .74$). Data collected from several different samples provide a composite of the SHS's discriminant and convergent validity. As one can see in Table 1, high SHS scores are associated significantly with low self-esteem, as measured by the Janis and Field Feelings of Inadequacy Scale (see Robinson & Shaver, 1973). Also, as one might expect, high self-handicappers score low on the Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1964). In addition, high self-handicappers have a tendency to make situational attributions for their outcomes, as assessed by the Lowe and Medway (1976) Person–Environment Causal Attribution Scale. In contrast, the SHS appears to be unrelated to Mehrabian's (1968) measure of need for achievement. Finally, one can see that high self-handicappers also score high on the Profile of Limbic Lability, an instru-

Please indicate (by writing a number in the blank before each item) the degree to which you agree with each of the following statements as a description of the kind of person you think you are most of the time. Use the following scale:

0 = disagree very much
1 = disagree pretty much
2 = disagree a little
3 = agree a little
4 = agree pretty much
5 = agree very much

_____ 1. When I do something wrong, my first impulse is to blame the circumstances.
_____ 2. I tend to put things off to the last moment.
_____ 3. I tend to overprepare when I have any kind of exam or "performance."*
_____ 4. I suppose I feel "under the weather" more often than most people.
_____ 5. I always try to do my best, no matter what.*
_____ 6. Before I sign up for a course or engage in any important activity, I make sure I have the proper preparation or background.*
_____ 7. I tend to get very anxious before an exam or "performance."
_____ 8. I am easily distracted by noises or my own creative thoughts when I try to read.
_____ 9. I try not to get too intensely involved in competitive activities so it won't hurt too much if I lose or do poorly.
_____ 10. I would rather be respected for doing my best than admired for my potential.*
_____ 11. I would do a lot better if I tried harder.
_____ 12. I prefer the small pleasures in the present to the larger pleasures in the dim future.
_____ 13. I generally hate to be in any condition but "at my best."*
_____ 14. Someday I might "get it all together."
_____ 15. I sometimes enjoy being mildly ill for a day or two because it takes off the pressure.
_____ 16. I would do much better if I did not let my emotions get in the way.
_____ 17. When I do poorly at one kind of thing, I often console myself by remembering I am good at other things.
_____ 18. I admit that I am tempted to rationalize when I don't live up to others' expectations.
_____ 19. I often think I have more than my share of bad luck in sports, card games, and other measures of talent.
_____ 20. I would rather not take any drug that interfered with my ability to think clearly and do the right thing.*
_____ 21. I overindulge in food and drink more often than I should.
_____ 22. When something important is coming up, like an exam or a job interview, I try to get as much sleep as possible the night before.*
_____ 23. I never let emotional problems in one part of my life interfere with things in my life.*
_____ 24. Usually, when I get anxious about doing well, I end up doing better.
_____ 25. Sometimes I get so depressed that even easy tasks become difficult.

*Indicates the item is reverse scored.

FIGURE 1. Self-handicapping scale (Jones & Rhodewalt, 1982).

TABLE 1. Correlations between SHS and Other Individual Difference Measures

Measure	Self-handicapping scale
Feelings of inadequacy[a]	−.43***
Social desirability[a]	−.43***
nachievement[a]	−.06
Person–environment[a]	.20***
Causal attribution[a]	
Profile of limbic lability[b]	.40***
Jenkins activity survey[b]	−.11
Beck depression inventory[c]	.43**
Feelings of inadequacy[c]	−.38** (−.37**)
Public self-consciousness[c]	.22* (.11)
Private self-consciousness[c]	.09 (.14)
Social anxiety[c]	.32** (.11)
Extraversion[c]	−.18 (−.17)
Other-directedness[c]	.36** (.26*)
Acting ability[c]	.00 (.05)

[a]Sample I, $n = 503$.
[b]Sample II, $n = 96$.
[c]Strube (1985) sample, $n = 168$; correlations for females are in parentheses.
* = $p < .05$; ** = $p < .01$; *** = $p < .001$.

ment designed by Pennebaker (1982) to measure the extent to which people are aware of their somatic functioning. This correlation is consistent with the notion that self-handicappers are likely to attend to their physical status for self-handicapping purposes (Smith *et al.*, 1983; Snyder & Smith, 1982).

As one will note in Table 1, the SHS is unrelated to scores on the Jenkins Activity Survey (Krantz, Glass, & Snyder, 1974), a measure of Type A coronary-prone behavior. The absence of this association is important because several investigators have speculated that Type A's should be prone to self-handicapping (Harris & Snyder, 1986; Weidner, 1980). I will return to this issue later in this chapter.

I (Rhodewalt, 1984) have also examined the item structure of the SHS by subjecting the responses of 503 respondents to principal components factor analyses (Gorsuch, 1974). These analyses extracted seven factors, each with eigenvalues greater than 1.0; they accounted for 52.3% of the total item variance. However, closer examination of these eigenvalues via a scree test revealed that one major break occurred between

Factors 2 and 3. This suggests that the SHS has two major factors. The item factor loadings for the two-factor solution are presented in Table 2. An item was included in a factor if it had a loading of greater than .40 on that factor and less than .20 on the others.

Factor 1 accounts for 17.4% of the variance and comprises nine items. This factor appears to reflect a proclivity for excuse making and includes items such as "When I do something wrong, my first impulse is to blame the circumstances," "I suppose I feel 'under the weather' more often than most," and "I would do much better if I did not let my emotions get in the way." Factor 2 accounted for 10.9% of the item variance and included four items that appeared to reflect concern about effort or motivation. The items included, "I tend to put things off until the last minute" and "I would do a lot better if I tried harder." Table 2 displays the item factor loadings, the individual item–remainder correlations, and the item–self-esteem correlations. Finally, respondents scor-

TABLE 2. Self-Handicapping Scale Factor Loadings

Item	Factor 1	Factor 2	Item/remainder	Item/self-esteem
1	.43	.19	.47	−.20
2	.13	.71	.47	−.11
3			.04	−.00
4	.68	.00	.52	−.32
5	.08	.39	−.23	.13
6			.02	.01
7			.26	−.19
8	.18	.44	.44	−.25
9	.58	.11	.47	−.27
10			−.04	.08
11	.11	.63	.42	−.11
12			.37	−.12
13			.04	.06
14	.19	.42	.43	−.15
15	.59	.08	.51	−.16
16	.55	.06	.51	−.29
17			.22	.15
18	.43	.20	.50	−.11
19	.62	.14	.51	−.37
20			−.16	.05
21	.40	.16	.49	−.13
22			−.11	.04
23			.21	−.10
24			.13	.15
25	.66	.07	.58	−.36

ing in the upper and lower quartiles of the SHS were selected, and *t* tests were computed between the groups on each individual item score. This analysis mirrored the item–remainder correlational analysis in that six of the items (Items 3, 6, 10, 13, 20, and 22) failed to discriminate reliably between the extreme groups.

Further validity data are provided by Strube (1985), although caution needs to be exercised when interpreting these data because an earlier 20-item version of the SHS was used. Strube reasoned that the SHS might be useful in resolving the debate over whether self-handicapping is in the service of self-protective or self-presentational motives (Berglas & Jones, 1978; Kolditz & Arkin, 1982). Accordingly, he included the Self-Consciousness Scale (Fenigstien, Scheier, & Buss, 1975) in order to examine the relations among the SHS, Private Self-Consciousness, Public Self-Consciousness, and Social Anxiety. Additionally, he correlated the SHS with the Extraversion, Other-Directedness, and Acting subscales of the Self-Monitoring Scale (M. Snyder, 1974; Briggs, Cheek, & Buss, 1980). Finally, Strube included the Feelings of Inadequacy Scale (Robinson & Shaver, 1973) and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). As in our data, the SHS was modestly, negatively correlated with low self-esteem and positively related to depression. For both males and females, SHS scores were related to the Other-Directedness component of self-monitoring and, for males only, scores were related to Public Self-Consciousness.

Strube interpreted these findings to be consistent with the view that self-handicapping was primarily for self-presentational concerns. However, the data are not completely consistent with this conclusion. First, the correlations between SHS and Public Self-Consciousness and Social Anxiety are not significant when self-esteem is covaried. Second, there is the reliable negative association between the SHS and concerns for social desirability mentioned previously. Thus it may be that concerns about social approval accompany low self-esteem, but it is not necessarily the case that such concerns are the sole, or even prime, motivation to self-handicap.

Taken together, these analyses suggest that future research with the SHS should use an abridged form containing the 14 items loading on Factors 1 and 2 in order to increase its reliability. The coefficient alpha of .79 for the 14-item scale is comparable to that of the full 25-item SHS. Likewise, the short and long forms of the SHS evidence negative correlations with self-esteem that are similar in magnitude ($rs = -.41, -.43$, respectively).

It is also striking that Strube's (1985) factor analysis of an earlier version of the SHS led to essentially the same recommendation. Keep in mind, however, that the SHS described here and used in most of the research described in this chapter differs in several ways from the form used by Strube (1985). In addition to having more items tapping into more domains of self-handicapping behavior, carry-over items from earlier forms of the 25-item SHS have been reworded to load less in the direction of low self-esteem. These differences not withstanding, all 10 items included on the short form of the SHS recommended by Strube are included in slightly reworded form in the abridged SHS derived from our own analyses. Thus, the Strube data may be viewed as a cross validation of the factor analysis presented here. It is also noteworthy that Strube's short form of the SHS correlated somewhat higher with low self-esteem ($r = -.50$) than our abridged SHS, indicating that our attempt to reword items to be less self-esteem laden was somewhat successful.

Finally, it is of interest that the SHS's largest factor is one that appears to reflect a general proclivity for excuse making. This finding is noteworthy because it lends support to Snyder, Higgins, and Stucky's (1983) contention that self-handicapping belongs in the larger category of anticipatory excuse making. Thus, the SHS may be measuring a general tendency to employ self-protective strategies including self-handicaps, excuses, disclaimers (Hewitt & Stokes, 1975), and, possibly, rationalizations.

Self-Handicapping and the Self-Handicapping Scale

Perhaps the most critical test in the validation of a measure of individual differences is its ability to predict the behavior or underlying characteristic in question. To what extent, then, is the SHS successful in predicting self-handicapping behavior? A handful of investigations now exist that document the predictive utility of the SHS for a variety of self-handicapping behaviors. Generally, this research finds that as the likelihood of threat to self-esteem increases, those scoring high on the SHS are more likely to acquire or claim a handicap than are those scoring low on the SHS.

For example, scores on the SHS should be inversely related to academic achievement. Jones and Berglas (1978) suggested that underachievement is a particularly chronic manifestation of self-handicapping behavior. The underachiever, by being respected for his or her potential rather than actual accomplishment, is able to protect the illusion that his or her ability is quite high. As a subsidiary interest in our study of self-handicapping among competitive athletes (Rhodewalt, Saltzman, & Wittmer, 1984). Andy Saltzman and I attempted to construct an index of over–underachievement using subjects' SAT scores as the measure of

aptitude and their grade point averages as the measure of achievement. In order to place this index on an interval scale, we employed the formula 1 + log (GPA/SAT × 1,000) and correlated the outcome with the subjects' SHS scores.

To illustrate, consider three students, all of whom have SATs of 1,200 but GPAs of 3.0, 2.0, and 1.0, respectively. Their corresponding over–underachievement scores would be 1.40, 1.22, and 0.92. In the Saltzman thesis (Rhodewalt *et al.*, 1984), high SHS scores were associated with underachievement ($r = -.25$), but not reliably so. Suspecting that both the small sample size ($n = 27$) and restricted ranges of SATs and GPAs weakened the test, I (Rhodewalt, 1984) examined the same relationship in a larger sample of introductory psychology undergraduates (substituting ACT scores for the SAT) and found high SHS scores to be reliably correlated with underachievement (r (90) $= -.43$, $p < .01$).

Self-handicappers also seem to be quite willing to bear the label of "underachiever." Embedded among background information appended to the end of the SHS, respondents are typically asked to categorize themselves as either a "distinct underachiever," "normal achiever," or "distinct overachiever." This self-rating of achievement correlates negatively with SHS scores ($r(503) = -.26$, $p < .001$). Thus, consistent with Jones and Berglas's assertion, both "objective data" and self-reports indicate that high self-handicappers tend to be underachievers.

The major purpose of the Saltzman thesis (study 1, Rhodewalt *et al.*, 1984) was to investigate differences between SHS-defined high and low self-handicappers in the strategic use of self-protective behavior. In particular, we were interested in the use of these strategies in the face of evaluative threat. We attempted to substantiate the Jones and Berglas (1978) contention that self-handicapping is prevalent in the world of athletics. In order to test this hypothesis, we collected SHS scores from all the members of the Princeton University men's swimming team in an unrelated context prior to the beginning of their season, and observed their behavior over the course of one season. Although a wide range of responses was collected, the focal dependent variables were the swimmers' strategic use of practice effort and claims of injury as self-handicaps. Evaluative threat was operationally defined as the team members' consensus rating of the importance of each swim meet to the success of the team's season. We then compared practice attendance and practice effort as rated by the coach prior to important and less important swim meets. In addition, on the day prior to each competition, the swimmers completed a questionnaire concerning their perceptions of their practice, health, visits to the trainer, eating and sleeping, and academic course load for the preceding week.

Our prediction was that high self-handicappers, as compared to low self-handicappers, would "take a dive" prior to important meets by withholding practice effort and by claiming health problems. The hypothesis was confirmed in a slightly altered fashion. For both practice attendance and coach's ratings of practice effort, low self-handicappers increased their training prior to important meets while high self-handicappers did not. In other words, high self-handicappers did not decrease training effort, they simply did not turn up their effort relative to their low self-handicapping counterparts. Interestingly, there were no high versus low self-handicapper differences on the coach's ratings of actual meet performance, nor were there differences in the swimmers' self-reported appraisals of their practice efforts. With regard to illness or injury reports, there was a marginally significant tendency for high self-handicappers to visit the team trainer more than low self-handicappers, regardless of meet importance.

Surprisingly, self-handicapping swimmers' self-reports of effort did not map on to their self-handicapping behavior as seen by their coach, nor did they engage in behavior that was obviously self-defeating. Our attempts to account for this paradox centered on the fact that participation in a team sport might inhibit one's more blatant attempts to self-handicap for fear of sanctions by teammates. Accordingly, Jerry Wittmer and I attempted to replicate our findings using athletes from an individual sport, golf (Study 2, Rhodewalt *et al.*, 1984).

Professional golfers competing in state-level tournaments completed the SHS at the beginning of their competitive season and then completed questionnaires prior to each tournament. The questionnaires probed such issues as the number of hours the player practiced in the past week, nongolf hours worked, and personal or health problems encountered. Tournaments were grouped into high and low importance based on consensus estimates provided by the golfers. The findings indicated that higher as compared to lower self-handicappers claimed to spend less time practicing in general, and significantly less time practicing during the week prior to important tournaments. However, the pattern of data was similar to that for the Princeton swimmers in that the significant handicapping effect resulted from low self-handicappers increasing their practice time before important tournaments rather than from high self-handicappers decreasing their effort. Again, as with swimmers, there was a marginal tendency for high self-handicapping golfers to report being in poorer physical condition compared to low self-handicappers.

Despite their claims and protestations, high self-handicappers appeared to compete as well as, if not better than, low self-handicappers.

Golfers in the study were awarded Grand Prix points for their finishes in each tournament. An analysis of the total Grand Prix point rankings at the end of the season revealed a marginally significant tendency for high self-handicappers to accumulate more points than low self-handicappers. This finding supports C. R. Snyder's view (see Chapter 4) that self-handicapping frequently provides benefits to the individual.

In both of the above investigations, athletes identified as high self-handicappers by the SHS curbed their practice preparation prior to important athletic contests. Ironically, but consistent with self-handicapping theory, data available only in the swimmers study indicated that self-handicappers rated important meets as also being more personally important than did low self-handicappers. In neither study was there a clear preference for the athletes to use claims of injury as handicaps, although there were indications that self-handicappers might do so. Another theoretically consistent but unpredicted outcome observed in both studies was that self-handicappers rated the performance conditions of important competitions as less favorable for good performance than did low self-handicappers. This suggests that handicappers may use different self-protective attributional strategies simultaneously.

The findings from the above field studies demonstrate, at minimum, that Lee Trevino is not alone in his appreciation for the value of forgoing practice as means of protecting self-esteem.* However, the interpretive ambiguities inherent in field studies have led us to pursue the relations among self-handicapping, evaluative threat, and effort in the laboratory. To do so, Marita Fairfield and I (Rhodewalt & Fairfield, 1989) modified a paradigm developed by Pyzsczynski and Greenberg (1983). Participants who had completed the SHS in an earlier unrelated setting were led to

*Anecdotal evidence from the Rhodewalt, Saltzman, and Wittmer study provides testimonial to the temporal stability of the preference for this tactic. One of the golfers was experiencing a particularly difficult season during the summer of the study (1982). This followed a year in which he had been quite successful, winning several state tournaments. When approached by one of the research assistants just prior to the start of a tournament, he angrily claimed that neither his personal nor professional life had gone right since agreeing to participate in our study. With that announcement, he took the questionnaire offered by the research assistant and trampled it with his golf spikes. We viewed this as a request to withdraw his consent to participate but could not resist the temptation to look at his self-handicapping score. He had the highest score of any surveyed in the study. A sidebar to this incident is that the same golfer recently finished first in a qualifying tournament for the United States Open. His statement to the local press when asked to comment on his victory was that he was very pleased, especially because he had not had time to practice before the event.

believe that they would be participating in an evaluation study of a culture-fair test of general intelligence (high ego relevance) or helping to pilot materials for an upcoming study (low ego relevance). After completing a set of practice problems that was either somewhat easy or fairly difficult, the experimental session was interrupted by an individual purporting to represent the psychology department which, ostensibly, was surveying all psychology experiment volunteers. Subjects were given a questionnaire which queried them concerning their treatment and their perceptions of the experiment. It was stressed that their responses were anonymous (there was no obvious identifying information on the form), and that they were to be as candid as possible because their responses would help researchers better interpret information gathered in such studies. After the "department representative" collected the questionnaires and left the laboratory, subjects were administered 50 items from the Culture Fair Test of g (Cattell & Cattell, 1960).

As expected, subjects who encountered difficult practice problems anticipated doing more poorly on the test than did subjects who received easy practice problems; high ego-relevance subjects reported the test to be more important than did low ego-relevance subjects. In addition, high self-handicappers, as compared to low self-handicappers, stated that they felt the test was more important and that they would be more displeased with failure. With regard to reports of intended effort, high self-handicappers indicated that they intended to put forth less effort in general, but were particularly likely to do so if they expected the test to be difficult. This interaction between self-handicapping and expected difficulty held regardless of whether subjects believed the test to be an important assessment of their intelligence or an unimportant experimental exercise. Analyses of the number of problems correctly solved on the actual test indicated that self-handicappers' professions of low effort were born out in their performances. Pair-wise comparisons revealed that, although high and low self-handicappers did not differ in their performances when they expected the test to be easy, low self-handicappers performed significantly better than high self-handicappers when they expected the test to be difficult. Moreover, as the level of anticipated difficulty increased, so did the performance of low self-handicappers, while the performance of high self-handicappers decreased.

The overall picture that emerges from these findings is that, in the realms of athletic and intellectual performance, high self-handicappers, as defined by the SHS, both report expending less effort and actually withhold effort and practice in the face of potential self-damaging feedback.

Self-Handicapping and Self-Esteem

There is another explanation for the findings presented in the previous section. Because high scores on the SHS are associated with low self-esteem, it may be that it is low self-esteem that is the operative individual difference accounting for our findings. That is, all of the self-report and behavioral data may be attributable to individuals with low self-esteem giving up in the face of difficult or important events. There are several pieces of logical and empirical evidence that argue against this conclusion, however.

First, self-handicapping theoretically is enacted in the service of self-esteem protection (see Jones & Berglas, 1978; Snyder & Smith, 1982; and Chapters 1 and 2 in this volume for more extended discussions). People with completely negative self-concepts should have nothing to protect and, consequently, should have no need to self-handicap. In support of this reasoning, Tice and Baumeister (1984) found that high self-esteem (but not low self-esteem) individuals handicapped by not practicing for a test. Following from Jones and Berglas's (1978) theorizing it is *uncertainty* about one's positive self-conceptions and abilities that is the critical motive driving self-handicapping behavior. Theoretically, the propensity to self-handicap should be independent of level of self-esteem.

This latter speculation is supported by recent evidence provided by Harris and Snyder (1986). Subjects in the Harris and Snyder study filled out a self-esteem inventory and indicated how certain they were of their responses to each item. Subjects were then provided the opportunity to practice or "warm up" for an intelligence test on which they would subsequently receive feedback. Male subjects who were uncertain of their self-evaluations self-handicapped more (practiced less) than any other group of subjects. This effect was independent of their actual level of self-esteem and indicates that it is individuals who are uncertain about their wherewithal to generate positive feedback or to avoid negative feedback who are most likely to self-handicap.

The fact remains, however, that roughly 16 to 20% of the variance in the SHS is shared with self-esteem. Some of this relationship is probably accounted for by the content of the items on the SHS. The respondent is quizzed about his or her shortcomings, failures, and unpleasant experiences—events that are undoubtedly more likely to be included in the personal histories of low self-esteem individuals. It is also more likely that low self-esteem individuals are willing to admit committing acts that cast a publicly unflattering image of themselves. This raises the possibility that the SHS is providing a more accurate estimate of the self-handicapping tendencies of lower self-esteem individuals than of others.

On the Independence of Self-Handicapping and Self-Esteem

Self-handicapping and self-esteem are psychometrically intertwined, but, theoretically, they are independent constructs. Therefore, it should be possible to examine self-handicapping behavior independently of its association with self-esteem. A follow-up study by Rhodewalt and Fairfield (Study 2, 1989) indicates that this is the case. We replicated our earlier demonstration of self-handicapping and intended effort in anticipation of an easy or difficult test and added a measure of self-esteem in our pretest. As in our first study, high self-handicappers anticipating a difficult test indicated that they would put forth less effort than did low self-handicappers expecting a difficult test and both high and low self-handicappers expecting an easy test. More importantly, these findings emerged even when subjects' levels of self-esteem were controlled. With regard to actual performance or effort, the interaction between level of self-handicapping and expected difficulty was again obtained. However, the interaction was attributable both to low self-handicappers' performance increasing when they expected the test to be difficult and to high self-handicappers' performance declining slightly. We also included a thought-listing procedure designed to tap cognitive interferences experienced by the participant while taking the exam. High self-handicappers taking a test they expected to be difficult reported levels of cognitive interference that were significantly higher than levels reported by high self-handicappers in the expected easy test condition and low self-handicappers regardless of test difficulty condition. That is, self-handicappers who were performing in an evaluative setting they anticipated being difficult complained that, while working on the task, their minds wandered to thoughts such as, "I thought about my level of ability," "I thought about how much time I had left," and "I thought about things unrelated to the experiment." Again, these findings were independent of the subjects' levels of self-esteem.

In a study paralleling ours, Strube (Study 2, 1985) assessed students for levels of self-handicapping and self-esteem. Then, on two occasions (after a first exam and 2 days prior to a second exam), subjects completed a checklist of extenuating circumstances that could have prevented (or might prevent) them from exhibiting their true abilities on the tests. Self-esteem scores were covaried from these ratings, and SHS

effects again remained reliable. Self-handicappers, particularly males, cited more extenuating factors being present both immediately after taking an exam (self-serving bias) and 2 days prior to taking an exam (claimed self-handicapping).

Strube and Roemmele (1985) have investigated the relation between SHS-defined self-handicapping and self-esteem from a different perspective than the one described above. Borrowing the self-evaluative task choice paradigm developed by Trope (1980), Strube and Roemmele (1985) asked SHS-defined high and low self-handicappers who were either above or below the median in self-esteem to select among tests of intelligence that varied in the diagnosticity of the success and failure feedback that they provided. Subjects were asked to indicate which test was most accurate and which they preferred. Although all subjects recognized that a highly diagnostic test is the most accurate, high self-handicappers who were low in self-esteem preferred (and actually opted to take) the test form that was high in diagnosticity for success but low in diagnosticity for failure. Interestingly, high self-esteem, high self-handicapping subjects evenly split in their test preferences. Some selected tests that were highly diagnostic of both success and failure, while others selected tests that were diagnostic of success only. Low self-handicappers, regardless of self-esteem level, preferred tests that were highly diagnostic of both success and failure.

On the Relation of Self-Handicapping to Self-Esteem

The findings discussed in the preceding section suggest that, although lower self-esteem is associated with high SHS scores, individual preferences for self-handicapping are fairly independent of self-esteem. Nonetheless, self-handicapping and self-esteem are intimately related in that the former is deployed in order to protect the latter. What, then, is the nature of the relationship between self-handicapping and self-esteem?

Among high self-handicappers, it is possible that level of self-esteem reflects a threshold for perceived threat to the self that triggers strategic self-protective behaviors. That is, low self-esteem, high self-handicapping individuals may engage in chronic self-handicapping, while high self-esteem, high self-handicapping individuals, may only self-handicap in the less frequent instances of perceived self-evaluative threat. An even more speculative hypothesis that we are presently exploring in our laboratory is that low self-esteem, high self-handicapping individuals exclusively engage in protective self-handicapping, but high self-esteem, high self-handicapping individuals enact self-handicapping

for primarily acquisitive purposes. That is, whereas low self-esteem individuals may self-handicap to discount the negative implications of failure, high self-esteem individuals may self-handicap to position themselves to augment the positive self-attributions resulting from anticipated success. Of course, if something goes wrong, the high self-esteem self-handicapper is still protected.

In designing the SHS, Jones and I attempted to reduce its shared variance with measures of self-esteem. This attempt was based on the assumption that self-handicapping is in the service of protecting positive, but tenuously held, self-images. This line of reasoning implies that low self-esteem individuals should be less likely to self-handicap because they hold fewer positive self-conceptions. Thus, we viewed the correlations between the SHS and self-esteem as nothing more than an artifact of shared "method variance" (i.e., items on both scales asked subjects to admit something unflattering about themselves). Snyder and Higgins (1988a; see also Harris & Snyder, 1986), however, have suggested a way in which self-handicapping and self-esteem might be related. They contend that it is general uncertainty about the performance outcome which motivates self-handicapping. In this view, low self-esteem individuals are likely to self-handicap more frequently than are high self-esteem individuals because they encounter more situations were they are uncertain about their ability to *produce* an important or self-relevant, desired outcome. Low self-esteem individuals may also employ self-handicapping when they are uncertain about how to *avoid* a self-relevant, undesired outcome (see Rhodewalt & Davison, 1986).

Further research is needed to explicate the relationships between self-esteem and chronic self-handicapping, but the available evidence indicates that the two constructs should be treated as separate, but interactive, entities.

Self-Handicappers, Esteem Threats, and Self-Attributions

I wish to introduce one last data set before turning from the SHS to other individual differences in self-handicapping. The self-handicapping notion, as put forth by Jones and Berglas (1978), is stated in terms of self-attributional processes. In a laboratory setting we have shown that individuals will cite a handicap as a discounting cue in the event of failure but are hesitant to use it to augment success (Mayerson & Rhodewalt, 1988). We now have evidence that SHS scores are related to an attributional or explanatory style (Peterson & Seligman, 1984). For purposes unrelated to self-handicapping issues, we adapted the Attributional Style Questionnaire (Peterson, Semmel, Metalsky, Abramson, von Beyer, & Seligman,

1982), an inventory that requires respondents to make attributions for hypothetical desirable and undesirable events. In the adapted form (Rhodewalt, Strube, Hill, & Sansone, 1988), we included events or situations that varied somewhat orthogonally in their threat to personal control or their threat to self-esteem. Although these constructs are related to one another, it was possible through pilot testing to design events that were low in both self-esteem and control threat (i.e., "You miss a final exam which cannot be made up because the electricity goes off during the night and you oversleep"); low in self-esteem threat but high in control threat (i.e., "You have very little time to meet an important deadline and people keep interrupting you"); high in self-esteem threat but low in control threat (i.e., "You get the nerve to ask someone for a date and he or she says no because he or she does not like your type"); or high in both types of threat (i.e., "You are rejected by all the graduate schools to which you apply"). Four desirable events were included with the eight negative ones (two from each of the above categories). Respondents were then asked to imagine the events happening to them, to write open-ended responses describing the major causes, and to indicate on a series of scales the extent to which the causes were internal–external, stable–unstable, global–specific, and self-responsible–unresponsible. SHS scores and self-esteem scores (Janis and Field Feelings of Inadequacy Scale; Robinson & Shaver, 1973) were collected for all respondents, and subjects were divided into high and low self-handicappers based on a median split of SHS scores. Self-esteem was employed as a covariate. Judges then rated the open-ended major cause statements for the extent to which they were self- or situational attributions. Two sets of analyses were performed; one comparing positive to negative events and one comparing level of self-esteem threat to level of control threat. When high self-handicappers and low self-handicappers were explaining positive as compared to negative events, three effects emerged. First, everyone was somewhat self-serving, in that negative events were attributed to situational factors and positive events were attributed to the self. Second, high self-handicappers made greater situational attributions in general than did low self-handicappers. Third, and somewhat surprisingly, the tendency for high self-handicappers to make situational attributions was most pronounced when the events to be explained were positive.

Analyses of the subjects' scale responses were consistent with the portrait provided by their open-ended attributions. High self-handicappers rated positive outcomes as less internally caused but did not differ from low self-handicappers in their external attributions for negative events. Similarly, self-handicappers, relative to non-self-handicappers, viewed positive events as caused by less stable factors and negative events as caused by more stable factors. The two groups did not differ in their global–specific attributions or in how important they viewed the events to be.

Turning to negative events that varied in type and degree of threat, level of control threat did not lead to differing patterns of attributions between high and low self-handicappers. However, as level of threat to self-esteem increased, high self-handicappers were less likely to make internal self-attributions than were low self-handicappers. The pattern was slightly reversed for low esteem-threat events. The same interaction emerged for the internal–external ratings and for the stable–unstable ratings. The global–specific dimension was not used differentially by the two groups. High self-handicappers, however, viewed any self-esteem threat as more important than did low self-handicappers. Taken together, these findings indicate that self-handicappers tend not to use attributions in an acquisitive, self-enhancing fashion but do employ them in a self-protective manner in response to threats to self-esteem.

Summary

The assumption guiding the line of research presented in this section is that individuals vary in their appreciation for and use of self-handicapping strategies. Accordingly, we have sought to develop a scale to probe individuals in a relatively straightforward way about these tendencies. To date, the SHS has demonstrated encouraging degrees of reliability and validity. Admittedly, more psychometric refinement is in order, and future researchers in the area might want to consider the recommendations for revision of the SHS made in this chapter. The SHS also has displayed impressive predictive validity. However, these demonstrations of validity largely have been limited to the domain of intellectual achievement and almost exclusively to claimed rather than acquired self-handicaps (cf. Arkin & Baumgardner, 1985). The next step is to demonstrate that the predictive utility of the SHS extends to other self-evaluative arenas such as social activities or interpersonal relationships and includes forms of self-handicapping other than anticipatory excuse making (e.g., the actual creation of impediments to performance).

It is noteworthy that available data suggest that high self-handicappers translate their claims into actions. When high self-handicappers avow not to expend effort on a task, their performance bears out their claim. Perhaps this conclusion is limited to the specific handicaps investigated by current research. It may be that other modes of self-handicapping, such as the choice of a nondiagnostic performance setting (see

Rhodewalt & Davison, 1986), free self-handicappers to expend greater effort than they would without the handicap.

There is one extremely paradoxical aspect of this individual difference approach to self-handicapping that has no doubt bothered the reader. We essentially identify high self-handicappers through their willingness to admit the use of self-handicaps. The paradox lies in the fact that the major theoretical perspectives on self-handicapping might argue that this approach should not work. One either employs self-handicaps for self-protective reasons (Jones & Berglas, 1978) or self-presentational reasons (or possibly both, Kolditz & Arkin, 1982; see also Chapter 2, this volume). Either motive should preclude an open admission of the use of such tactics.

Perhaps one can be aware of his or her general tendency to handicap but engage in it automatically in the face of self-evaluative threat—much like one can appreciate the process of dissonance reduction but yet get caught up in it. Or, one may be willing to confess to self-handicapping on a questionnaire and, yet, think of each enactment of self-handicapping as a discrete event in which the audience is not knowledgeable of his or her self-presentational modus operandi across other situations. In a related discussion, Snyder and Higgins (1988b) have placed excuse making on a continuum ranging from retrospective accounts to what they term incorporated excuses. It is incorporated excuses that are relevant here. The incorporated excuse maker has become, in a sense, the excuse. For example, test-anxious individuals always have the "handicap" of test anxiety available, and they are willing to confess to being anxious on self-report measures. Likewise, the chronic procrastinator and the "habitually ill" hypochondriac have "incorporated" those traits into their self-conceptions, and they will admit to them on the SHS while being "unaware" of their self-handicapping function.

It is also possible that the SHS is failing to identify the more discrete, selective, or self-deceptive self-handicapper. This suggests that other approaches to individual differences in self-handicapping might better enable us to triangulate the phenomenon. We turn next to these efforts.

ALTERNATIVE APPROACHES TO SELF-HANDICAPPING BEHAVIOR: DIFFERENCES IN SELF-HANDICAPPING MOTIVES

Rather than probing for individual differences in the admitted use of self-handicapping strategies, one might search for individual differences in the motives to self-handicap. If it is uncertainty about one's ability that motivates self-handicapping (Berglas & Jones, 1978; Snyder & Smith, 1982), then there may be consistent differences among people in their tendencies to question their abilities. Likewise, if it is self-presentational concerns that drive self-handicapping behavior (Kolditz & Arkin, 1982), then the question may become one of whether there are individual differences or self-presentational styles that predispose one toward self-handicapping.

Protection of Desired but Uncertain Self-Conceptions

In the Jones and Berglas (1978) formulation, uncertainty about one's skill or ability motivates self-handicapping. According to Jones and Berglas, desired but tenuously held self-conceptions are the ones that require protection. Several experiments have provided support for this view (Berglas & Jones, 1978; Higgins & Harris, 1988a; Kolditz & Arkin, 1982; Mayerson & Rhodewalt, 1988; Rhodewalt & Davison, 1986; Tucker *et al.*, 1981). Subjects provided with noncontingent success feedback, as compared to contingent success feedback, are more uncertain of their ability and more likely to self-handicap. Pursuing this line of reasoning, it follows that individuals who are characteristically uncertain of their self-conceptions or who are deficient in self-confidence would be tempted to self-handicap when entering situations that provide evaluative feedback. Harris and Snyder (1986), in a study mentioned previously, provided initial support for this proposition.

Subjects in the Harris and Snyder study were assessed for both their levels of self-esteem and the certainty with which they held these self-conceptions, and then were confronted with a test of intellectual performance. The amount of time they practiced was the measure of self-handicapping. As reported earlier, uncertain males, regardless of their actual level of self-esteem, practiced less than subjects in all other conditions. Compared to self-certain subjects, uncertain males also reported trying less.

Findings that can be interpreted as compatible with the Harris and Snyder data come from a study by Harris, Snyder, Higgins, & Schrag (1986). These researchers measured a variety of variables they thought to be pertinent to self-handicapping. They found that female subjects who were either high in test anxiety or high in covert self-esteem (a measure of how subjects inwardly felt about themselves) offered self-protective attributions prior to taking an important test. Although the authors did not report the interactions in their analyses, it appears from the stepwise multiple regression analyses that the effects of self-esteem on self-handicapping were mediated by test anxiety. Thus, self-handicappers might

have been those individuals who wanted to maintain a desired self-image (high covert self-esteem) but were uncertain about their ability to do it (high test anxiety).

Protection of Desired Public Images

A contrasting analysis of self-handicapping motives is that the self-handicapper wishes to maintain a positive public image (Kolditz & Arkin, 1982; see also Baumgardner, Lake, & Arkin, 1985). This view still implicates the role of self-certainty. It is the individual who has attained a positive public image on the basis of past performance, but is uncertain about his or her ability to replicate this performance, who is most likely to self-handicap. Kolditz and Arkin demonstrated that when subjects performed in private (no one else knew their test scores), the frequency of self-handicapping decreased. Are there individual differences, then, that might predispose people to be unduly concerned about their public images and, thus, to be drawn to self-handicapping?

Findings reported by Tice and Baumeister (1984) indicate that self-esteem is a reasonable candidate. As mentioned previously, they recruited high and low self-esteem subjects and permitted them to practice for an upcoming test of their abilities. Amount of practice was the measure of self-handicapping behavior. Half of the subjects practiced alone (private condition) and half practiced in front of the experimenter (public condition). High self-esteem subjects practiced less (handicapped more) in the presence of the experimenter than when alone, but low self-esteem subjects tended to practice more in public. Thus, we have some evidence that high self-esteem individuals are concerned about their public image and will engage in self-handicapping to protect it.

Unfortunately, other attempts to take an individual differences approach to self-presentational concerns and public self-handicapping have failed to provide consistent findings. Shepperd and Arkin (1989) have speculated that public self-consciousness (Fenigstein *et al.*, 1975) might be associated with the self-presentational motive to handicap. Subjects who scored high and low on the Public Self-Consciousness subscale of the Self-Consciousness Scale were placed in the Rhodewalt and Davison (1986) paradigm in which they were permitted to chose to perform in a diagnostic or nondiagnostic setting. The task was represented as either important or unimportant. High Public Self-Consciousness males who anticipated an ego-relevant test selected the nondiagnostic performance setting more than others, although the percentage doing so raises doubts that subjects were self-handicapping to a reliable degree.

Even more problematic is the fact that Arkin and Shepperd (1988) failed to replicate the high versus low Public Self-Consciousness effect in a study that essentially was identical to that of Shepperd and Arkin (1989). They did, however, find that subjects low in Social Anxiety (another subscale of the Self-Consciousness Scale) self-handicapped in public conditions. The picture is further clouded by the fact that Kolditz and Arkin (1982) reported that separate analyses of their data using median splits on each of the Self-Consciousness Scale subscales (Public Self-Consciousness, Private Self-Consciousness, and Social Anxiety) failed to account for variance in self-handicapping behavior. Findings reported by Gibbons and Gaeddert (1984) are also inconsistent with a self-presentational perspective on self-handicapping. In their investigation self-consciousness was experimentally manipulated, and they found that *non*-self-conscious subjects reported pill side effects that were consistent with strategic self-handicapping.

Even if the data consistently supported the predictive utility of one or the other subscales of the Self-Consciousness Scale, clear understanding of the meaning of these results would be difficult, because Public Self-Consciousness, Private Self-Consciousness, and Social Anxiety are correlated. Moreover, Strube (1985) found, for males but not females, that both Public Self-Consciousness and Social Anxiety are correlated with the SHS. Thus, the operating individual difference and, therefore, the motive are somewhat in question. Additional research is needed to clarify the relations among individual difference variables, self-presentational concerns, and self-handicapping behavior. Just as self-esteem and self-handicapping are intertwined, self- and social-esteem may be inseparable and mutually operative in self-protective behavior (Snyder, Higgins, & Stucky, 1983).

Protection of Self-Efficacy

Arkin and Baumgardner (1985) raised the intriguing possibility that self-handicapping may, at times, be in the service of maintaining one's sense of personal control (see also Rhodewalt & Davison, 1986; Snyder & Higgins, 1988a; Chapter 4, this volume, for similar discussions). In essence, the self-handicapper who is caught in a hopeless situation may entertain the belief that he or she could be effective if it were not for the handicap. This line of speculation leads to the nomination of control-related individual differences as candidates for the prediction of self-handicapping. Arkin and Baumgardner suggest that expectations or fears of no control are the antecedent to this form of self-handicapping and speculate that low self-esteem people or those high on the SHS might be prone to this tactic.

I am aware of no research to date that directly addresses these hypotheses. However, Weidner (1980) reports research that, on the surface, appears to provide findings pertinent to this discussion. She predicted that Type A individuals, because of their concerns about achievement and control, would be more likely to self-handicap than Type B's. In a modification of the Berglas and Jones (1978) paradigm, Weidner instructed Type A and B subjects to perform a pretest in which they received either contingent success feedback or noncontingent failure feedback. They did this in anticipation of taking the actual test. Prior to taking the test, subjects chose to take a performance-facilitating, -hindering, or -neutral drug. The results indicated that noncontingent failure Type A's avoided taking the performance-enhancing drug to a greater extent than subjects in all other conditions. There was no clear evidence, however, that Type A's preferred to self-handicap. Even if they had done so, inferring the underlying motive would have been difficult because achievement motives (failure) were confounded with control motives (noncontingent feedback). Moreover, Harris *et al.* (1986) found Type A or B to be unrelated to self-handicapping attributions.

Finally, because we found the Weidner finding curious, James Davison included a measure of Type A in his dissertation study (Davison, 1985), which was an extension of Rhodewalt and Davison (1986). Among his measures were questions probing subjects about their choice of distracting, facilitating, or neutral music. Type A's, regardless of manipulated condition, opted to perform while listening to distracting music. The reason they provided for this choice was that it made the task more challenging. This finding should raise concern among researchers about the confidence with which they interpret their operationalizations of self-handicapping behavior. It also argues that Type A behavior is not a useful person variable in the study of self-protective behavior and perceptions of self-efficacy. The Type A self-handicapping findings notwithstanding, the Arkin and Baumgardner (1985) hypothesis is interesting and, I believe, merits further investigation.

SELF-HANDICAPPING AND SEX DIFFERENCES

The phenomenon of self-handicapping is provocative and has sparked a full decade of research. One of the most consistent findings in this effort has been that men and women differ in their self-handicapping behaviors. Unfortunately, no systematic investigation of these differences has been undertaken. Thus, one can only speculate, as have others (e.g., Snyder, Ford, & Hunt, 1985), about the nature of these sex effects.

There are only a handful of studies that have directly compared males' and females' self-handicapping behavior. In practically all such cases, males have been found to self-handicap, while females have not. The post hoc conjecturing about these findings has been as varied as the studies in which the differences were observed.

For example, Berglas and Jones (1978) found that males, but not females, who experienced noncontingent success selected a performance-inhibiting drug. Their explanation for this finding centered on differences in the attributions males and females offer for success. It appeared in their data that noncontingent success males were more willing to make ability attributions than were females. Males also appeared to be less confident of their attributions. Although the Berglas and Jones speculation is quite reasonable, the data across the two studies they reported are not completely consistent with this explanation.

In a conceptual replication of Berglas and Jones (1978), Rhodewalt and Davison (1986) used an external acquired handicap (choice of nondiagnostic performance setting) and found that only noncontingent success males handicapped. Unfortunately, we failed to find an interpretable pattern of attributional differences between males and females. Because subjects preferred either distracting music (the handicap) or pleasant music over neutral music, Rhodewalt and Davison speculated that there may be several pathways available to defend against potential threats to self-esteem. Individuals might focus on self-esteem threats (and thus handicap), or they might focus on negative affective states presumed to be associated with such self-esteem threats (and thus attempt to blunt or reduce the affect by listening to pleasant music).

Other sex differences in self-handicapping have been reported. For example, Snyder *et al.* (1985) found that shy males scored higher on a measure of social avoidance in anticipation of taking a test of social intelligence than did shy females. Their account of these findings centered on differences between males and females in the ways shyness is displayed: Shy males tend to be more socially avoidant, while shy females are more passively pleasing (cf. Pilkonis, 1977). Snyder *et al.* thus argued that the dependent measure in their study was a more appropriate handicapping vehicle for males than for females. Finally, Harris and Snyder (1986) reported that males who were uncertain of their self-esteem self-handicapped by withholding practice effort to a greater degree than did self-uncertain females and self-certain males and females. In brief, although there are demonstrations of self-handicapping among females, self-handicapping behavior is more prevalent in males.

There are probably several reasons for the preference for self-handicapping among males. Only additional research directed specifically at

the sex difference issue will be able to unravel the cause(s) of these effects. Nonetheless, existing data might provide some clues concerning which variables might be critical. In order to facilitate the examination of sex differences in self-handicapping, Table 3 presents the available studies organized by subject population (male, female, or both), the mode of self-handicapping (acquired and claimed), the nature of the threat to self-esteem (intellectual ability or social skill), and whether or not certainty of positive performance was manipulated.

At first glance, the findings summarized in Table 3 appear highly inconsistent and not very informative. On closer inspection, however, several themes emerge that might be useful in guiding future research. In addition to the tendency of males to self-handicap more frequently than females, there is very little evidence that females will engage in acquired or behavioral self-handicapping (Leary & Shepperd, 1986). Six studies using only males found behavioral self-handicapping. Of the four studies comparing males and females on behavioral self-handicapping, only Strube and Roemmele (1985) found no gender differences in that both male and female low self-esteem, SHS-defined self-handicappers selected tests nondiagnostic of failure. One other study, that of Tice and Baumeister (1984), apparently did not analyze for sex of subject and is not informative.

In a study designed to test issues other than self-handicapping, Gibbons and Gaeddert (1984) had female subjects ingest a placebo that was represented as being arousing (in one condition it was stated to inhibit performance and in another it was stated to facilitate performance). Attentional self-focus was experimentally manipulated while subjects worked on a mathematics task portrayed to be a correlate of general intelligence. In contrast to self-aware females, non-self-aware females reported experiencing more pill-induced arousal when the arousal could be an excuse for poor performance than when it could not. This finding is consistent with a self-handicapping, self-protective attribution prediction. However, it is probably better categorized as an example of claimed handicapping because subjects did not choose to handicap. Overall, there is fairly consistent evidence that women will claim a handicap, but will not actively erect an impediment to performance.

Two other features of Table 3 are informative. First, evaluative threat has been manipulated in two ways in studies of self-handicapping. Many studies simply manipulate the evaluative feedback and assume it is ego relevant. For example, subjects anticipate an exam that is either a valid measure of some desired ability like intelligence or a test that is unimportant. In contrast, other studies lead subjects to anticipate engaging in an ego-important performance, and they are made uncertain about their ability to perform well. This uncertainty is either manipulated through noncontingent success feedback on practice items or is measured as an individual difference variable such as low self-esteem, high self-uncertainty, test anxiety, or social anxiety. In almost every study in which concerns about ability to perform have been directly manipulated or assessed as an individual difference, males have self-handicapped.

It appears that, for males, it is being called upon to display desired but weakly held self-conceptions that motivates self-handicapping. For females, in contrast, noncontingent success feedback (Berglas & Jones, 1978; Rhodewalt & Davison, 1986) or uncertainty about the self (Harris & Snyder, 1986) does not appear to motivate self-handicapping. Only dispositional test anxiety, which in all likelihood reflects a chronic level of uncertainty about one's ability, has been found to promote self-handicapping in women. And, when females do handicap, it is through the claimed mode of appeals to test anxiety, lack of effort, or traumatic recent experiences rather than through the behavioral mode. As Berglas and Jones (1978) suggested, it may be that differing patterns of performance attributions underlie the differences in self-handicapping behavior between males and females. This contention appears to be well supported empirically (see Ickes & Layden, 1978). For example, Deaux and Emsmiller (1974) examined male and female performance attributions for outcomes on masculine and feminine tasks. Males were more likely than females to attribute success to skill regardless of the nature of the task.

It is also noteworthy that, when women do self-handicap it is in the form that was earlier labeled domain–strategy-specific self-handicapping. That is, test-anxious women will claim test anxiety, and hypochondriacal women will claim symptoms. These data may be taken as further evidence that self-handicapping, as a general strategy, is not normally preferred by women. Perhaps when women do self-handicap, they do so because they have come to learn of the self-handicapping benefits of a behavior initially performed for other reasons.

SUMMARY AND CONCLUSIONS

Do certain individuals have a tendency to engage in self-handicapping behavior more than others? In this chapter this question has been approached from several perspectives and the answer from each appears to be "yes." Research indicates that an aspect of many limiting or apparently defeating behaviors is their potential use as a self-handicap. Individual differences in test anxiety, social shyness, and symptom re-

TABLE 3. Gender Differences in Self-Handicapping

	Handicap	Attribute	Certainty manipulated	Results
I. Males only				
Greenberg, Pyszczynski, & Paisley (1985)	Claimed (test anxiety)	I.Q.	Test anxiety	Test-anxious subjects (S's) handicapped
Higgins & Harris (1988a)	Acquired (alcohol)	I.Q.	Yes	Uncertain S's handicapped
Higgins & Harris (1988b)	Acquired (alcohol)	Social competence	No	Heavy drinkers handicapped
Kolditz & Arkin (1982)	Acquired (drug choice)	I.Q.	Yes	Uncertain S's handicapped
Mayerson & Rhodewalt (1988)	Claimed (reported pain)	I.Q.	Yes	Uncertain S's handicapped
Rhodewalt, Saltzman, & Wittmer (1984)	Claimed & acquired (practice effort)	Athletic ability	???	S's both claimed and acquired when threatened
Tucker, Vuchinich, & Sobell (1981)	Acquired (alcohol)	I.Q.	Yes	Uncertain S's handicapped
Weidner (1980)	Acquired (drug choice)	I.Q.	Yes, but confounded	Uncertain S's handicapped
II. Females only				
Baumgardner, Lake, & Arkin (1985)	Claimed (mood)	Social I.Q.	No	S's used mood as a handicap when it was suggested by the exp.
DeGree & Snyder (1985)	Claimed (high life change)	Social I.Q.	No	High threat S's handicapped
Gibbons & Gaeddert (1984)	Claimed (pill side effects)	I.Q.	No	Non-self-aware S's reported arousal if it served as a handicap
Harris, Snyder, Higgins, & Schrag (1986)	Claimed (effort)	I.Q.	Test anxiety	Test-anxious and high self-esteem S's handicapped
Pyzsczynski & Greenberg (1983)	Claimed (effort)	I.Q.	Yes, expected difference	Anxious S's handicapped
Smith, Snyder, & Handelsman (1982)	Claimed (test anxiety)	I.Q.	Test anxiety	Test-anxious S's handicapped
Smith, Snyder, & Perkins (1983)	Claimed (physical symptom reports)	Social I.Q.	No	Hypochondriacal S's handicapped
III. Males and females				
Berglas & Jones (1978)	Acquired (drug choice)	I.Q.	Yes	Uncertain males handicapped
Harris & Snyder (1986)	Acquired (practice effort)	I.Q.	Yes	Uncertain males handicapped
Snyder, Smith, Augelli, & Ingram (1984)	Claimed (shyness)	Social I.Q.	No	Shy males handicapped
Rhodewalt & Davison (1986)	Acquired (performance setting)	I.Q.	Yes	Uncertain males handicapped
Rhodewalt & Fairfield (1989)	Claimed (effort)	I.Q.	Yes, expected difference	Females who expected hard test handicapped most
Strube (1985)	Claimed (excuses)	Academic performance	No	Only males handicapped
Strube & Roemmele (1985)	Acquired (task choice)	I.Q.	No	No gender differences found. High SHS low self-esteem S's handicapped
Tice & Baumeister (1984, May)	Acquired (practice)	Game performance	No	Sex differences not analyzed

porting, among others, also identify those who frequently self-handicap. These differences were discussed in terms of domain–strategy-specific self-handicaps. That is, individuals are thought to differ in their propensities to use one mode of handicapping or handicap (i.e., symptom reports) in circumscribed domains (i.e., scholastic evaluations).

From a different research perspective, a growing body of evidence shows that one can identify individuals who possess a general inclination to self-handicap across a variety of domains, employing a wide range of handicapping strategies. Although additional validation work is necessary, research with the Self-Handicapping Scale shows promise in this direction.

While the SHS measures preferences for the use of self-protective coping strategies, other research indicates that it is also fruitful to investigate individual differences in the motivational concerns that predispose certain individuals to self-handicap. Individual differences in certainty about desired self-conceptions, in concerns about public images, and perhaps in cares about self-efficacy all tend to promote the use of self-handicapping strategies. Finally, studies consistently reveal differences between males and females in the employment of self-handicapping, although the precise form of and explanation for these differences is not clear.

Taken together these literatures support the merit of an individual differences approach to the study of self-handicapping behavior. At the same time, they highlight the need for additional programmatic and integrative research. In particular, the developmental antecedents of self-handicapping tendencies have received little attention (see, however, Chapter 5 in this volume for further discussion of this issue).

The basic question that needs to be addressed concerns the preconditions that will simultaneously cause people to be uncertain of their traits and abilities and to choose self-handicapping as the coping response over other strategies. Stated differently, one might ask if there is a group of core dispositions or developmental experiences that set the stage for chronic self-handicapping. Jones and Berglas (1978) have proposed that inconsistent (noncontingent) positive reinforcement histories promote self-handicapping. Although there is laboratory evidence to support this contention (Berglas & Jones, 1978, among others), noncontingent positive reinforcements alone do not necessarily, inevitably lead to self-handicapping. The same experiences could just as well lead individuals to overprepare, perseverate, and overachieve (see Jones & Berglas, 1978). Research on individual differences in self-handicapping, then, should focus on the identification of the necessary antecedent conditions that result specifically in chronic self-handicapping.

The findings surveyed in this chapter lead me to propose that individual differences in explanatory style (Peterson & Seligman, 1984) is a likely candidate for future research. It may be that an external explanatory style combines with uncertainty about the self, perhaps stemming from a capricious reinforcement history, to produce the chronic self-handicapper. That is, a person who characteristically construes negative self-relevant outcomes as externally caused and who is uncertain about how to produce a self-flattering outcome or avoid a self-damaging outcome might be the person most drawn to self-handicapping.

The above speculation implicitly suggests a second direction research with the SHS should go. Both the factor structure of the SHS and differences between high and low self-handicappers in the self-attributions they offer for negative events suggest that the SHS may be measuring a general individual difference in the tendency to externalize potential self-damaging outcomes. In other words, the SHS is assessing individual differences in excuse making. If this observation is accurate, then research is needed to demonstrate the relation between SHS-defined high self-handicappers and their use of other self-protective "defenses" such as rationalization and externalization.

Finally, it appears that many of the issues concerning the development and maintenance of individual tendencies to self-handicap would be better understood if a life span approach was employed in research. In order to illustrate this suggestion I return one last time to Lee Trevino.

Trevino may not have been inclined to self-handicap earlier in his career but, perhaps as he aged and his physical skills declined, he became more likely to engage in self-handicapping behavior. Research strategies such as those employed by Cantor and her colleagues would be useful in exploring issues such as how self-handicapping becomes incorporated into the "social intelligence" of the person (Cantor, Norem, Niedenthal, Langston, & Brower, 1987). Investigations of this type would view self-handicapping as a cognitive–behavioral strategy for coping with life tasks such as age-related decline. Such a research strategy would also permit the identification of the individual and situational antecedents, the chronicity, and the short- and long-term benefits and costs associated with strategic self-handicapping.

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