Predictors Of Social Dysfunction: A Multiple Regression Analysis

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***Abstract*—The present study aimed to identify the significant predictors of social dysfunction among adults in Kerala. Social dysfunction is an important dimension of general health, reflecting difficulties in performing daily activities, taking decisions, assuming responsibilities, and maintaining effective social functioning. The study examined the predictive contributions of self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-reliance, spirituality, self-respect, somatic symptoms, anxiety and insomnia, and depression to social dysfunction. The sample consisted of 300 individuals randomly selected from the general population of Kerala, aged between 20 and 40 years. Data were collected using standardized psychological tools, including the Self-Control Scale, General Stress Scale, E-I Inventory, A Self-Profile, Spirituality Scale, General Health Scale, and Personal Information Schedule. Pearson's product-moment correlation and stepwise multiple regression analyses were employed to analyse the data.**

The results revealed that self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, and general stress were significant predictors of social dysfunction, jointly accounting for 28 per cent of the variance ($R = 0.529$, $R^2 = 0.280$). Self-image emerged as the strongest predictor, followed by self-reliance and self-satisfaction. Self-image, self-reliance, self-satisfaction, extraversion, and spirituality showed negative associations with social dysfunction, whereas depression and general stress showed positive associations. The findings highlight the importance of psychological and personal factors in understanding social dysfunction and suggest that enhancing positive self-perception, self-reliance, self-satisfaction, and stress management may contribute to improved social functioning and general well-being.

***Index Terms*—Social dysfunction, self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, general stress, multiple regression.**

I. INTRODUCTION

What is health? A large body of literature has grown up around this question. According to Seedhouse (1986) in modern society many theories of health, with many purposes, are in use:

1. The theory that health is an ideal state: a 'Socratic' goal of perfect well-being in every respect; an end in itself; and to count as health, disease, illness, handicap, and social problems must be absent.
2. The theory that health is the physical and mental fitness to do socially defined daily tasks (i.e., to function normally in the person's own society): a means towards the end of social functioning; and to count as health, all disabling disease, illness and handicap must be absent.
3. The theory that health is a commodity which can be bought or given: the rationale which lies behind medical theory and practice; usually an end for the provider and a means for the receiver; and health is lost in the presence of disease, illness, pain, malady. It might be restored piecemeal.
4. A group of theories, which hold that health, is a personal strength or ability, either physical, metaphysical or intellectual: These strengths and abilities are not commodities which can be given or purchased. Nor are the ideal states. They are developed as personal tasks. They can be lost. They can be encouraged.
5. The World Health Organization's definition of health, used in its constitution in 1947, was 'a state of complete physical, mental and social well-being' (WHO, 1947). This is a holistic definition, that is, it refers to the health of a whole, socially active person. WHO modified the definition of health, recently, as 'a dynamic state of complete physical, mental, spiritual, and social well-being

and not merely the absence of disease or infirmity' (WHO, 1998).

6. Wellness or well-being is the word usually used to denote an excellent state of subjective health, the opposite of which is, by reference to the definitions quoted above, illness. Psychological and social problems lead to a significant proportion of primary health care contacts. The World Health Organization is therefore sponsoring research on a triaxial classification (physical, psychological, social) of health problems (Clare, Gulbinat, & Sartorius, 1992; Broome, & Loewelyn, 1995) to complement traditional medical diagnoses.
7. Kaplan (1990) asserts that it is behavior that is the central outcome of health care: that biological, environmental, and psychological outcomes are simply predictors or mediators of behavioral outcomes. Goldberg (1981) defines general health precisely as a state free from anxiety and sleep disturbances, somatic symptoms, social dysfunction, and severe depression. Goldberg used somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression as the components of general health (This classification of general health was used for the present study).

a). Somatic symptoms

The word 'somatic' means pertaining to body. Symptoms are usually the patient's subjective descriptions of a physical or mental disorder (Carson, Butcher, & Mineka, 2003). somatic symptoms are sometimes associated with physical conditions, sometimes associated with psychological conditions, still sometimes with both psychological and physical conditions. Common somatic symptoms complaints include fatigue, irritability, headaches, sleep disturbances, muscle tension, chest pain, throat pain, shoulder pain, back pain, and quick variations in body temperature (Goldberg, 1981). Some perceive themselves as having good health and their optimistic beliefs help them to remain healthy. Some, on the other hand, perceive themselves as physically weak and it worsens even very simple symptoms in them. Some somatic symptoms may be the product of heredity. Research evidence showed that headaches are relatively higher among women than among men (Carson, Butcher, Mineka, 2003). Both tension and migraine headaches usually appear during adolescence and recur periodically during stressful times (Blanchard, 1994).

b). Anxiety and Insomnia

Everyone experiences anxiety from time to time. It is a natural and common reaction to many of life's difficulties. For some people, however, anxiety becomes a chronic problem. These people experience high levels of anxiety with disturbing regularity. Anxiety is a feeling of apprehension accompanied by sympathetic nervous system arousal, which produces increases in sweating, heart rate, and breathing rate (Sdorow, 1998). Though anxiety is a normal and beneficial part of everyday life, warning us about potential threats, in anxiety disorders it becomes intense, chronic and disruptive of everyday functioning.

Insomnia is the most common sleep disorder. Insomnia refers to chronic problems in getting adequate sleep. It occurs in three basic patterns: (1) difficulty in falling asleep initially, (2) difficulty in remaining asleep, and (3) persistent early-morning-awakening. Nearly everyone suffers occasional sleep difficulties because of stress, disruptions of biological rhythms, or temporary circumstances. Fortunately, these problems clear up spontaneously for most people. However, about 15 percent of adults report severe or frequent insomnia, and another 15 percent complain of mild or occasional insomnia (Bootzin et al., 1993). The prevalence of insomnia increases noticeably during old age (Mellinger, Balter, & Uhlenhuth, 1985).

Insomnia has many causes (Bootzin et al., 1993; Kales & Kales, 1984). In some cases, excessive anxiety and tension prevent relaxation and keep people awake. Insomnia is frequently a side effect of emotional problems, such as depression, or of significant stress, such as pressures at work. Health problems such as back pain, ulcers, and asthma can lead to insomnia. The use of certain drugs, especially such stimulants as cocaine and amphetamines may also lead to problems in sleeping.

Anxiety about sleep difficulties leads to poorer sleep, which increases anxiety further, which in turn leads to even greater difficulties in sleeping (Weiten, 1998).

The most common approach to the treatment of insomnia is prescription of sedative drugs (sleeping pills) (Mendelson, 1990). Anything that relaxes us,

whether it's music, meditation, prayer, or a warm bath, can aid us in falling asleep (Benson, & Klipper, 1988).

c). Social dysfunction

Social dysfunction includes taking more than enough time for usual works, inability to engage in activities, inability in taking decisions, running away from leadership roles, inability to enjoy day-to-day matters, dissatisfaction in one's own working manner, etc., (Goldberg, 1981). Social dysfunction sometimes may be the result of some psychological or physical disorders. Sometimes it is related to personality. Procrastination behavior is a usual feature of social dysfunction.

d). Depression

Most individuals, at one time or another, have periods in which they feel depressed or uncertain. Events seem to be out of control and they see themselves as unable to cope. During such periods, a person may become apathetic, despondent, and withdrawn. For most people, these periods are short lived. After a period of "feeling down" they progress forward. For some, however, those feelings do not dissipate and become over whelming (Ingersoll, 1989). Depression, in the clinical sense of the term, refers to general feelings of sadness, helplessness, and despair. Those who are depressed may feel out of control of their feelings or have vague, unclear feelings of dread (Ingersoll, 1989). Social dysfunction is an important dimension of general health, reflecting an individual's ability to perform daily activities, make decisions, and maintain satisfactory social relationships. Goldberg (1981) identified social dysfunction as one of the four dimensions of the General Health Questionnaire (GHQ-28), emphasizing its significance in psychological well-being. Seedhouse (1986) viewed health as not merely the absence of disease but also as an individual's ability to function effectively in society. Similarly, the World Health Organization (1947) emphasized the physical, mental, and social dimensions of health.

Self-image plays an important role in psychological adjustment. Dufner et al. (2019), in their meta-analytic review, reported associations between positive self-views and psychological adjustment. Positive self-appraisal has also been associated with better social relatedness in research examining social functioning.

Depression is another important factor associated with social dysfunction. Kupferberg, Bicks, and Hasler (2016) highlighted the relationship between depression and difficulties in social interaction, communication, and interpersonal relationships. Renner, Cuijpers, and Huibers (2014) also emphasized the importance of improving social functioning in psychological interventions for depression.

Personality characteristics, particularly extraversion, may influence social participation and psychological well-being. Kroencke et al. (2023) demonstrated the relevance of extraversion to social interactions and well-being. Similarly, Garssen, Visser, and Pool (2021), through a meta-analysis of longitudinal studies, identified a small positive relationship between spirituality or religion and mental health.

The literature also indicates that stress may interfere with psychological adjustment and everyday functioning. Taken together, previous research suggests that personal characteristics, emotional experiences, personality, and spirituality are relevant to understanding social functioning.

The present study extends this understanding by examining the combined predictive contributions of self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-reliance, spirituality, self-respect, somatic symptoms, anxiety and insomnia, and depression to social dysfunction among adults in Kerala.

1.1 Hypotheses

There will be significant predictors of social dysfunction among the variables viz., self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-reliance, spirituality, self-respect, anxiety and insomnia, Somatic symptoms, and depression.

II. METHOD

Participants: The sample consisted of 300 individuals randomly selected from the general population of Kerala. Participants ranged in age from 20 to 40 years.

Variables: The dependent variable was social dysfunction. The independent variables were self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-reliance, self-respect, spirituality, somatic symptoms, anxiety and insomnia, and depression. The General Health Scale

comprised four dimensions: somatic symptoms, anxiety and insomnia, social dysfunction, and depression.

Tools

- Self-Control Scale I (Ajilal & Raju, 2003)
- General Stress Scale (Ajilal & Raju, 2003)
- E–I Inventory (Ajilal & Raju, 2003)
- A Self-Profile (Ajilal & Raju, 2003)
- Spirituality Scale (Sreekumar & Sananda Raj, 2002)
- General Health Scale (Laiju & Sananda Raj, 2002)
- Personal Information Schedule

Procedure for data collection

The investigator met each participant individually and obtained informed consent before participation. Necessary information regarding the purpose and importance of the study was provided to all participants. Subsequently, the seven tools were administered to each participant as a set in the following order: Personal Information Schedule, E-I Inventory, General Stress Scale, SC Scale I, A Self-Profile, Spirituality Scale, and General Health Scale. Participants were instructed to respond independently and honestly to all items. All the instruments used in the study were self-administered. Necessary instructions were printed on each tool; therefore, no separate instructions were required. However, the investigator provided clarifications whenever necessary. The investigator ensured that participants completed the questionnaires independently. Completed questionnaires were collected immediately.

Statistical techniques

The data were analysed using Pearson's product-moment correlation and stepwise multiple regression.

III. RESULTS AND DISCUSSION

To identify the predictors of social dysfunction, a stepwise multiple regression analysis was conducted, with social dysfunction as the dependent variable. The independent variables were self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-respect, self-reliance, spirituality, somatic symptoms, anxiety and insomnia, and depression. Seven variables emerged as significant predictors: self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, and general stress. Self-control, self-confidence, self-respect, somatic symptoms, and anxiety and insomnia did not make significant contributions to the model and were therefore excluded from the final regression equation. The results are presented in Table 1.

Table 1-Results of Regression Analysis with Social dysfunction as Dependent Variable

Sl. No	Variable	B	Std. Error	Beta	R	R2
1	Self-image	-.161	.034	-.259	.444	.197
2	Self-reliance	-.118	.026	-.221	.482	.232
3	Self-satisfaction	-.103	.030	-.198	.492	.242
4	Depression	.094	.037	.141	.502	.252
5	Extraversion	-.056	.022	-.116	.511	.261
6	Spirituality	-.031	.012	-.115	.519	.269
7	General stress	.039	.016	.120	.529	.280
Constant		39.35	2.44	-	-	-

The regression results presented in Table 1 show that the seven significant predictors jointly explained 28.0% of the variance in social dysfunction ($R = 0.529$, $R^2 = 0.280$).

Self-image was the first variable included in the final regression equation. This variable independently explained 19.7 percent of variance in social dysfunction. The multiple correlation (R) was 0.444 and R^2 was 0.197. The beta value obtained for self-image was -0.259. The negative nature of beta value showed that a higher social dysfunction score was associated with low score in self-image.

Self-reliance was the second variable entered into the regression equation. It contributed an additional 3.5 percent of variance in social dysfunction. That is, it raised the multiple correlation (R) from 0.444 to 0.482

and therefore the R^2 raised from 0.197 to 0.232. The second R^2 (0.232) showed that self-image and self-reliance together explained 23.2 percent of variance in social dysfunction. The beta value obtained for self-reliance was -0.221, indicating that an increase in the social dysfunction score was associated with a decrease in self-reliance score, and vice versa.

Self-satisfaction, the third variable entered into the regression equation, explained an additional 1.0% of the variance in social dysfunction, increasing the multiple correlation (R) to 0.492. Therefore, the R^2 rose from 0.232 to 0.242. The R^2 (0.242) showed that 24.2 percent of variance in social dysfunction was jointly explained by the variables self-image, self-reliance, and self-satisfaction. The beta value of self-satisfaction (Beta = -0.198) showed that a higher social dysfunction score was related to low score in self-satisfaction.

Depression was the fourth variable entered into the regression equation. The beta value obtained for depression was 0.141. It indicated that there was a positive association between depression and social dysfunction, that is, an increase in social dysfunction was associated with an increase in depression. Depression raised the multiple correlation (R) from 0.492 to 0.502 by contributing to explain an additional 1 percent variance in social dysfunction. The obtained R^2 was 0.252, which showed that 25.2 percent of variance in social dysfunction was jointly explained by the variables self-image, self-reliance, self-satisfaction and depression.

Next variable entered into the regression equation was extraversion. Extraversion explained an additional 0.9% of the variance in social dysfunction, increasing the multiple correlation (R) to 0.511. Then the R^2 was 0.261. This R^2 showed that the variables self-image, self-reliance, self-satisfaction, depression, and extraversion together explained 26.1 percent of variance in social dysfunction. The beta value obtained by extraversion was -0.116. This negative beta value showed that an increase in social dysfunction was associated with a decrease in extraverted behaviour, and vice versa.

Spirituality was the sixth variable entered into the regression equation. It increased the multiple correlation (R) to 0.519, explaining an additional 0.8% of the variance in social dysfunction. The obtained R^2 was 0.269. This indicates that 26.9% of the variance in social dysfunction was explained jointly by six variables: self-image, self-reliance, self-satisfaction, depression, extraversion, and spirituality. The beta value for spirituality was -0.115. It indicated that there was a negative association between spirituality and social dysfunction.

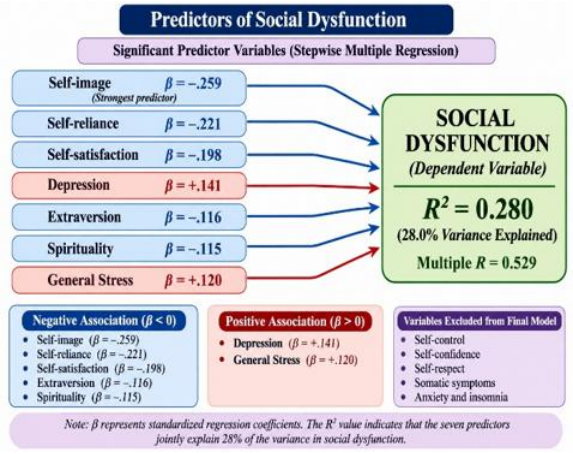
General stress was the seventh and final variable entered into the regression equation. The beta value obtained for general stress was 0.120. The beta value indicated that the relationship between general stress and social dysfunction was positive in nature. General stress explained an additional 1.1% of the variance in social dysfunction. It was evident from the obtained multiple correlation. The multiple correlation (R) was 0.529 and R^2 was 0.280. The R^2 showed that 28.0 percent of variance in social dysfunction was explained by a linear combination of the seven variables, namely, self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, and general stress.

To compare the strength of contribution made by each variable, the beta value was used. Self-image had the largest absolute standardized beta coefficient among the seven predictors. This showed that self-image made the strongest unique contribution to explaining social dysfunction than the variance explained by all the other six variables individually. Self-reliance had the next-largest absolute standardized beta coefficient, indicating the next-strongest unique contribution. Spirituality had the smallest absolute standardized beta coefficient, indicating the weakest unique contribution.

Using the unstandardized regression coefficients (B) and the constant, the following regression equation was formulated:

$$Y = 39.352 - 0.161X_1 - 0.118X_2 - 0.103X_3 + 0.094X_4 - 0.056X_5 - 0.031X_6 + 0.039X_7$$

where Y = social dysfunction; X_1 = self-image; X_2 = self-reliance; X_3 = self-satisfaction; X_4 = depression; X_5 = extraversion; X_6 = spirituality; and X_7 = general stress.



The regression analysis indicated that lower self-image, lower self-reliance, lower self-satisfaction, lower spirituality, lower extraversion, and higher levels of depression and general stress were associated with higher social dysfunction scores. Among these predictors, self-image had the largest absolute standardised beta coefficient. Social dysfunction, as measured in this study, includes taking an unusually long time to complete routine activities, difficulty assuming responsibility in social activities, difficulty making decisions, and an inability to enjoy day-to-day activities. These findings suggest that personal self-evaluation, independence, emotional well-being, and stress are relevant to social functioning. However, the associations identified in this study should not be interpreted as causal relationships.

IV. DISCUSSION

The present study examined the psychological and personal predictors of social dysfunction among adults in Kerala. The findings revealed that seven variables self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, and general stress were significant predictors of social dysfunction. Together, these variables explained 28% of the variance, indicating that social functioning is associated with a combination of personal and psychological factors.

Self-image emerged as the strongest predictor, followed by self-reliance and self-satisfaction. Their negative associations with social dysfunction suggest that positive self-perception, independence, and satisfaction with oneself may be important for effective everyday functioning. This finding is broadly consistent with Dufner et al. (2019), who reported an association between positive self-views and psychological adjustment.

Depression and general stress were positively associated with social dysfunction. This indicates that individuals experiencing greater emotional distress may also experience more difficulties in daily activities and social functioning. Kupferberg et al. (2016) highlighted the close relationship between depression and impaired social functioning. Extraversion and spirituality showed negative associations with social dysfunction, suggesting that interpersonal engagement and a sense of meaning may also be relevant to psychological well-being. Garssen et al. (2021) reported a small positive association between spirituality or religion and mental health. Overall, the findings highlight the importance of considering both personal strengths and emotional difficulties when understanding social dysfunction. However, the cross-sectional nature of the study does not establish causal relationships. Further research involving larger and more diverse samples may help clarify these relationships.

V. CONCLUSION

The present study was undertaken to identify the psychological and personal variables that significantly predict social dysfunction among adults in Kerala. The study examined the contribution of self-control, general stress, extraversion, self-image, self-confidence, self-satisfaction, self-reliance, spirituality, self-respect, anxiety and insomnia, somatic symptoms, and depression.

The findings of the stepwise multiple regression analysis revealed that self-image, self-reliance, self-satisfaction, depression, extraversion, spirituality, and general stress were significant predictors of social dysfunction. The overall regression model produced a multiple correlation coefficient of 0.529 and explained 28% of the variance in social dysfunction.

Among the significant predictors, self-image emerged as the strongest predictor, followed by self-reliance and self-satisfaction. Depression and general stress showed positive associations with social dysfunction, whereas self-image, self-reliance, self-satisfaction, extraversion, and spirituality showed negative associations.

The findings indicate that social dysfunction is associated with a combination of personal self-

evaluation, independence, emotional experiences, personality characteristics, and psychological resources. The study therefore highlights the importance of understanding social functioning beyond the mere presence of psychological symptoms. Overall, the findings provide useful insights into the psychological and personal factors associated with everyday social functioning among adults in Kerala.

A. Implications of the Study

The findings have several theoretical and practical implications.

1. Importance of positive self-image: Since self-image emerged as the strongest predictor, programs promoting positive self-evaluation, self-awareness, and personal acceptance may be valuable areas for psychological well-being initiatives.
2. Promotion of self-reliance: The significant contribution of self-reliance highlights the relevance of independence, decision-making, and personal responsibility in everyday functioning.
3. Development of self-satisfaction: Encouraging realistic self-appraisal and a healthy sense of personal satisfaction may support psychological adjustment and effective daily functioning.
4. Attention to emotional well-being: The significant associations of depression and general stress with social dysfunction emphasize the importance of identifying and addressing emotional distress.
5. Recognition of personality factors: The contribution of extraversion suggests that interpersonal engagement and opportunities for meaningful social participation deserve attention, without treating introversion as a dysfunction.
6. Role of spirituality: The association between spirituality and lower social dysfunction indicates that personal meaning and spiritual resources may be relevant to psychological well-being.
7. Implications for counselling and mental health programs: The findings may help counsellors, psychologists, and mental health professionals consider both personal strengths and psychological difficulties when assessing social functioning.

B. Limitations of the Study

The findings should be interpreted in the light of the following limitations:

1. The sample consisted of 300 adults from Kerala aged between 20 and 40 years. Therefore, the findings may not be generalisable to all age groups or populations.
2. The study was based on self-reported responses, which may have been influenced by individual perceptions, response tendencies, and social desirability.
3. The cross-sectional research design does not establish cause-and-effect relationships among the variables.
4. The study considered only twelve selected psychological and personal variables. Other factors, such as family relationships, socioeconomic conditions, occupational experiences, and social support, may also be associated with social dysfunction.
5. The regression model explained 28% of the variance in social dysfunction, leaving 72% unexplained by the variables included in the model.
6. The use of stepwise multiple regression may make the selection and order of predictors sensitive to the particular sample. The findings therefore require confirmation through further research.

C. Suggestions for Future Research

Based on the findings and limitations, the following suggestions are proposed:

1. Future studies may include a larger sample drawn from different districts of Kerala to improve the representativeness of the findings.
2. Similar studies may be conducted among adolescents, middle-aged adults, and older adults to examine age-related differences in social dysfunction.
3. Comparative studies may be undertaken across gender, rural and urban backgrounds, educational levels, and occupational groups.
4. Future researchers may include additional variables such as family support, social support, resilience, coping strategies, emotional intelligence, and socioeconomic status.
5. Longitudinal studies may be conducted to understand how psychological and personal characteristics are associated with changes in social functioning over time.

6. Further research may examine the possible mediating and moderating roles of self-image, self-reliance, depression, and stress in social functioning.
7. Intervention-based studies may be undertaken to evaluate whether programs aimed at strengthening self-image, self-reliance, stress management, and emotional well-being are associated with improvements in social functioning.
8. Future studies may use different research methods, including interviews and qualitative approaches, to obtain a deeper understanding of individuals' experiences of social dysfunction.

D. Final Observation

The present study emphasizes that effective social functioning is closely associated with how individuals perceive themselves, manage their personal responsibilities, and respond to emotional challenges. The prominence of self-image, self-reliance, and self-satisfaction suggests that personal strengths deserve attention alongside psychological difficulties.

The findings offer a meaningful foundation for further research and for developing approaches that promote psychological well-being and effective everyday functioning. Ultimately, understanding social dysfunction requires an integrated perspective that recognises the relationship between the individual, personal resources, emotional experiences, and the social environment.

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