Primenjena psihologija
Vol. 15, No. 1, pp. 3-27, 2022

Research Article

The relevance of authenticity to clinical distress: Reaffirming the role of self-alienation

Katerina Naumova ✉[1] and Florijan Naumov[2]

[1] *Department of Psychology, Faculty of Philosophy, Ss. Cyril and Methodius University in Skopje, North Macedonia*

[2] *University Clinic of Psychiatry, Medical Faculty, Ss. Cyril and Methodius University in Skopje, North Macedonia*

ABSTRACT

Several counselling psychology perspectives have argued that authenticity should be the primary goal of treatment, while defining alienation from the self as the root cause of distress and psychopathological suffering. Recent findings have provided evidence that the tripartite model of dispositional authenticity based on Rogers' person-centered theory can predict mental well-being. Considering the lack of research in clinical samples, this study examined the unique predictive utility of trait authenticity for distress in outpatients seeking counselling (N = 105, 58% female; age range: 18-65) and demographically matched controls (N = 102, 62% female; age range: 18-52 years). Most of the outpatients were diagnosed with anxiety and/or mood disorders, while the controls were screened for utilization of mental health services. Results revealed higher self-alienation and acceptance of external influence in the clinical sample, as well as higher neuroticism and symptomatic and overall distress relative to controls. Only self-alienation was able to account for unique variance in clinical distress in outpatients, above and beyond neuroticism, reaffirming the assumption that the greater the discrepancy between actual experiences and their symbolization, the greater the risk of psychological dysfunction. The findings further revealed a differentiated role of self-alienation relative to the severity of experienced distress and a need to examine causal links with neuroticism. Implications

regarding clinical practice and the measurement of authenticity as treatment outcome are discussed.

Keywords: authenticity, self-alienation, person-centered theory, psychological distress

UDC: 159.944:615.851
DOI: 10.19090/pp.v15i1.2361
Received: 10.09.2021.
Revised: 26.11.2021.
Accepted: 02.12.2021.

✉ Corresponding author email: knaumova@fzf.ukim.edu.mk

Introduction

Several counselling psychology perspectives have argued that authenticity should be the primary goal of treatment. For instance, authenticity is conceptualized as critical to psychological functioning in psychodynamic (Horney, 1951; Winnicot, 1965), humanistic (Rogers, 1954, 1961) and existential (May, 1981; Yalom, 1980) psychology. Accordingly, alienation from the self as its core component is at the root of distress and psychopathological suffering. The study of authenticity has undoubtedly provoked interest in other fields, such as developmental (Harter, 2002), social (Kernis & Goldman, 2006) and positive psychology (Smallenbroek et al., 2016), however, since the mid-2000s, the empirical interest in this topic in counselling psychology has revived as well. Although conceptual inconsistencies prevail in the literature and often obscure efforts to compare and interpret findings, in the context of counselling psychology, the humanistic model has provided the most comprehensive framework.

Within the person-centered approach (PCA), Rogers (1961, 1980) defined congruence (genuineness/realness) as accurate matching of experience, awareness, and communication. He conceptualized it both as a condition of therapeutic presence and as the upper end of the continuum of change that clients experience. According to the PCA all psychopathology stems from distorted conscious representations of experiences due to alienation from the self (Patterson, 2017). Based on Rogers' theory, Barrett-Lenard (1998, p.82) subsequently proposed a tripartite model of authenticity (congruence), defining it as the "consistency between the three levels of (a) a person's primary experience, (b) their symbolized awareness, and (c) their outward behavior and communication". In an effort to provide a psychometrically sound measure of dispositional authenticity, Wood et al. (2008) further specified this model, designating incongruence between the first two levels - the true self and cognitive awareness - as self-alienation; defining life in accordance with one's values and beliefs as authentic living; and denoting acceptance of external influence as the tendency to conform to expectations of others and allow influences of others to distort self-

perception or prevent authentic behavioral expression of one's self. Hence, authenticity is comprised of low self-alienation, i.e., having an identity consistent with beliefs, feelings and objective reality; high authentic living, that is living in accordance with one's identity, and low acceptance of external influences that are not in line with one's beliefs. Therefore, the greater the mismatch between actual experiences and their symbolization, the greater the risk of dysfunction or psychopathology. However, from a humanistic-experiential point of view, what is defined as alienation or maladjustment from an external frame of reference, is experienced as 'psychological suffering' from an internal frame of reference (Schmid, 2005).

Authenticity as core cause of mental well-being has recently been examined in various cultures, although, all studies have relied on college or community samples. Research that specifically utilized the authenticity scale by Wood et al. (2008) has shown negative associations with psychological distress, negative affect (depression and anxiety), perceived stress, psychological vulnerability, self-handicapping behavior, and aggression (Akin & Akin, 2014; Boyraz & Kuhl, 2015; Grijak, 2017; Pinto et al., 2012; Satici et al., 2013; Wood et al., 2008), as opposed to positive association with life satisfaction, positive affect, self-esteem, unconditional positive self-regard and general well-being (e.g., Grégoire et al., 2014; Pillow et al., 2017; Wood et al., 2008). Additionally, there is some evidence that trait authenticity is moderated by culture (Robinson et al., 2012; Slabu et al., 2014) and predicts positive mental health more strongly than context-specific authenticity measures. One longitudinal study (Boyraz et al., 2014) further found that lack of authenticity increases psychological distress. Among the three components, it seems that self-alienation is most important to affective functioning (Stevens, 2016; Wood et al., 2008). It is worth noting that studies predominantly examined the links with positive mental health indicators, consistent with the humanistic model of psychological functioning.

Research has further shown that perceived authenticity is related to other personality traits, although it cannot be reduced to them. For instance, quite predictably, it is negatively related to neuroticism, while positively to

the other Big Five traits, albeit to a varying degree (Grégoire et al., 2014; Wood et al., 2008). One study also found that authenticity loads on the honesty-humility factor of personality (Maltby et al., 2012).

Considering the lack of research in clinical samples as opposed to the conceptualized relevance of (in)authenticity to psychopathological distress, the objective of the current study is to examine the unique predictive utility of trait authenticity with respect to symptomatic and overall distress in outpatients seeking counselling services. We will include gender and age as control variables, as well as neuroticism since it has been consistently evidenced to be a transdiagnostic risk factor for psychopathology (Jeronimus et al., 2016), while few studies have found a moderate bidirectional association between neuroticism and authenticity. Based on the literature and empirical findings, we hypothesize that a) authenticity dimensions have a significant incremental contribution to the prediction of clinical distress, and b) self-alienation is a stronger predictor of symptomatic and overall distress than authentic living and acceptance of external influence.

Method

Participants

The clinical sample consisted of 105 outpatients referred to counselling at a psychiatric clinic (58% female; M_{age}= 28.6 ± 9.4; range: 18-65 years; 55% had a university degree, 45% had secondary education). Most had been diagnosed with anxiety and/or mood disorders (anxiety disorders 46.7%; mood disorders 20.9%; mixed anxiety and depressive disorder 20%), while other disorders were less prevalent (psychosis 5.7%; conduct disorder 2.9%; personality disorder 1.9% and psychoactive substance use 1.9%). Only individuals who had less than three counselling sessions before data collection began were invited to participate. Over half (59%) responded to measures as part of an extensive psychological assessment prior to their first counselling session (21% prior to the second and 20% prior to the third session). None of the invited outpatients declined to participate and all

provided informed consent. The data was collected from December 2018 until June 2019.

Due to lack of normative data for the utilized measures, we recruited a demographically matched control sample (N = 102; 62% female; M_{age}= 30 ± 9.4; range: 18-52 years; 56% had a university degree, 44% had secondary education). Thus, controls did not differ significantly from outpatients in age ($t(205) = -1.08$, $p = .28$), gender ($\chi^2(1) = 0.29$, $p = .59$), or education ($\chi^2(1) = 0.00$, $p = .99$). Potential participants were recruited from the general population through snowball sampling by trained undergraduate psychology students for course credit (during May-June 2019 and November 2019-February 2020). All were screened for utilization of mental health services in the previous six months (based on self-reports) and provided informed consent to participate in the study.

Data in both samples were collected via the paper-and-pencil method. Personal identifiers were not recorded. Procedures performed in the study were in accordance with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

The data reported in this manuscript were collected as part of a larger data collection. The data on psychological distress provided by the clinical sample and half of the control sample were used in Blazhevska-Stoilkovska and Naumova (2020), however, the relationships examined in this paper have not been previously published.

Instruments

Brief Symptom Inventory (BSI)

Psychological distress was measured with the 53-item Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983, for model fit of the Macedonian adaptation partially based on this data set see Blazhevska-Stoilkovska & Naumova, 2020). It is one of the most widely used multidimensional self-report instruments that measures nine symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Number of items per

subscale ranges from four to seven, with most subscales comprising five or six items. Participants rate the level of distress experienced during the previous seven days on a 5-point scale (from 0 = *not at all* to 4 = *extremely*). Higher mean scores indicate higher symptomatic distress, i.e., specific dimensional psychopathology (Derogatis, 2017). From the three available global distress indices, for the purpose of this study, only the General Severity Index (GSI) is utilized as the most sensitive indicator of overall distress, since it combines data on the number of experienced symptoms and the intensity of perceived distress. In defined clinical populations the BSI complements expert clinical judgement on one's psychological status. Cronbach's α for all subscales and the GSI are presented in Table 1.

The Authenticity Scale

The Authenticity Scale (Wood et al., 2008) was used as a measure of dispositional authenticity, created in line with the tripartite authenticity model. Accordingly, it consists of three subscales, each comprising four items: self-alienation, authentic living and accepting external influence. Participants respond on a 7-point scale (from 1 = *does not describe me at all* to 7 = *describes me very well*), with higher total scores indicating greater self-alienation and acceptance of external influence, as well as a more pronounced tendency of living in accordance with one's identity. The authors report that the subscales correlate with well-being measures and the Big Five traits. CFA revealed good fit of the proposed three-factor structure of the scale in the clinical sample and acceptable fit in the control sample (Schermelleh-Engel et al., 2003). Due to multivariate non-normality and samples sizes the MLM estimator was used (outpatients: $\chi^2(51) = 58.36$, $p = .22$, *CFI* = .98, *TLI* = .97, *RMSEA* = .04, *SRMR* = .07; controls: $\chi^2(51) = 68.70$, $p = .05$, *CFI* = .96, *TLI* = .95, *RMSEA* = .06, *SRMR* = .06). Cronbach's α (Table 1) indicate satisfactory internal consistencies in both samples.

Neuroticism from Big Five Inventory (BFI)

Neuroticism was measured with the 8-item subscale from the Big Five Inventory (BFI; John & Srivastava, 1999). The items consist of short phrases

assessing prototypical markers of neuroticism, although three items are worded positively and reversely scored. Participants rate each item on a 5-point scale (from 1 = *does not describe me at all* to 5 = *describes me very well*). Considering the ease of responding, the original strongly disagree-strongly agree response format was replaced with the Authenticity Scale categories. Higher mean scores indicate higher neuroticism. CFA revealed good fit of the unidimensional structure of the scale in both samples (Schermelleh-Engel et al., 2003) when correlated errors of positively worded items and selected negatively worded items were included in the model. Data were multivariate normal, so the ML estimator was used (outpatients: $\chi^2(15) = 19.72$, $p = .18$, *CFI* = .98, *TLI* = .96, *RMSEA* = .06, *SRMR* = .04; controls: $\chi^2(16) = 18.50$, $p = .29$, *CFI* = .99, *TLI* = .99, *RMSEA* = .04, *SRMR* = .04). The internal consistency of the scale is satisfactory in both samples (Table 1).

Prior mental health service utilization

Data on prior mental health service utilization was collected by asking potential controls "Have you seen a psychologist and/or psychiatrist in the previous six months (for counselling, psychotherapy and/or pharmacotherapy?" Response categories were a) No; b) Yes, on few occasions (1-3 sessions); c) Yes, on many occasions or continuously for a longer period. Only individuals who have not used any mental health services were included in the control sample.

Preliminary Data Screening

In the clinical sample, 18 cases had missing data, almost all on one or two items, while in the control sample 4 cases had missing data on one item. Little's MCAR test showed that data were missing completely at random (outpatients: $\chi^2 = 1290.14$, $df = 1282$, $p = .43$; controls: $\chi^2 = 314.54$, $df = 288$, $p = .13$), thus imputation was conducted with the EM method.

With respect to the regression analyses, based on standardized residual values > ± 3.3, two outliers were detected in the control sample (one per separate regression model). However, the diagnostic plots revealed that

these were not influential observations and were not excluded from the analyses.

Statistical analysis

Confirmatory factor analyses (CFA) were conducted using the Lavaan package (Rosseel, 2012) in R environment (R Core Team, 2020). Model fit was evaluated using recommendations by Schermelleh-Engel et al. (2003) for good fit: $0 \leq \chi^2 \leq 2df$, *CFI* ≥ .97, *TLI* ≥ .97, *RMSEA* ≤ .05, *SRMR* ≤ .05; and acceptable fit: $2df < \chi^2 \leq 3df$, *CFI* < .97, *TLI* < .97, *RMSEA* ≤ .08, *SRMR* ≤ .10. All other analyses were conducted in SPSS 24.0.

Results

The initial comparison of the clinical and control sample (Table 1) revealed that the experiences of outpatients are significantly more distant from their beliefs, feelings and objective reality, as well as more conforming to expectations of others. The participants did not, however, differ significantly in authentic living. Neuroticism was also significantly higher in the clinical sample, as well as all dimensions of psychological symptoms and overall distress, with anxiety and obsession-compulsion being most pronounced in both groups. It is worth noting that medium to large effect sizes were found between the differences.

Table 1

Descriptives, Cronbach's alphas and mean differences

	Outpatients		Controls		Samples differences	
Authenticity Scale	*M (SD)*	α	*M (SD)*	α	*t*(205)	*d*
Self-alienation	14.52 (6.03)	.72	9.93 (5.60)	.85	5.68***	0.79
Authentic living	21.58 (4.76)	.71	21.71 (4.90)	.75	-.18	0.03
Accepting external influence	15.25 (6.55)	.87	11.08 (4.77)	.77	5.22***	0.73
BFI	*M (SD)*	α	*M (SD)*	α	*t*(205)	*d*
Neuroticism	3.41 (.80)	.79	2.64 (.87)	.85	6.62***	0.92
BSI	*M (SD)*	α	*M (SD)*	α	*t*(205)	*d*
Somatization	1.18 (.95)	.86	.76 (.66)	.80	3.63***	0.51
Obsession-compulsion	1.78 (1.05)	.86	1.10 (.81)	.83	5.21***	0.72
Interpersonal sensitivity	1.56 (.96)	.68	.73 (.72)	.76	7.19***	0.98
Depression	1.64 (1.00)	.85	.75 (.75)	.84	7.29***	1.01
Anxiety	1.96 (1.02)	.87	1.12 (.80)	.84	6.56***	0.92
Hostility	1.34 (.95)	.79	.86 (.81)	.82	3.91***	0.54
Phobic anxiety	1.19 (.95)	.73	.42 (.54)	.66	7.17***	1.00
Paranoid ideation	1.48 (.95)	.76	.98 (.74)	.72	4.26***	0.59
Psychoticism	1.21 (.81)	.68	.58 (.63)	.68	6.19***	0.87
General Severity Index	1.48 (.74)	.96	.82 (.55)	.96	7.37***	1.01

Notes. BFI = Big Five Inventory; BSI = Brief Symptom Inventory. *** $p < .001$

Bivariate correlations (Table 2) revealed similar patterns of association between authenticity dimensions and psychological symptoms in both samples. Self-alienation was moderately to strongly positively correlated to all symptom dimensions, with the strength of association being highest for depression, psychoticism and obsession-compulsion. Accepting external influence had small to moderate positive associations with all symptom dimensions, being most relevant to interpersonal sensitivity, depression and psychoticism, while authentic living was weakly and negatively correlated to psychopathology, being most relevant to depression. Additionally, neuroticism and authenticity components were moderately related in both samples (outpatients: r = .45 with self-alienation, r = -.26 with authentic living, r = .29 with accepting external influence; controls: r = .53 with self-alienation, r = -.23 with authentic living, r = .32 with accepting external influence). Lastly, self-alienation was moderately related to authentic living (outpatients: r = -.21; controls: r = -.24) and accepting external influence (outpatients: r = .40; controls: r = .37), while authentic living was insignificantly related to acceptance of external influences in both samples (outpatients: r = - .17, controls: r = - .15).

Table 2

Correlations between authenticity dimensions and psychological symptoms in outpatients and controls

	SOM	OC	IS	DEP	ANX	HOS	PA	PI	PSY	GSI
Self	.40***	.53***	.45***	.62***	.36***	.24*	.37***	.24*	.56***	.54***
alienation	(.36***)	(.60***)	(.58***)	(.69***)	(.53***)	(.40***)	(.46***)	(.47***)	(.71***)	(.70***)
Authentic	-.14	-.23*	-.19	-.29**	-.17	-.06	-.08	.00	-.23**	-.20*
living	(-.05)	(-.11)	(-.18)	(-.22*)	(-.01)	(-.11)	(-.15)	(-.15)	(-.15)	(-.15)
Accepting	.25*	.23*	.33**	.30**	.24*	.04	.17	.21*	.26**	.29**
ext. influence	(.16)	(.29**)	(.36***)	(.26**)	(.23*)	(.05)	(.16)	(.20*)	(.36***)	(.30**)

Notes. Control sample correlations presented in parentheses. SOM=Somatization; OC=Obsession-compulsion; IS=Interpersonal sensitivity; DEP=Depression;

ANX=Anxiety; HOS=Hostility; PA=Phobic anxiety; PI=Paranoid ideation; PSY=Psychoticism; GSI=General Severity Index.

* $p < .05$, ** $p < .01$, *** $p < .001$.

We then conducted two series of hierarchical regression analyses to examine the unique predictive power of authenticity with respect to symptomatic and overall distress, after controlling for the effects of demographic and personality covariates. The assumptions of linearity and independence of errors, as most relevant assumptions of regression analysis, were not violated in any model in both samples. Normality of errors was mildly violated in several models in the control sample, while homoscedasticity was mildly violated in several models in both samples, however, due to sample sizes, the regression models can be considered robust to mild violations of these two assumptions (Ernst & Albers, 2017). As for multicollinearity, the obtained *VIF* values were < 1.70 and *Tolerance* values were > 0.60.

In all models, gender and age were included in the first block, neuroticism in the second and the three authenticity dimensions in the final block. The analyses for both samples are presented comparatively in Table 3 and Table 4. In the clinical sample, the demographic covariates account for a small degree of variance in symptomatic and overall distress, however, their contribution is significant only for somatization and anxiety symptoms (Table 3). Neuroticism accounted for a considerable degree of variance in all models (highest for anxiety and overall distress, lowest for paranoid ideation). Adding the dimensions of authenticity in the final block, significantly increased the predictive power of several models, with self-alienation being the only dimension with a significant contribution. More specifically, self-alienation accounted for a considerable degree of variance in depression, psychoticism, obsession-compulsion and to a lesser degree in interpersonal sensitivity and overall distress. Considering the significant zero-order correlations with all other symptom dimensions, exploratory mediation analyses were conducted and revealed that neuroticism fully mediated the effect of self-alienation on anxiety and somatization, and partially mediated its effect on hostility.

However, a causal relationship between self-alienation and neuroticism was not the focus of this study, thus further exploratory analyses were not conducted.

Table 3

Authenticity dimensions as predictors of somatization, obsession-compulsion, interpersonal sensitivity, depression and anxiety in outpatients and controls

	Outpatients					Controls				
Block and Variables	SOM	OC	IS	DEP	ANX	SOM	OC	IS	DEP	ANX
Gender	.25*	.05	.03	.08	.26**	.03	.12	.13	.04	.14
Age	-.04	-.05	-.20*	-.12	.06	-.05	-23*	-.22*	-.27**	-.17
ΔR^2	.07*	.00	.04	.02	.07*	.00	.07*	.07*	.07*	.05
Neuroticism	.49***	.52***	.52***	.53***	.65***	.32**	.46***	.52***	.48***	.64***
ΔR^2	.22***	.25***	.24***	.25***	.38***	.09**	.20***	.24***	.20***	.36***
Self-alienation	.19	.40***	.22*	.47***	.08	.30*	.48***	.38***	.59***	.30**
Authentic living	.01	-.08	-.02	-.12	.01	.06	.05	-.01	-.05	.18*
Accepting ext. influence	.05	-.02	.16	.02	.02	.01	.03	.12	-.03	-.02
ΔR^2	.03	.13***	.08**	.20***	.01	.06	.16***	12***	.24***	.08**

Notes. Gender – 0 = *male*, 1 = *female*. SOM - Somatization; OC - Obsession-compulsion; IS - Interpersonal sensitivity; DEP - Depression; ANX - Anxiety.

* $p < .05$, ** $p < .01$, *** $p < .001$.

In the control sample, demographic covariates significantly predicted obsession-compulsion, interpersonal sensitivity and depression symptoms (Table 3) as well as overall distress (Table 4), however, only age made a significant contribution to these models. The indicators of symptomatic and overall distress in this sample can thus be interpreted as primarily reflecting developmentally normative fluctuations in negative affect and interpersonal functioning. The findings on neuroticism are identical to the ones in the clinical sample, the only difference being that this trait is less relevant to

somatization in the control sample. Finally, with respect to authenticity, the results are quite similar, although in controls authenticity is also relevant to anxiety (with authentic living having a significant contribution apart from self-alienation) (Table 3). Furthermore, it accounted for a higher degree of variance in psychoticism and overall distress (Table 4).

It is noteworthy that, due to both positive and negative associations between authenticity dimensions, suppressor effects were present in the models. The two most evident cases were the models for anxiety (Table 3) and hostility in the control group (Table 4), with significant beta weights for authentic living and acceptance of external influences being opposite in sign relative to their respective zero-order correlations.

Table 4

Authenticity dimensions as predictors of hostility, phobic anxiety, paranoid ideation, psychoticism and overall distress in outpatients and controls

Block and Variables	Outpatients					Controls				
	HOS	PA	PI	PSY	GSI	HOS	PA	PI	PSY	GSI
Gender	.00	.12	.00	-.04	.13	.04	.08	-.16	.06	.07
Age	-.15	-11	-.12	-.08	-.12	-23*	-.22*	-.14	-.13	-.24*
ΔR^2	.02	.03	.01	.01	.03	.05	.06	.05	.02	.06*
Neuroticism	.51***	.43***	.29**	.50***	.63***	.57***	.42***	.30**	.43***	.60***
ΔR^2	.24***	.17***	.08**	.23***	.37***	.29***	.16***	.08**	.17***	.33***
Self-alienation	.08	.22*	.10	.44***	.31**	.16	.32**	.39***	.67***	.52***
Authentic living	.07	.07	.11	-.07	.03	.02	-.03	-.04	.03	.04
Accepting ext. influence	-.10	.00	.14	.01	-.01	-.18*	-.07	.06	.10	.00
ΔR^2	.02	.04	.04	.17***	.08***	.04	.07*	12***	.33***	.18***

Notes. Gender – 0 = *male*, 1 = *female*. HOS - Hostility; PA - Phobic anxiety; PI - Paranoid ideation; PSY - Psychoticism; GSI - General Severity Index.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Overall, the findings partially confirmed the first and second assumption since, in outpatients, only self-alienation was a significant predictor of most symptom dimensions and overall distress.

Discussion

Classical person-centered theory rejected the concept of psychopathology and provided a model of distress, dysfunction and maladjustment defined as outcomes of inauthenticity (incongruence) or alienated ways of being in the world (Rogers, 1961; 1980). Contemporary theory and practice, however, are open to the possibility of dimensional assessment of mental health problems and a person-centered approach to psychopathology (Joseph, 2017; Warner, 2017; Wilkins, 2017). In this context, our study provides several valuable findings. First of all, given the need for

psychometrically robust tools for the assessment of PCA concepts, the differences between outpatients and controls in terms of inauthenticity dimensions demonstrate the discriminative ability of the Authenticity Scale (AS), although examinations with larger clinical samples are necessary. The absence of differences regarding authentic living, at the same time, can be interpreted in two ways. In an elaborate analysis of the relationship between alienation and authenticity, Schmid (2005) argues that authentic living is possible even in states of severe dysfunction or clinical distress, given that authenticity is a staged process of balancing one's individuality and interrelatedness with others. Thus, striving towards balance 'coincides' with suffering. On the other hand, recent psychometric explorations of the AS in a non-Western culture (Nartova-Bochaver et al., 2021) indicate the risk of social desirability bias related to the positive wording of all items on the authentic living subscale. Additionally, even though authenticity components were interrelated in the expected direction according to the tripartite model, authentic living was insignificantly related to acceptance of external influences in both samples.

These arguments and findings may also help explain why authentic living and accepting external influence were not found to be relevant predictors of distress. Additionally, although previous studies have provided correlational evidence on the association between these two dimensions and negative affect or distress in community samples (Grégoire et al., 2014; Grijak, 2017; Wood et al., 2008), one study using path analysis (Stevens, 2016) has not found significant relationships between these dimensions and affective functioning. Therefore, further cross-cultural examinations of the tripartite model are needed as well as more nuanced insights into the relative contribution of each component to the utility of the model.

With respect to the humanistic-existential conceptualization of self-alienation, our study confirmed that it is the core component of authenticity that significantly determines psychological functioning, even after accounting for the effects of another relevant and widely evidenced personality risk factor (neuroticism). If we approach the assessed

psychopathological dimensions from the perspective of the PCA as differentiated client processes (Tudor & Worall, 2006), it is important to note that this discrepancy between the perceived self and the actual experience was most relevant for depression in the clinical sample, consistent with Rogers' assertions, while in the control group it had the strongest effect on symptoms of psychoticism, which when less pronounced primarily reflect the tendency towards social alienation, one that inevitably arises from alienation from one's self (Rogers, 1980).

The findings further point to a differentiated role of self-alienation relative to the severity of experienced distress, while the relationship patterns between neuroticism and symptom dimensions were identical in both samples (except in the case of somatization). Therefore, the findings in the control group are in line with the empirical and theoretical literature (except for hostility), however for individuals experiencing clinical distress self-alienation was not relevant for paranoid ideation, while it was partially, i.e., fully mediated by neuroticism in the cases of hostility, somatization and anxiety. Considering that anxiety is most pronounced in outpatients both from a dimensional and a categorical perspective, and given that Rogers (1957) defined anxiety as a threat occurring when the individual becomes gradually aware of self-alienation - these findings might reflect the causal relationship between self-alienation and the formation of a 'neurotic' self-structure. However, high neuroticism can also promote and augment self-alienation processes. Although the link of neuroticism to authenticity was out of the scope of this study, it is relevant to note that robust meta-analytic studies have not found conclusive evidence that any of the dominant models seeking to explain the role of neuroticism in psychopathology can account for all findings (Ormel et al., 2013), nevertheless, with respect to anxiety disorders, the evidence is most consistent with the common cause model, with the issue of operational overlap confounding the interpretation of findings. Thus, given that from a PCA perspective all psychological disturbances arise from believing that one is what one is not and denying who one truly is (Lambers, 2003a, 2003b, 2003c, 2003d), further studies should

examine the relationships with incongruence outcomes for which self-alienation was not found to have a significant incremental contribution and to disentangle its association with neuroticism, as well.

The differentiated findings could also result from the overall heterogeneity of distress in outpatients, greater variance in their styles of processing experiences (Warner, 2017) and the absence of data that could contextualize their current condition (such as, past and current adverse life events, baseline symptom levels and duration of their mental health problems, previous treatments, etc.), as well as the cross-sectional study design.

We can, however, reaffirm that self-alienation is a relevant explanatory factor associated with a wide range of symptom dimensions, even when it does not profoundly disrupt the functioning of the individual at the intra- and interpersonal level (as in the control group). Furthermore, taking into account the complex pathways and interconnected causes involved in the development and maintenance of clinical distress, it might not seem surprising that self-alienation was a stronger predictor of lower overall distress in the control sample (additionally, as previously discussed, neuroticism may act as a mediator). On the other hand, experiencing elevated distress may also lead to self-alienation by reducing awareness of one's physiological, emotional and cognitive experiences (Boyraz et al., 2014). So there is a need for prospective studies examining the potentially reciprocal relationship between specific aspects of authenticity and psychopathological processes.

With respect to clinical practice implications and considering that the outpatients were counselling clients, the findings suggest that an increase of self-knowledge, i.e., of congruence between actual and symbolized experiences needs to be a more explicit and direct goal of treatment as well as a measured outcome (Patterson, 2017). From a humanistic-experiential perspective, psychological symptoms are seen as cries for help, as expressions of loss of balance in the striving for authenticity and as key to understanding the person that is suffering (Schmid, 2005). Therefore, elevated

self-alienation in the clinical sample should not be interpreted as a psychological setback, but rather as an expression of the wish to understand oneself and of the preparedness to embark on a supported stage of authenticity development. In line with this, a recent study (Mørken, 2019), conducted concurrently with ours, has shown that the AS could be used as a measure of treatment evaluation. Hence, future research could also examine whether the promotion of authenticity during treatment can improve psychological functioning and overall well-being, irrespective of the therapeutic orientation and complement the focus on reduced symptoms as the primary outcome. This could also entail a shift in the narrative and a move closer to treatment in terms of authenticity and alienation, rather than health and disorder (Tudor & Worrall, 2006).

Despite the limitations of using a cross-sectional design, a restricted set of control variables and a heterogeneous outpatient sample, our findings contribute to the literature on authenticity and psychopathology, since this is a rare study conducted in clinical context with implications relevant both for the development and treatment of clinical distress. The findings also provide further psychometric and cross-cultural evidence on the utility of the Authenticity Scale. Given that elevated psychological distress and treatment involvement are not rare in community samples (Thurston et al., 2008), an additional strength of the study is the screening of the control group for mental health service use, thus providing stronger evidence on the discriminative ability of the measures used.

Conflict of interest

We have no conflicts of interest to disclose.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

References

Akin, A., & Akin, U. (2014). Examining the relationship between authenticity and self-handicapping. *Psychological Reports*, *115*(3), 795–804. https://doi.org/10.2466/09.PR0.115c26z1

Barrett-Lennard, G. T. (1998). *Carl Rogers' helping system: Journey and substance*. Sage.

Blazhevska-Stoilkovska, B. & Naumova, K. (2020). Psychometric properties of the Brief Symptom Inventory in a clinical and nonclinical sample. *Psihologija: nauka i praktika,* IV(7-8), 9–23. https://doi.org/10.37509/psyscip207-8009bs

Boyraz, G., & Kuhl, M. L. (2015). Self-focused attention, authenticity, and well-being. *Personality and Individual Differences*, *87*, 70–75. https://doi.org/10.1016/j.paid.2015.07.029

Boyraz, G., Waits, J. B., & Felix, V. A. (2014). Authenticity, life satisfaction, and distress: A longitudinal analysis. *Journal of Counseling Psychology*, *61*(3), 498–505. https://doi.org/10.1037/cou0000031

Derogatis, L. R. (2017). Symptom Checklist-90-Revised, Brief Symptom Inventory, and BSI-18. In M. E. Maruish (Ed.), *Handbook of psychological assessment in primary care settings* (p. 599–629). Routledge/Taylor & Francis Group.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, *13*(3), 595–605. https://doi.org/10.1017/S0033291700048017

Ernst, A.F, & Albers, C.J. (2017). Regression assumptions in clinical psychology research practice-a systematic review of common misconceptions. *PeerJ, 5*, e3323. https://doi.org/10.7717/peerj.3323

Grégoire, S., Baron, L., Ménard, J., & Lachance, L. (2014). The Authenticity Scale: Psychometric properties of a French translation and exploration of its relationships with personality and well-being. *Canadian Journal of Behavioural Science / Revue Canadienne Des Sciences Du Comportement*, *46*(3), 346–355. https://doi.org/10.1037/a0030962

Grijak, D. (2017). Authenticity as a predictor of mental health. *Kliničkа Psihologija*, *10*(1–2), 23–34. https://doi.org/10.21465/2017-KP-1-2-0002

Harter, S. (2002). Authenticity. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 382–394). Oxford University Press.

Horney, K. (1951). *Neurosis and human growth*. Routledge.

Jeronimus, B. F., Kotov, R., Riese, H., & Ormel, J. (2016). Neuroticism's prospective association with mental disorders halves after adjustment for baseline symptoms and psychiatric history, but the adjusted association hardly decays with time: A meta-analysis on 59 longitudinal/prospective studies with 443 313 participants. *Psychological Medicine*, *46*(14), 2883–2906. https://doi.org/10.1017/S0033291716001653

John, O. P., & Srivastava, S. (1999). The Big Five Trait taxonomy: History, measurement, and theoretical perspectives. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and research* (pp. 102–138). Guilford Press.

Joseph, S. (2017). Mental health and the person-centred approach. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice* (pp. 12–23). PCCS Books.

Kernis, M. H., & Goldman, B. M. (2006). A multicomponent conceptualization of authenticity: Theory and research. In *Advances in Experimental Social Psychology* (Vol. 38, pp. 283–357). Elsevier. https://doi.org/10.1016/S0065-2601(06)38006-9

Lambers, E. (2003a). The person-centred perspective on psychopathology: The neurotic client. In D. Mearns (Ed.), *Developing person-centred counselling* (pp. 103–109). SAGE Publications Ltd. https://www.doi.org/10.4135/9781446279779.n25

Lambers, E. (2003b). Borderline personality disorder. In D. Mearns (Ed.), *Developing person-centred counselling* (pp. 110–112). SAGE Publications Ltd. https://www.doi.org/10.4135/9781446279779.n26

Lambers, E. (2003c). Psychosis. In D. Mearns (Ed.), *Developing person-centered counselling* (pp. 113–116). SAGE Publications Ltd. https://www.doi.org/10.4135/9781446279779.n27

Lambers, E. (2003d). Personality disorder. In D. Mearns (Ed.), *Developing person-centered counselling* (pp. 117–120). SAGE Publications Ltd. https://www.doi.org/10.4135/9781446279779.n28

Maltby, J., Wood, A. M., Day, L., & Pinto, D. (2012). The position of authenticity within extant models of personality. *Personality and Individual Differences*, *52*(3), 269–273. https://doi.org/10.1016/j.paid.2011.10.014

May, R. (1981). *Freedom and destiny.* Basic Books.

Mørken, D. (2019). *The Authenticity Scale as an outcome measure for psychological therapies* [Doctoral dissertation, University of Roehampton]. UR Repository.

Retrieved from https://pure.roehampton.ac.uk/portal/en/studentTheses/the-authenticity-scale-as-an-outcome-measure-for-psychological-th

Nartova-Bochaver, S., Reznichenko, S., & Maltby, J. (2021). The Authenticity Scale: Validation in Russian culture. *Frontiers in Psychology*, *11*, 609617. https://doi.org/10.3389/fpsyg.2020.609617

Ormel, J., Jeronimus, B. F., Kotov, R., Riese, H., Bos, E. H., Hankin, B., Rosmalen, J. G. M., & Oldehinkel, A. J. (2013). Neuroticism and common mental disorders: Meaning and utility of a complex relationship. *Clinical Psychology Review*, *33*(5), 686–697. https://doi.org/10.1016/j.cpr.2013.04.003

Patterson, T. G. (2017). Assessing efficacy and effectiveness in person-centered therapy: challenges and opportunities. In S. Joseph (Ed.), *The handbook of person-centered therapy and mental health: Theory, research and practice* (pp.699–732). PCCS Books.

Pillow, D. R., Hale, W. J., Crabtree, M. A., & Hinojosa, T. L. (2017). Exploring the relations between self-monitoring, authenticity, and well-being. *Personality and Individual Differences*, *116*, 393–398. https://doi.org/10.1016/j.paid.2017.04.060

Pinto, D. G., Maltby, J., Wood, A. M., & Day, L. (2012). A behavioral test of Horney's linkage between authenticity and aggression: People living authentically are less-likely to respond aggressively in unfair situations. *Personality and Individual Differences*, *52*(1), 41–44. https://doi.org/10.1016/j.paid.2011.08.023

R Core Team (2020). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing. Retrieved from https://www.R-project.org/

Robinson, O. C., Lopez, F. G., Ramos, K., & Nartova-Bochaver, S. (2013). Authenticity, social context, and well-being in the United States, England, and Russia: A three country comparative analysis. *Journal of Cross-Cultural Psychology*, *44*(5), 719–737. https://doi.org/10.1177/0022022112465672

Rogers, C. R. (1954). *Client-Centered Therapy: Its current practice, implications, and theory.* Houghton Mifflin

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy.* Constable.

Rogers, C. R. (1980). *A way of being*. Houghton Mifflin.

Rosseel, Y. (2012). Lavaan: An R Package for Structural Equation Modeling. *Journal of Statistical Software,* 48, 1–36. https://doi.org/10.18637/jss.v048.i02

Satici, S. A., Kayis, A. R., & Akin, A. (2013). Predictive role of authenticity on psychological vulnerability in Turkish university students. *Psychological Reports*, *112*(2), 519–528. https://doi.org/10.2466/02.07.PR0.112.2.519-528

Schermelleh-Engel, K., Moosbrugger, H., & Müller, H. (2003). Evaluating the fit of structural equation models: Tests of significance and descriptive goodness-of-fit measures. *Methods of Psychological Research, 8*(2), 23–74.

Schmid, P. F. (2005). Authenticity and alienation: Towards an understanding of the person beyond the categories of order and disorder. In S. Joseph & R. Worsley (Eds.), *Person-centered psychopathology* (pp. 75–90). PCCS Books.

Slabu, L., Lenton, A. P., Sedikides, C., & Bruder, M. (2014). Trait and State authenticity across cultures. *Journal of Cross-Cultural Psychology*, *45*(9), 1347–1373. https://doi.org/10.1177/0022022114543520

Smallenbroek, O., Zelenski, J. M., & Whelan, D. C. (2017). Authenticity as a eudaimonic construct: The relationships among authenticity, values, and valence. *The Journal of Positive Psychology*, *12*(2), 197–209. https://doi.org/10.1080/17439760.2016.1187198

Stevens, F. L. (2016). Authenticity: A mediator in the relationship between attachment style and affective functioning. *Counselling Psychology Quarterly*, *30*(4), 392–414. https://doi.org/10.1080/09515070.2016.1176010

Thurston, I.B., Curley, J., Fields, S., Kamboukos, D., Rojas, A., & Phares, V. (2008). How nonclinical are community samples? *Journal of Community Psychology,* 36(4), 411–420. https://doi.org/10.1002/jcop.20223

Tudor, K., & Worrall, M. (2006). *Person-Centred Therapy*. Routledge. https://doi.org/10.4324/9780203965252

Warner, M. (2017). A person-centred view of human nature, wellness and psychopathology. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice* (pp.151–188). PCCS Books.

Wilkins, P. (2017). Assessment and 'diagnosis' in person-centered therapy. In S. Joseph (Ed.), *The handbook of person-centered therapy and mental health: Theory, research and practice* (pp.217–246). PCCS Books.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment.* International Universities Press.

Wood, A. M., Linley, P. A., Maltby, J., Baliousis, M., & Joseph, S. (2008). The authentic personality: A theoretical and empirical conceptualization and the development of the Authenticity Scale. *Journal of Counseling Psychology*, *55*(3), 385–399. https://doi.org/10.1037/0022-0167.55.3.38

Yalom, I. D. (1980). *Existential psychotherapy.* Basic Books.

Relevantnost autentičnosti za klinički distress: reafirmacija uloge samootuđenja

Katerina Naumova[1] i Florijan Naumov[2]

[1] *Odsek za psihologiju, Filozofski fakultet, Univerzitet Sveti Ćirilo i Metodije, Skoplje, Severna Makedonija*

[2] *Univerzitetska Klinika za psihijatriju, Medicinski fakultet, Univerzitet Sveti Ćirilo i Metodije, Skoplje, Severna Makedonija*

SAŽETAK

Nekoliko teorijskih perspektiva u psihologiji savetovanja tvrde da autentičnost treba da bude primarni cilj tretmana, dok su otuđenje od sebe definisali kao osnovni uzrok distresa i psihopatološke patnje. Nedavni empirijski nalazi pokazuju da tripartitni model dispozicijske autentičnosti, zasnovan na Rogersovoj teoriji usmerenoj na osobu, uspešno predviđa mentalno blagostanje. Uzimajući u obzir nedostatak istraživanja na kliničkim uzorcima, ova studija je ispitivala unikatni doprinos autentičnosti kao osobine u predikciji distresa kod ambulantnih pacijenata upućenih na savetovanje (N = 105; 58% ženskog pola, uzrasta 18-65 godina) i kod demografski izjednačenih kontrolnih ispitanika (N = 102; 62% ženskog pola, uzrasta 18-52 godine). Kod većine ambulantnih pacijenata dijagnostikovani su anksiozni poremećaji i/ili poremećaji raspoloženja, dok su kontrolni ispitanici prošli kroz skrining za korišćenje usluga za mentalno zdravlje. Rezultati su pokazali veće samootuđenje i prihvatanje spoljašnjih uticaja u kliničkom uzorku, kao i izraženiji neuroticizam, ali i simptomatski i generalni distres u odnosu na kontrolnu grupu. Jedino je samootuđenje dalo unikatni doprinos u predikciji kliničkog distresa kod ambulantnih pacijenata, nakon kontrole efekta

neuroticizma, potvrđujući tako pretpostavku da što je veće neslaganje između iskustava i njihove simbolizacije, to je veći rizik od psihološke disfunkcije. Nalazi su dalje ukazali na različitu ulogu samootuđenja u odnosu na intenzitet doživljenog distresa, kao i na potrebu za ispitivanjem kauzalne veze sa neuroticizmom. Razmatraju se i implikacije u odnosu na kliničku praksu i na merenje autentičnosti kao ishod tretmana.

Ključne reči: autentičnost, samootuđenje, teorija usmerena na osobu, psihološki distres