Turkish Journal of Psychology, December 2019, *34*(84), 107-110 DOI: 10.31828/tpd1300443320180911m000012

Summary
The Role of Authentic Orientation, Hope and Vitality in Psychological Symptoms and Affect: Investigation in a Clinical Sample

Bilge Yalçındağ
Nuh Naci Yazgan University

Yasemin Kahya
Social Sciences University of Ankara

Authenticity has been emphasized both by early theorists (e.g., Maslow, 1968; Rogers, 1961) and contemporary ones (e.g. Deci & Ryan, 2000; Kernis & Goldman; 2006; Wood, Linley, Maltby, Baliousis, & Joseph, 2008) in terms of its benefits in different areas of life. The multicomponent conceptualization of authenticity (Kernis & Goldman, 2006) states that authenticity is the pursuit of life in line with one's genuine self. Accordingly, an authentic person is aware of one-self, processes self-related information in an unbiased manner, behaves in line with one's self, and has a genuine relational orientation towards others. Having an authentic life is associated with a genuine high self-esteem (e.g., Kernis, 2003), lower levels of psychological stress (e.g., Ryan, LaGuardia, & Rawsthorne, 2005), both psychological and subjective well-being (e.g., Wang, 2016). In early studies, authenticity predicted decreases in negative affect and increases in positive affect (Goldman & Kernis, 2002; Harter, Marold, Whitesell, & Cobbs, 1996) which were conceptualized as proximal constructs to psychopathology (Nolen-Hoeksema & Watkins, 2011).

According to the hope theory of Snyder et al. (1991), hope consists of two components. Agency, the motivational part of hope, is the perceived capacity of the individual related to goal direction, determination of pursuing the goal. Pathways, is the individual's perceived capacity to produce successful maps or solutions. Having an authentic orientation has a facilitatory role on being hopeful (Davis & Hicks, 2013). On the other hand, lower levels of hope is associated dysfunctional coping style (Jackson, Taylor, Palmatier, Elliott, & Elliott, 1998), suicidal thoughts (Range & Penton, 1994), depression and anxiety symptoms (e.g., Arnau, Rosen, Finch, Rhudy, & Fortunato, 2007; Chang, 2003; Lysaker & Salyers, 2007). It was also indicated that hope was negatively related to negative affect, and positively related to positive affect (Snyder et al., 1996).

The feeling of vitality has been associated with the discovery, expression and development of the true self (Jones & Crandall, 1986; Ryan & Frederick, 1997). According to Govindji and Linley (2007), the vitality feeling of authentic individuals increase due to the consistency of their behavior with their self and autonomous initiation of the behavior. Vitality appears to be an important factor in predicting psychological health (Duan, Bai, Tang, Siu, Chan & Ho, 2012). Ryan and Frederick (1997) reports independent studies in which a decrement in vitality is associated with various psychological complaints such as depression, anxiety, or somatization. They also showed subjective vitality was influential for individuals' state of affect.

Taking the literature summarized above, our aim was to investigate the effect of authenticity on psychological complaints along with hope, vitality, and affect in different process mediation models. Our hypotheses were stated below:

-Authenticity would predict psychological symptoms negatively and directly.

-Authenticity would predict increase in hope, which in turn would be related to increase in positive affect, and by this way, authenticity would be indirectly and negatively associated with psychological symptoms. (Model 1)

- Authenticity would predict increase in hope which in turn would be related to decrease in negative affect, and by this way, authenticity would be indirectly and negatively associated with psychological symptoms. (Model 2)

-Authenticity would be positively related to subjective vitality which would be successively related to increase in positive affect, and thus authenticity would be indirectly and negatively associated with psychological symptoms. (Model 3)

Address for Correspondence: PhD. Bilge Yalçındağ, Nuh Naci Yazgan University, Faculty of Arts and Science, Department of Psychology, Kuzey Çevreyolu Erkilet Dere Mahallesi, Kocasinan / Kayseri.
E-mail: bilgeyalcindag@gmail.com

-Authenticity would be positively related to subjective vitality which would be successively related to decrease in negative affect, and thus authenticity would be indirectly and negatively associated with psychological symptoms. (Model 4)

Considering Turkey, we did not encounter any study tackling the current topic on a clinical sample. Another limitation in the literature is the overemphasis of the psychological symptoms and their relation to negatively valenced variables (Seligman & Csikszentmihalyi, 2000). However, scrutinizing positive psychological variables that are possibly related to psychological complaints may contribute to our understanding of protective factors necessary for psychological resilience and their incorporation to clinical intervention field. The current study aims to fill this gap in the literature.

Method

Participants

The sample consisted of 113 participants (71 females, 42 males) between 13 and 55 years of age and who had psychological/psychiatric complaints and have been receiving professional help from a psychologist or a psychiatrist. To eliminate the possibility of age being a confounding variable, information related to 14 participants whose age is under 18 were excluded. Therefore sample characteristics and results are presented for 99 participants (59 females, 40 males). The mean age of the sample was 30.96 (*SD* = 8.06) and 60% is between 18 and 31. Most of the respondents were from middle to upper SES background.

Most of the participants were receiving professional help from a private counseling center in Bursa and the rest of them were individuals receiving psychological or psychiatric help from private centers in Ankara or İstanbul. There were 72 participants consulting a psychologist (missing information = 27) and 38 participants were examined by a psychiatrist (not examined by a psychiatrist = 30, missing information = 31). The complaints of 42 participants were diagnosed by a psychiatrist (not received a diagnosis = 6, missing information = 51). The diagnoses can be summarized as anxiety related (19 people), depression related (9), substance abuse related (3), schizophrenia related (1), and other (10). As for the medication, 16 participants were on medication, 56 participants were not (missing = 27). The sixteen of participants were under medication while the most of remaining (n = 57) were not using medications for their psychological complaints (missing information = 27). The duration of complaints differed amongst participants (24 participants for one year, 16 for 2 years, 12 for 3 years, 8 for 4 years, 26 for 5 or more years; missing information = 13).

Materials and Procedure

Demographic information form. Participants were responded to demographical questions such as age, sex, socio-economic status, and their psychological complaints.

Authenticity. To measure authenticity level of participants, Turkish version of Authenticity Inventory (Kernis & Goldman, 2006) were used. Authenticity Inventory composes 45 items tapping four dimensions (awareness, unbiased processing, authentic behavior, and relational orientation) and also measures a general orientation of being authentic. Imamoglu, Günaydin, & Selçuk, (2011) used the 27 items that work best in Turkish. This study used the 27 item short version and measured the general authentic orientation rather than its subscales. The internal consistency of the scale was .83.

Hope. Hope has been defined as having the pathways (to be able to produce some solutions to the problems encountered) and agency (to have the motivation and determination to reach the goals) (Snyder et al., 1991). Snyder and his colleagues (1991) tested the 12-item Hope Scale (4 pathways, 4 agency and 4 filler items) in a series of studies and provided evidence for its reliability and validity. In the current study, the Turkish version of the scale (İmamoğlu, Güler, & İmamoğlu, 2004) and a general hope score was used (a = .85).

Vitality. Subjective Vitality Scale (SVS) (Ryan & Frederick, 1997) measures participants' vitality, enthusiasm, zest, and energy towards life. The scale consists of 6 items and translated to Turkish by Yalçındağ and Özkan (2011). The internal consistency of the scale was .88 in the current study.

Affect. To measure participants' affect, the Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988; Turkish version by Gençöz, 2000) was used. PANAS consists of 20 items measuring positive and negative affect (10 items for each). In the current study, the internal consistency coefficients of both scales were .87.

Psychological symptoms. To measure participants' psychological symptoms, Brief Symptom Inventory (BSI) (Derogatis, 1992 cited in Şahin & Durak, 1994) was used. BSI consists of 53 items and 10 sub-dimensions (such as anxiety, depression, obsessive compulsive, somatization). This study used the Turkish version of BSI (Şahin & Durak, 1994) and a total score of psychological symptoms (a = .97).

Procedure. After preparing the questionnaire booklets, approvals were obtained from the related ethics commission and the institutions where the questionnaires would be applied. The booklets were distributed to participants before their session starts with the professional. Since the sample is a clinical one and accessibility is rather low, the data collection procedure took about 2 years.

Results

Before testing the proposed relations, 12 participants were excluded due to missing information. Then, the variables were tested in terms of assumptions. The assumption of univariate normality was met ($K^2_{\text{authenticity}} = 1.47$, $K^2_{\text{hope}} = 5.04$, $K^2_{\text{vitality}} = 1.44$, $K^2_{\text{positive affect}} = 5.64$, $K^2_{\text{negative affect}} = 3.94$, $K^2_{\text{psychological symptoms}} = 4.49$, $p > .06$) (for omnibus univariate assumption test, see DeCarlo, 1997).

The correlations among variables (Table 1) indicated that authenticity had strong positive relations with hope ($r = .50$) and vitality ($r = .40$). Positive affect had strong and positive relations with hope and vitality ($r = .45$, $r = .46$, respectively), whereas negative affect was associated with low levels of authenticity ($r = -.39$), hope ($r = -.31$), and vitality ($r = -.35$). As the psychological symptoms increased, vitality, positive affect, authenticity, and hope decrease ($r = -.49$, $r = -.52$, $r = -.44$, $r = -.42$, respectively). The association between psychological symptoms and negative affect ($r = .60$) was stronger than the association between symptoms and positive affect ($r = -.44$), $t\,(96) = 7.87$, $p < .01$ (for correlation comparison see Field, 2009).

Before testing the four models, the analyses for each model indicated that there was no multivariate outlier indicated by Mahalanobis distance. Also, the models met the assumptions of multivariate normality test (Small's test) and Mardia's kurtosis (although Mardia's multivariate skew results were significant for Model 2 and 4, there was no difference in terms of explained variance, power and standardized coefficients between natural and log transformed scores) (for tests, see DeCarlo, 1997; 2014). The four models were tested using PROCESS macro (Hayes, 2018) as two-serial-mediators model (PROCES Model 6) and power of each indirect relation was computed (Schoemann, Boulton, & Short 2017) (see Table 2 and Figure 1).

The relations that these four models show can be summarized in 3 steps. Firstly, the only mediator indirect relations show that the relation between authenticity and psychological symptoms was not mediated by positive affect (Model 1 and 3) or hope (Model 1 and 2), but it was mediated by negative affect (Model 2 and 4) and vitality (Model 3 and 4). In other words, vitality, under the influence of authenticity, is a protective factor in decreasing psychological symptoms while hope or positive affect has no such role. On the other hand, authenticity decreases negative affect and therefore has an indirect effect on psychological symptoms.

Secondly, the two-serial-mediator relations showed that, high levels of authenticity and hope consequently increased positive affect and therefore decreased psychological symptoms (Model 1). On the other hand, hope did not have this protective role on symptoms by influencing negative affect (Model 2). Vitality also increased under the influence of authenticity and in turn increased positive affect (Model 3) and decreased negative affect (Model 4), thereby decreasing psychological symptoms. When looking from an affect view, negative affect is influenced by only vitality whereas positive affect is influenced by both positive and negative affect. In conclusion, for the two-mediator affect of the 3 models, H_1 was accepted, for Model 2 (A->H->Negative Affect->Symptoms) H_0 was failed to reject.

Lastly, throughout the four models, the direct effect of authenticity on psychological symptoms was significant. In other words, although authenticity indirectly affects psychological symptoms, higher scores on authenticity predicts lower scores on psychological symptoms as well.

Discussion

The aim of this study was to investigate the relationship between psychological symptoms and psychological main factors of positive psychology literature in a clinical sample. Results indicated authenticity was negatively related to psyhological symptoms via the increase in hope which was in turn associated with increase in positive affect. Hope and positive affect were not separately influential with regard to the relationship between authenticity and psychological symptoms; that is, hope and positive affect should work together with authenticity in relation to decrease in psychological symptoms. On the other hand, the process in which authenticity was related to hope that was in turn associated with decrease in negative affect and then decrease in psychological symptoms was not statistically significant. These findings implied that hope was not influential in decreasing negative affect, rather it was more related to positive affect. Additionally, authenticity predicted decrease in psychological symptoms through subjective vitality and this process was mediated by increase in positive affect and decrease in negative affect. Lastly, authenticity was linked to less psychological symptoms via the mediator role of only negative affect. Findings showed that authentic orientation also need hope and subjective vitality to be able to have an effect on positive affect, and then on psychological symptoms. However, an authentic orientation is enough to have an effect on negative affect, and then on psychological symptoms. Also, the direct effect of authenticity was significant on psychological symptoms in a negative direction in all of the process models.

The significant direct effect of authenticity on psychological symptoms is consistent with the other studies (e.g., Kernis, 2003; Kernis and Goldman, 2006; Ryan,

LaGuardia, & Rawsthorne, 2005; Theran, 2011; Wang, 2016; Wickham, Reed, & Williamson, 2015). The theoretical view is that as long as the individual is in line with the authentic interests and values, the quality of the experiences, motivation, and eventually well-being is increased. On the other hand, inauthentic experiences result in inner conflict, diminished motivation and low levels of well-being.

The current study also depicted the direct effect of authenticity on hope and vitality. Some findings in the literature indicate that implications of having an authentic self are having high levels of hope (Rego, Sousa, Marques, & Cunha, 2014) and vitality (Govindji & Linley, 2007). That is why, the fact that individuals having some psychological complaints also have varying low levels of hope and vitality may be explained with the lack of an or impoverished authentic self.

The literature suggested a significant negative relationship between hope and psychological symptoms (Chang & DeSimone, 2001; Range & Penton, 1994). However, hope was not a direct influential factor both on negative affect and psychological symptoms in the present clinical sample. The participants of current study was taking either psychological or psychiatric help, so their hope level might be increased by this help. The fact that their hope might be increased by the help they were taking may account for why hope was not a significant predictor of negative affect and psychological symptoms. Future studies in clinical samples should take into account this factor of getting help. In some studies, high hope level did not result in low levels of negative affect, but only high levels of positive affect (Uzun Özer ve Tezer, 2008). Another explanation for the current finding is that hope may not be a construct that has a positive effect on negative affect system. It may only boost positive affect system. Scholars pointed to the partly different bio-behavioral processes under positive and negative affect systems (Davidson, Jackson, & Kalin, 2002), which makes the second explanation plausible.

Our findings further supported that subjective vitality was closely related to well-being (Duan et al., 2012; Ryan ve Frederick, 1997). Authenticity needs subjective vitality to be related to positive affect and then decrease in psychological symptoms. The indirect effect of subjective vitality on psychological symptoms was also significant for both negative affect and positive affect system. Findings indicate that individuals with authentic orientation should be also supported for subjective vitality that will faciliate affect system and then well-being.

Findings highlight that there are positive direct and indirect effects of creating awareness about the authentic orientation and supporting the acquisition of authenticity in therapeutic interventions to increase well being along with a focus on elimination of psychological symptoms. Therapeutic interventions aiming at discovering one's self, express oneself, give way to authentic orientation, increase one's hope and vitality is vital. Additionally, affect has an important role in healing psychological symptoms as well; although negative affect is a stronger predictor of psychological health, positive affect was a powerful predictor as well.

Findings were obtained by a clinical sample that had ongoing psychological complaints. On the one hand this strengthens our claims that were mostly confirmed and contributes to the literature that is generally built upon data from community samples. On the other hand, data collection phase took a long time and there was participant attrition, therefore one can claim that the sample size is not ideal. Additionally, since the current study's design was cross sectional, causality cannot be inferred. To explain authenticity and psychological symptoms causally, longitudinal studies must be carried out. Further studies should continue to work on effects of authenticity, hope, and vitality with larger clinical samples. It is evident that psychological symptoms and affect should not be thought independently from positive psychological variables.