

Relational Authenticity as the Condition for Personal Recovery: Selfhood in the Aftermath of Trauma

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Abstract

Authenticity and personal recovery have become central ideals in mental health care: that a person should be able to live a life authentically their own, and that recovery should follow their own sense of meaning rather than an externally defined standard of health, despite the presence of mental health challenges. These ideals are ordinarily well aligned, since living a fulfilling and meaningful life appears at once as a way of becoming more fully oneself. This article examines a hard case that tests this alignment. When a person's suffering has become woven into their sense of an authentic self, being authentic may mean continuing to suffer. Recovery then reads as a loss of self rather than living one's life more fully. An illustrative case of a teenage trauma survivor shows where the dilemma lies: in her belief that being authentic means holding onto a fixed, self-enclosed truth about herself. Drawing on a relational account of authenticity, I argue that holding authenticity as something worked out through one's relations is the condition under which recovery becomes possible. The task of mental health care is to sustain the relationship within which one's authenticity comes to meet agency for self-authorship.

Introduction

Authenticity has become a central concern in mental health care: the conviction that a person should be able to live in a way that feels truly their own, and that care should help them toward such a life rather than hinder it (Elliott, 1998). The personal recovery approach — an increasingly influential person-centred alternative to the still-dominant aim of diagnosing and treating disorder — holds that care should follow the person's own sense of a meaningful life rather than impose a clinical definition of health (Anthony, 1993). These two aims, authenticity and personal recovery, seem closely aligned with each other: helping someone discover new meanings, relationships, and roles is, at the same time, a way of helping them become more fully themselves. Yet, the two ideals could collide in some cases. Consider a young woman who was abused throughout her childhood. The danger, the isolation, and the sense of herself as worthless pervade how she inhabits the world and relates to herself and others, both reflectively and pre-reflectively. When suffering itself is woven into the core of who she is, becoming well or finding meaning in life would be to become a stranger to herself. In other words, if being true to herself means holding onto a life of suffering and isolation, then honouring her authenticity, on the one hand, and helping her toward a life worth living, on the other, seem to demand opposite things. Despite the increasing recognition of the importance of both aims, these two ideals have been explored mostly in separate fields. As a result, the dilemma such a case presents has remained largely underexamined.

This article aims to provide a direction for addressing this dilemma. I argue that the complication lies in how one holds one's sense of self: fixed and self-enclosed, a solitary truth closed to revision, so that any departure from this rigid self-view registers as an estrangement from oneself. Personal recovery, by contrast, is an ongoing process of discovering new meanings, relationships, and roles (Anthony, 1993) — the very movement a rigid sense of self cannot accommodate. Hence, the dilemma emerges when one's sense of self is rigid, since personal recovery depends on the exploration of personal meaning.

I argue that what is needed is a way to help those people inhabit themselves as someone able to hold who they are flexibly, in and through their relations with others — a way of being oneself that Gallagher et al. (2018) call relational authenticity. This sense of authenticity is the condition under which personal recovery becomes possible at all. With this, a change in what one wants or believes in need not cost them the sense of who they are, since that sense is no longer a fixed, solitary possession but something that is constantly discovered and created. What it asks of care, then, is not to teach, steer, or direct a person toward a particular way of being, but to hold open a space safe enough for exploration and to remain present within it as a companion to their own authoring of who they are.

This article proceeds by way of an illustrative case modelled on a person I encountered in a care setting: Lisa, a young survivor of childhood trauma who resists psychotherapeutic treatment because she feels that a happy, meaningful life lies outside who she is. I first show how childhood trauma can come to shape a person's very way of being, becoming constitutive of her authentic self. The paper then considers the two central goals guiding current mental health care — the treatment of disorder and personal recovery — and their bearing on authenticity. Lisa's case reveals how personal recovery and authenticity can pull apart. In response, I turn to a relational conception of authenticity to show how this tension can be resolved conceptually. Finally, what it asks of care in practice will be discussed.

The Case of Lisa

Lisa is a 19-year-old university student diagnosed with complex post-traumatic stress disorder (C-PTSD) and dissociative identity disorder. Throughout her early childhood, she experienced prolonged physical and sexual abuse by her brother. The impact of her trauma pervades every part of her life, from how she experiences herself to how she lives among others. She lives with depression, dissociation, flashbacks, and persistent suicidal thoughts, and a deep sense of isolation. She frequently voices a profound self-loathing, such as "I hate myself" and "I am not worth living". Her attendance at university is irregular, her family relationships are strained, and she experiences herself as fundamentally different from her peers and estranged from them. The relationships in which she feels most accepted are those with her psychiatrist and nurses, who she says "accept me as who I am".

Lisa willingly accepts medication, which stabilises her symptoms enough that she can attend classes, go to her part-time job, and speak about it with enthusiasm. Yet, she resists psychotherapy aimed at the deeper roots of her suffering, beyond this stabilisation of symptoms. She states:

"I've been this way for as long as I can remember. I don't know what it's like not to be this way, or not to be treated as a trauma victim. It's scary to think about becoming someone I can't even imagine. So I don't want to be a normal, happy person. That's not who I am."

Trauma-Shaped Self

What stands out in Lisa's case is the way her suffering, symptoms, and identity as a trauma survivor have become inseparable from her understanding of herself. Existing literature on illness identity offers an

important starting point for understanding cases like Lisa's. Individuals with chronic (mental) illness often come to define themselves through the diagnostic category they occupy, internalising the social meanings, expectations, and stereotypes associated with the disorder (Lysaker et al., 2007; Yanos et al., 2010). In some instances, individuals describe themselves as "nothing but" their illness (Oris et al., 2016; Van Bulck et al., 2019). This illuminates how social positioning, diagnostic labels, and feedback from others can shape one's self-definition, and helps to explain why Lisa understands herself as a trauma survivor and how this identity is reinforced by how others respond to her.

Yet, illness identity captures only part of what is at stake in Lisa's case. That is, it is not only her self-understanding that is shaped by the trauma: rather, it is her very way of being that has been shaped by and through it. Her entire meaning structure, from the way she relates to herself and others to the way she experiences the world, is built within conditions that trauma has laid down (Brison, 2002). Merleau-Ponty (2002) describes how what is first actively lived through — a perception, a response, a way of relating to another person — comes to settle into the tacit background from which further experience proceeds, no longer needing to be taken up anew each time it recurs. This process, called *sedimentation*, is the very condition of a stable sense and world: to act and perceive from what has already been acquired, rather than reconstituting oneself and one's surroundings at every instant. In Lisa, it is the patterns of perception, affect, and response laid down by the trauma that occupy this structure, settling into the ground from which her subsequent experience unfolds. This settled ground gives her experience its internal coherence (Wilde, 2022). It establishes expectations about how others will behave and how she must navigate the world, and importantly, it allows her to place her experiences within a narrative that, however painful, feels intelligible and familiar. In this way, her trauma-shaped way of being, though imbued with suffering, is experienced as her own.

The degree to which trauma permeates one's being is even more significant in cases of childhood abuse. Trauma can be understood as an existential injury: an assault upon the self severe enough to cut a person off from their sense of who they are (Thompson & Walsh, 2010). This injury bears with particular force upon children, who have not yet developed an adult sense of self. For a child, this takes hold within the very process through which their sense of self comes to be: the capacities for regulating affect, for sustaining a continuous thread of experience, for relating to others, all still underway and available for trauma to shape from within (Cook et al., 2005; Van der Kolk, 2005). Trauma of this kind is also, characteristically, prolonged and repeated, sustained within a relationship of dependency the child cannot escape (Herman, 1992), so that it forms the very conditions within which a child's world comes into being. There is no prior, uninjured self to return to, no baseline from which to distinguish the trauma's influence on one's values, feelings, and actions. This is Lisa's case: trauma was present throughout her formative years, shaping the process through which her selfhood came to emerge. The trauma-shaped way of being is the only way of being herself that Lisa has ever known. And it is experientially authentic precisely because it was formed through the conditions of her suffering. This is what underlies her resistance to psychotherapeutic treatment: for her, what is clinically regarded as improvement or recovery would mean becoming a different person.

Authenticity and Mental Health Care

As Charles Taylor (1991) famously wrote, “If I am not true to myself, I miss the point of my life; I miss what being human is for me” (p. 29), the concern with being true to oneself lies at the heart of the human condition. The question of authenticity has long occupied philosophy and has become central in fields such as sociology, politics, and psychology, reflecting a fundamental human aspiration to live in a way that feels true to oneself. Despite the diverse ways in which this concept has been employed across these disciplines, there is a shared understanding that “we are authentic when we exhibit or are in possession of what is most our own—our own way of flourishing or being fulfilled” (Parens, 2005).

It therefore makes sense that the concept has also become an ethical ideal in mental health care practice. Empirical research has consistently shown that self-reported authenticity correlates with indicators of psychosocial adaptation, including higher self-esteem, psychological wellbeing, positive affect, and relationship quality (Goldman & Kernis, 2002; Schlegel et al., 2016; Wood et al., 2008), affirming that attaining a coherent sense of authentic self in the face of mental disorder is critical for overall wellbeing.

Discussions on authenticity in mental health have largely centred on the question, “If I experience X, is it because of the illness, the medication, or is it just me?” (Karp, 2006). This question arises for mental disorder in a way it rarely does for physical illness. Whereas physical illness is typically perceived as something external to the person (“she was struck down by cancer”, “I have asthma”), mental disorders are more often understood as modes of being (“I am an alcoholic”, “I am depressed”) whose disruption therefore reaches core aspects of the personal self such as agency, identity, life trajectory, and one’s very perspective on experience and the world (Sadler, 2007). When a disorder cuts this deeply, the boundary between authentic self and disorder blurs into what has been termed *self-illness ambiguity*, and it is this ambiguity that most recent work on authenticity in mental health has taken as its object (Dings & Glas, 2020; Erler & Hope, 2014; Howard, 2006). Hope et al. (2011), for instance, conducted interviews with women diagnosed with anorexia nervosa and suggest that authenticity becomes a live question when an individual experiences an inner conflict between competing desires, values, or actions and attempts to discern which reflect her “real” self and which do not in order to achieve a coherent sense of self.

The focus on such ambiguity indicates a gap in current research: cases like Lisa in which what is clinically considered disordered, unhealthy, or maladaptive is constitutive of one’s sense of authenticity have rarely received attention. Although there is a large body of literature on the ubiquitous impact of childhood trauma on the self, philosophical discussion of authenticity has yet to engage with this phenomenon. Nevertheless, it is compelling not only philosophically but, more importantly, clinically, given the resistance to treatment that it may result in, as seen in Lisa’s case.

To what extent the ideal of authenticity is aligned with the way mental health practice operates depends on what goal the practice is guided by. With the aim of engaging with the actual mental health care practice, I begin by considering two dominant goals in current mental health practice and how the ideal of authenticity sits within each.

Treatment of Disorder as the Goal of Mental Health Care

The idea that mental health care exists to diagnose mental disorder and administer the intervention required to cure it has been the almost taken-for-granted goal of psychiatry and clinical psychology for a long time. On this view, mental disorder is conceived analogously to physical disease — as a dysfunction located within the individual, identifiable in principle through diagnostic criteria, and treatable through appropriately targeted intervention (Wakefield, 1992). Much of the framework's authority comes from its alignment with the broader biomedical paradigm that has historically legitimised psychiatry as a branch of medicine (Deacon, 2013), which supplies an apparently value-neutral vocabulary for identifying suffering and a clear metric of success in symptom remission.

This framework rests on a normative judgement of what counts as normal versus abnormal, healthy versus disordered (Boorse, 1999). Constellations of experience, affect, and behaviour are classified into discrete diagnostic categories codified in manuals such as the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), and the clinician's task is matching a presentation against these criteria to identify which disorder best accounts for the person's suffering (Kendler, 2016). Treatment then proceeds by applying the interventions that the evidence base associates with that category, with the explicit aim of reducing symptoms and restoring the person to normal functioning (Insel et al., 2010).

With many of the discussions of authenticity in mental health implicitly taking for granted that treatment of the disorder is and should be the goal of mental health care, the concern of authenticity lies in its alignment with treatment. Here, bioethical questions become central: for instance, should the disorder be considered a hindrance to expressing one's authentic self, or a genuine expression of who one truly is? Does pharmacological treatment enhance or hinder one's authenticity?

One chief example of this is the enhancement debate: whether an enhancement technique such as psychopharmacological interventions or brain stimulation helps a person achieve their authentic self or estranges them from it. Kramer (1993) observed that patients who were prescribed Selective Serotonin Reuptake Inhibitors (SSRIs) for their depression felt "better than well", more confident and positive than they had ever felt. At the same time, they also expressed that they felt strangely unlike themselves. Here, whether this is a treatment to restore baseline health or does something more to the person comes to be an issue. The debate emerges largely between the two positions that take up two principal theories of authenticity: the self-discovery view and the self-creation view (Parens, 2005). Whereas the self-discovery account holds that the self is a fact about a person that is innate and to be discovered through reflection and carefully listening to the inner voice, the self-creation account on the other hand contends that there is no fixed, true self, and that being authentic is about actively and continuously shaping one's life with one's own will. On the first account, psychopharmacological treatment is seen as a threat; such treatment gives patients a personality that was never theirs. The second account considers it favourable; it is a tool of self-creation, and through its use they can achieve traits that they genuinely value (Levy, 2011). What this debate elucidates is that once treatment of the disorder occupies the centre of mental

health care, the bioethical concern of the alignment between authenticity and becomes difficult to avoid. The attempt to resolve this concern often do so by importing a particular theory of authenticity as the objective definition and applying it to the case wholesale — Kramer's patients are read as either estranged from an authentic self or freed to construct one, depending on which theory is assumed from the outset. Yet, a theory settled in advance can only ask which side of the debate a given case falls under, not what authenticity would mean for the person living it.

Personal Recovery as the Goal of Mental Health Care

An alternative and increasingly influential goal reframes mental health care around what has come to be called personal recovery: living a meaningful, fulfilling life — with a sense of personal meaning, values, relationships, roles, and ways of being — regardless of whether what is defined as a “symptom” is present (Anthony, 1993). It is explicitly distinguished from “clinical recovery,” which retains symptom reduction as its measure of success (Slade, 2009). The goal of personal recovery centres the person's own subjective sense of their life, and prioritises their autonomy and agency over externally defined markers of health. This shift is captured in the CHIME framework, which identifies connectedness, hope, identity, meaning, and empowerment as the core processes of recovery (Leamy et al., 2011). It also observes that what disables a person is often not the disorder itself but its social consequences — stigma, diminished expectations, and the loss of valued roles and rights — such that treating clinical symptoms alone is insufficient and practice guided by this goal must address housing, employment, relationships, and civil rights directly.

Anthony (1993) discusses several practical implications of this reorientation. First, it reframes the practitioner's role from producing a clinical outcome to facilitating a process that belongs to the person. The practitioner contributes expertise, resources, and support, but the person determines the direction of that process and what counts as its success. Recovery, on this view, is not a state the practitioner brings about, but one the person works towards on their own terms. In addition, because recovery is understood as non-linear, services are expected to tolerate and work through setbacks rather than treat them as failures of treatment, and to focus on building the skills and supports that allow someone to live well with a limitation rather than aiming to eliminate the limitation itself. Deegan (1996) grounds this in the principle of the “dignity of risk” and the client's right to fail. When practitioners manage risk on a client's behalf, steering them away from choices that might go wrong, this protective stance can itself obstruct recovery, since recovery requires the person to exercise agency, including the agency to make mistakes. Treatment remains possible within this framework, but only as one option among others that the person, as an autonomous agent with decision-making capacity, may choose — not as something imposed upon them.

This goal of personal recovery bears a close relationship to the ideal of authenticity. On any account, being authentic centrally involves being oneself, living in a way that is congruent with what feels most one's own, and this is precisely what the concepts of autonomy and agency, central to personal recovery, are meant to protect. Here, the focus is not on the objective theories of what authenticity consists in.

Rather, the goal of personal recovery is closely related to the person's own subjective sense of feeling authentic: whether they feel they are living in a way that expresses what feels most their own.

In some cases, a person may decide that treatment does not align with their authenticity, because what psychiatric authority labels as disordered, abnormal, or unhealthy is in fact part of the authenticity they want to embrace. Consider a person who hears voices. Rather than construing this as a clinical symptom to be eliminated, they may come to experience the voices as part of themselves, such that suppressing the voices does not feel right. The recovery-oriented path is then to understand the voices, to enter into a different relationship with them, and to learn to live in a way that is no longer ruled by them (Corstens et al., 2014; Longden et al., 2012; Romme & Escher, 1989). Or consider a person diagnosed with attention-deficit/hyperactivity disorder (ADHD). What the diagnosis classifies as "attention-deficit" or "hyperactivity" may be experienced by the person not as something to be regulated away but as parts of themselves they value — the source of creative sparks, high energy, and spontaneity (Sedgwick et al., 2019; White & Shah, 2006). Rather than construing these traits as deficits to be medicated away, they may choose to embrace them and to seek out work and relationships suited to who they are. In each case, the point is that the person is living the life they choose rather than the life others — family, friends, clinicians, or voices — choose for them, based on what feels truly authentic. In declining treatment, they are authoring their life in a direction that is conducive to their wellbeing and flourishing. This shows that treating what psychiatry considers disordered is not always aligned with achieving authenticity — and that personal recovery tends for the same reason to align with authentic living. To facilitate personal recovery is, in most cases, to facilitate a person's authentic life.

Authenticity and Personal Recovery – the Dilemma

As the preceding discussion has shown, the personal recovery framework is typically conducive to authentic living. To protect a person's autonomy and agency, to resist steering them toward a clinically prescribed trajectory, and to honour their own subjective sense of what a good life consists in is generally also to protect their capacity to be themselves.

Yet, there is an uncomfortable tension in committing to this view once we are confronted with a case like Lisa's. In her situation, the suffering, trauma, suicidality, isolation are all woven into her authentic self. In other words, she feels authentic just the way she is. The question then arises: if being this way genuinely feels authentic to Lisa, is this what mental health care should support? We may say that since she lives a life that feels most her own, her recovery is in an important sense already achieved, and the task of mental health care is simply to let her be. Yet, our intuition may ask, is this kind of life what a subjectively meaningful life amounts to for her?

The force of this tension becomes clearer when we set Lisa's case beside the examples considered earlier. For both the voice-hearer and the person with ADHD, declining the clinical approach of treating the symptoms was a way of navigating their own life in a direction conducive to their flourishing. It is about choosing their own version of a meaningful life without being pressured by the authority of

psychiatry. Although they are not trying to suppress the voices or the impulsivity that comes with ADHD, personal recovery means finding their own way of flourishing alongside these traits, rather than giving up on a good and meaningful life because of the struggles they bring. In Lisa's case, however, the same move is not available to her. The voice-hearer and the person with ADHD flourish alongside their traits, building a life despite the struggles they bring; Lisa does not experience her suffering, isolation, and wish to disappear as something to build a life alongside, but as what she is. To ask her to pursue a good and meaningful life in spite of them is, on her own understanding of herself, to ask her to become someone else entirely. It is one thing to learn to live with these struggles, and another to derive one's sense of authenticity from them in such a way that one actively stays with them, so that a life of meaning and happiness comes to feel like a betrayal of oneself.

It is tempting to locate the source of this tension in the content of Lisa's authentic self — in the fact that she identifies with trauma-saturated suffering, isolation, and self-destruction — materials that seem ill-suited to living a meaningful life. However, to locate the fault here, to say that her sense of what is most her own is defective because of what it contains, would be to reinstate the external, objective standard of the good life, which is exactly what the personal recovery framework aims to repudiate. Personal recovery takes the person's own subjective sense of a meaningful life as its starting point, not a prior judgement about which contents are acceptable, healthy, or adaptive from a normative perspective. The real problem, I argue, lies in the way Lisa holds her sense of authentic self.

To see what this means, we may recall what personal recovery actually asks of a person. Personal recovery is not a state but an open-ended process: it involves an ongoing discovery and construction of new meanings, values, feelings, relationships, and roles (Anthony, 1993; Leamy et al., 2011; Slade, 2009). A peer support group is one good example: someone struggling with alcohol addiction may share her experience, and others with similar experiences may help her come to understand her drinking differently, or discuss different strategies for managing urges when they arise. Or, she may come to perceive treatment differently through hearing others' experiences with it and decide to try a treatment programme she had previously resisted. By going through this process of discovering what may be possible for oneself, one can find what feels both truly oneself and meaningful. A harmony between personal recovery and authenticity presupposes that a person's sense of authenticity is itself capable of accommodating such movement, that to be oneself pertains to finding what feels most one's own through this kind of flexible, relational, and agentic searching. When a person's sense of authentic self has this open structure, personal recovery and authenticity travel together.

The problem with Lisa's case is that her sense of authenticity is rigid and self-enclosing. It is rigid in that it is held as fixed and closed to revision: her identity as a trauma survivor is treated not as one chapter of an unfolding story but as the whole and settled truth of who she is, such that any change reads to her not as growth but as annihilation — "becoming someone I can't even imagine." This rigidity serves as a way of preserving continuity at the expense of imagining alternatives. She does not want to become a "happy normal person" because such a change would require her to inhabit a self she cannot recognise as her own. And it is self-enclosing in that this self is construed as a solitary, self-contained fact about her,

something she possesses and consults inwardly, rather than something formed in and through her relationships and her engagements with the world. Here, the two ideals that mental health care wants to hold up come apart: her authenticity cannot house the very movement that personal recovery requires, and so recovery can only appear to her as a demand to betray herself.

Relational Authenticity in Mental Health Care

We want both ideals for Lisa: a life that feels meaningful to her and one that feels truly her own. The difficulty of holding them together is not merely conceptual but pressing, since it is clinicians, and mental health care as a whole, who must respond to her. How can they help her recover — come to author a meaningful life in her own way — while respecting her sense of authenticity?

My response is that rather than choosing between the two ideals, the task is to help a person foster a flexible and relational sense of who they are — a way of being themselves worked out through their relations with others and open to what those relations make possible. Where authenticity takes this shape, the exploration that recovery requires registers as an expression of self rather than a betrayal of it. This turns on the concept of relational authenticity I am going to set out.

Relational Authenticity

The relational account of authenticity is developed by Gallagher et al. (2018) out of phenomenology and embodied cognition. They share the existentialist claim at the centre of the self-creation view: a self is something one makes rather than something one finds. There is no interior settled in advance to which a person could be faithful; being oneself is something one does, worked out in how one lives, in what one commits to and what one lets go of. While they take this as the starting point, they reject the core idea that is postulated in both self-creation and self-discovery views: that authenticity is achieved, either discovered or created, in solitude. The self-discovery view locates authenticity in an interior self to be uncovered through introspection; the self-creation view locates it in the freedom to author oneself against inherited roles and social expectations. However different in orientation, both rest on the assumption that genuine selfhood requires some degree of insulation from one's relations.

The relational account starts elsewhere, from a premise about our being that can be traced back to twentieth-century phenomenologists such as Heidegger: we are essentially, inescapably social beings. Our sense of who we are, what matters to us, and how we navigate the world does not develop in isolation and only later enter into relation with others; it is constituted through intersubjective processes from the very beginning of life. Even long before infants can reflect on who they are, they are attuned to the rhythms, expressions, and affective states of their caregivers, adjusting their responses and developing a bodily sense of what the world is like and how to move through it (Beebe & Lachmann, 1988; Trevarthen, 1979). What we later experience as most deeply our own — our values, emotional orientations, and ways of relating to others — has its roots in this pre-reflective history of being with others. This suggests that the insulation both views require does not hold. The values one recovers

through the inward turn have themselves been cultivated through a history of conversations, relationships, and cultural meanings, and the freedom exercised in self-creation was made possible by the very relations it seeks to transcend. Even the capacity to recognise an expectation as an expectation, and to weigh or refuse it, is acquired through relations with others.

Relational authenticity is what results when self-creation is set within this social existence. One creates oneself in and through one's relations with others, drawing on the understanding, the vocabulary, and the possibilities they afford. Authenticity then lies in how one takes up that existence: in "facing up to the richness and complexity of our situated existence that comes from being-in-the-world-with-others" (Gallagher et al., 2018, p. 141), acknowledging the relations through which one has come to be who one is and going on to make a life of one's own from within them.

It is important to note that this does not mean that being true to oneself amounts to deferring to what others expect of one. Mihailov et al. (2021) describe relational authenticity as the co-authorship of the self: who one is takes shape in genuine dialogue with others, whose perspectives, challenges, and responses play a formative role, while one retains the position of author. This highlights that the agency of the self remains, while acknowledging the role that others play in authoring it.

This understanding is also helpful when we think about the role that our past experiences play in shaping our authentic being since co-authorship extends not only to the life ahead but to the life already lived. To hold one's self-narrative open to co-authorship is to treat one's present way of being as one configuration among others, which took shape under particular relational conditions and might yet give way to others. Even what feels most fixed, most constitutive, most essentially one's own is revisable. Revisable does not mean inessential; it means open to reinterpretation in and through one's ongoing relations with others (De Haan, 2020). This openness — the capacity to hold even what feels most settled as subject to revision — is what a rigid and self-enclosing sense of authenticity forecloses, and what relational authenticity, as a goal of mental health care, aims to cultivate.

Relational Authenticity as the Condition for Recovery

The dilemma that I set out to settle arises when a person's sense of who they are has closed around their suffering, so that they cannot experience any movement away from it without feeling the loss of themselves. What personal recovery asks of them, to explore and living a life that feels meaningful to themselves, is just what their authenticity, held as a fixed and settled truth, cannot accommodate. My claim is that this dilemma follows from this shape that their authenticity has taken, and that a relational sense of authenticity is the condition under which recovery becomes possible for them. It is what allows the two commitments Lisa's situation had forced apart — being herself and authoring a meaningful life — to align. As she comes to hold her authenticity as something worked out in and through her relations, rather than as a settled fact she finds within herself, the space that recovery requires begins to appear.

That space opens because the concept of relational authenticity holds one's authentic way of being as revisable — as one configuration among others, open to reinterpretation in and through one's relations,

rather than as a settled truth any change would violate. A self held in this way can admit the exploration personal recovery asks for as an unfolding of who one is, so that what once registered as a betrayal of oneself can come to appear as a way of becoming oneself.

Yet making exploration conceivable is not the same as making it bearable. Even where change no longer means losing oneself, to venture beyond the only self one has known can be frightening. For someone who is suffering in the aftermath of trauma, physically, mentally, and socially, to undertake this venture alone, drawing only on one's own resources, asks a great deal. If one's sense of being oneself itself becomes relational, the venture no longer needs to be a solitary one. Because being oneself is an ongoing co-authorship with others, moving into new ways of being is something done with other people, not a solo act. One does not need to face the venture alone — the people one trusts are part of how the change happens at all. What relational authenticity offers is thus not only a self that can change, but a self that can be inspired and supported by others.

To describe a relational sense of authenticity as the condition of recovery might seem to pass a verdict on the self a person already is, as though her trauma-shaped self were the wrong thing to be and recovery a matter of leaving it behind. To pass a verdict — to name one self deficient and another the self she ought to want — would reinstate the very standard of the good life that the personal recovery framework was developed to refuse. This is not what I am claiming. What the proposal offers is not a better self, but the room in which other ways of being can come into view as genuinely her own to take up or decline. It changes whether any other way of being is available to her at all, and passes no judgement on the one she now inhabits. To make a possibility available is to widen what she might be, not to rank anything above the self she already is. Which of different ways she grows into, and whether she grows into any, is what she works out in and through her relations, rather than along a course fixed for her in advance.

Implications for Practice

What, then, does it mean in practice for mental health care to help someone like Lisa come to hold their sense of authentic self relationally? I have argued that a relational sense of authenticity is the condition of her recovery. Cultivating it, however, is itself a change not only to how she understands and reflect on herself, but to how she experiences herself. If she resists change as such, the proposal seems simply to reintroduce the very problem it was meant to solve.

I argue that the resolution lies in a principle the personal recovery framework has long held: change is embraced as one's own only when it arises from one's own agency, rather than being imposed on (Deegan, 1996). What care offers is not an attempt to change her, but the space and environment within which her agency is supported to emerge. Hence, to help someone like Lisa should also involve creating a space of co-authorship, a safe environment in which exploration feels supported and possible, rather than teaching her, as an expert who knows better, what a good life would look like.

Working in this direction, in practice, is largely a matter of the quality of the relationship rather than of technique: non-hierarchical and collaborative, in that the practitioner does not hold the final word on who Lisa is or what her experience means; non-judgemental, in that Lisa is respected as an agent with autonomy over her own life. What the relationship offers is not direction but availability. Bowlby (1988)'s account of the therapist as a secure base captures this well: he suggests that a therapist should first and foremost provide a reliable ground from which a person can venture toward what would otherwise feel uncomfortable or distressing, and to which they can return – not a figure directing the course of treatment, but a companion in her own exploration of herself (Mikulincer & Shaver, 2012). This matters because the opposite is still so often what people encounter in mental health services: feeling powerless, silenced, and judged; medicated against their wishes; having their own account of one's experience discounted as merely a further symptom of it (Ahmed et al., 2021; Crichton et al., 2017; Leamy et al., 2011; Mertens et al., 2025). Returning to Lisa's case, within such a relationship, what was once unthinkable and lay outside the settled sense of who she is – speaking of her trauma to a classmate, moving out of her parents' house, reading about another trauma survivor's experience of recovery – may gradually become realistic options that she could imagine or try out. And when she ventures, someone is there with her, as a partner in this exploration, without rejection or correction. It is this absence of judgement that allows her to practise exercising her agency on her own terms. This companionship, not any technique brought to bear within it, is what is conducive to a sense of being oneself arising in and through connection with others.

Such practice is necessary because her trauma-shaped way of being is a history settled into her lived body, structuring what is salient to her and what appears possible on a pre-reflective level (Merleau-Ponty, 2002). Operating beneath the level of reflection, it cannot be argued away. Sedimentation, however, is an ongoing process rather than a finished settlement: what it has laid down in her, it can lay down differently as she continues to live. The more she imagines and tries out ways of being that lie outside her settled sense of herself, the more these too begin to sediment: what was once unimaginable becomes something she has done before, and with practice, ordinary. Recovery, on this view, is a matter of learning by doing rather than being taught the right way to be.

I should be candid that what this yields is not a novel prescription for practice. Recovery-oriented practice has long endorsed and embodied an emphasis on relationship over technique: on collaboration rather than hierarchy and respect over judgement (Borg & Kristiansen, 2004), on the unremarkable, non-technical gestures through which a practitioner comes to be experienced as reliable and present (Topor et al., 2018), on the connectedness that relationships themselves provide (Lorien et al., 2024), and on the creation of a safe space in which the person is met as a whole person rather than a diagnosis (Chatwiriyaiphong et al., 2024). The analysis of Lisa's case through the lens of authenticity strengthens the grounds personal recovery-oriented care already holds for this relationship-based practice. What this analysis shows is that, where mental health practice can feel at a loss, uncertain what there is to offer someone who resists change, the answer still comes down to relationship.

Conclusion

This paper has examined a dilemma that arises when a person's suffering has come to constitute the core of who they are to the degree that being true to themselves and authoring a meaningful life are experienced to demand opposite things. What generates this difficulty, I have argued, is the way such a person holds their sense of who they are: as a fixed and self-enclosed truth, closed to revision, so that any movement away from it registers as a loss of self rather than its unfolding. This is the sense of authenticity that forecloses the exploration personal recovery presupposes. My proposal is that what mental health care can do to help such a person is to help them come to hold their sense of authentic self relationally, as something to be created in and through their relations with others, so that the exploration personal recovery asks for can register as self-expression rather than self-betrayal. The practical task of care that this view implies is the focus on the relationship — creating a safe relational space within which their agency finds room to work.

This analysis brings into view a tension between the ideals of authenticity and personal recovery that are both important for humanistic mental health care practice. The contribution of this paper lies in explicating this dilemma and arriving at the implication that what helps in resolving this tension may be to return to the basic principle of personal recovery-oriented practice: the focus on creating a safe, trusted relationship. What can look like the unremarkable background of good care, presence, reliability, and a readiness to work without imposing a direction, is, at the limit, what her recovery depends on. What this kind of relationship-centred care concretely looks like, and how practitioners come to embody it, is a question the literature has been working out over recent decades, and its continued development is part of what will make a recovery of this kind available to people like Lisa.

Declarations

Author Contribution

The sole author is entirely responsible for the conceptual design, theoretical arguments, literature analysis, and the drafting and final revision of this manuscript.

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