Using Early Recollections to Explore Personality Trait, Self-efficacy, and Insight in Depressive Patients

Wei-Jen Chen, M.D., Ph.D.[1,2], Frank Huang-Chih Chou, M.D., Ph.D.[1]*

[1]Departments of Neuropsychiatry, Kaohsiung Municipal Kai-Syuan Psychiatric Hospital, [2]Graduate Institute of Counseling Psychology and Rehabilitation Counseling, National Kaohsiung Normal University, Kaohsiung, Taiwan

Abstract

Objective: Early life experience forms a template for the self-perception of an individual, and negative representations make individuals vulnerable to depression. To explore the deep inner world of patients with depression using objective early life experience measures is not easy. In the present study, we intended to clarify the use of subjective early recollections (ER) in exploring the inner world of depressive patients. **Methods:** We interviewed 80 depressive inpatients with ER and evaluated whether they had a feeling sense of belonging to their caregivers, and whether they had a positive self-image. They were also assessed using the Taiwanese version Type D Scale-14, Chinese version General Self-efficacy Scale, the Taiwanese version of the Mini-International Neuropsychiatric Interview, and Insight Interview. **Results:** Independent *t*-test was used to test the significant differences between feeling belonging/not feeling belonging groups and between positive or negative self-image groups on the variables of Type D personality traits, self-efficacy, illness insight, and comorbid psychiatric disorders with effect sizes ranging from 0.4 to 1.3. **Conclusion:** Our study showed that ER could function as a window through which depressive patients' inner life. Thus, we suggested that ER can be considered an important part of the clinical assessment methods for depressive patients.

Key words: illness insight, individual psychology, self-efficacy, and type D personality
Taiwanese Journal of Psychiatry (Taipei) 2021; 35: 64-69

Introduction

Depression is a common disorder. The 12-month and lifetime prevalence of depression is 7.2% and 10.8%, respectively [1]. About 40%–80% patients with suicide are associated with great social burden [2]. The rising cost associated with depression is a major public health problem worldwide [3]. Depression will become the leading cause of disease burden by 2030 [4]. Therefore, public health programs on preventing depression have been promoted in many countries. The more we can understand patients with depression, the more we can provide them with better treatments.

Coping has been described as a personality response under stress [5]. Broadly, personality is defined as the characteristic patterns of beliefs over time and across situations. A resurgence of interest exists that patients' personality might contribute to vulnerability and presentation of symptoms of depressive disorder. Among personality styles, Type D personality is a vulnerability factor for general psychological distress [6] and has been described as tendency to experience a high concurrent social inhibition and negative emotion [7]. Many studies exist to study the effects of Type D personality relating to clinical and psychological outcomes in patients [6, 8, 9].

In addition, individuals who are confident to cope with stressful events can be less affected by those stressing situations [10]. Individuals with higher self-efficacy can reduce their stress, manage their environment, and show interest in pursuing their better health [11], and those with low self-efficacy may be more likely to have depression because they are less apt to control depression and cope with challenging situations [12]. Self-efficacy is related to depressive patients' beliefs in coping with challenging situations.

*Corresponding author. No.130, Kaisyuan Second Road, Lingya District, Kaohsiung City 802211, Taiwan.
E-mail: Frank Huang-Chih Chou <f50911.tw@yahoo.com.tw>

Access this article online

Quick Response Code:

Website:
www.e-tjp.org

DOI:
10.4103/tpsy.tpsy_15_21

To get a more complete picture of depressive patients, many studies have been designed to explore the relation between early life experiences and their personality styles [13, 14] and self-efficacy [15]. Among those studies, most researchers use objective measures to assess early life experiences. But objective measures generally involve a series of written questions, which are not effective in exploring the deep inner world of patients with depression. Many person-centered practitioners may not like to use objective self-report measures because of their relatively impersonal format.

The rôle of negative interactions with significant others forms a template for self-perception in adulthood, and negative representations of self and/or others leave individuals vulnerable to depression [16, 17]. The therapist who practices individual psychology may use early recollections (ERs) to assess an individual's unique worldview [18]. Subjective ERs are a representation of capsule summaries of an individual's present life philosophy, giving clues or hints about depressive patients' fundamental outlook on life. The ERs of depressive patients suggested more disturbed relationships with family members, more fear, anxiety, or other negative affects, and little acceptance of responsibility for what happens in their memories [19]. There was a correlation between Beck Depression Inventory scores and negative affect in reported ER [20].

After Rorschach inkblot and thematic apperception tests appeared, ER has been one of first projective methods [21]. As a projective technique, ER can help us understand depressive individuals through an empathic interaction. In this study, we proposed that using recollections as an alternative approach to understand the early life experiences of depressive patients more thoroughly.

Other than a belief system, a lack of insight is a clinical problem in mood disorders [22]. Illness insight is generally acknowledged as an important factor which influences compliance with the treatment and outcome of depressive disorder [23]. Depressive patients who lack insight are to do poorly. Ghaemi et al. have reported an association between a lack of insight and a poor outcome [23].

The memories recalled in ERs are important indicators of depressive patients, and we can use their ER to assess their unique worldview. In the present study, we intended to clarify the use of subjective ER in exploring the depressive patients, especially regarding type D personality traits, self-efficacy, and illness insight.

Methods

Study procedures and subjects

Study participants who were diagnosed with major depressive disorder according to *the Diagnostic and Statistical Manual of Mental disorder, the Fifth Edition (DSM-5)* by specialist psychiatrists in Kaohsiung Municipal Kai-Syuan Psychiatric Hospital were recruited for our study. The inclusion criterion was an age of 20 years or older, because people aged 20 years or older were considered legally competent in Taiwan without the need of obtaining informed consent from a custodian. First, we gave an introduction in Kaohsiung Municipal Kai-Syuan Psychiatric Hospital, and then study participants were referred for the consideration for participating in the study.

Written informed consent was obtained from all the study participants before the assessment. We recruited 80 qualified participants totally. The study participants did not have any dropout or withdrawal from the study. Measurements were done completing copies of self-report questionnaire and receiving structured interview. The participants first filled out copies of self-report questionnaire, which included the Taiwanese version Type D Scale-14 (DS-14) and Chinese version General Self-efficacy Scale (GSES). They were then asked to give 3 to 5 ERs. Furthermore, comorbid psychiatric illnesses were evaluated using the Taiwanese version of the Mini-International Neuropsychiatric Interview (MINI), and insight level was also assessed by specialist psychiatrists. The study was approved by the institutional review board of Kaohsiung Municipal Kai-Syuan Psychiatric Hospital (study protocol number = KSPH-2016-13 and date of approval = January 9, 2017) with the stipulation of obtaining informed consents from the study participants.

Measurements

Taiwanese version D scale-14

We used the Taiwanese version of the DS-14 to evaluate participants' personality styles. Type D personality refers to the conjoint effect of two stable personality traits, negative affectivity, and social inhibition. Persons with high levels on both personality traits are classified as type D personality. The Type D construct can be measured with DS-14 questionnaire [7], consisting of two seven-item subscales assessing social inhibition and negative affectivity. Study participants answered items on a five-point Likert scale, and those who score 10 points or more on both dimensions are classified as Type D personality. Taiwanese version DS-14 also has good reliability and validity [24]. Cronbach's α was 0.86 and 0.79 for the NA and SI subscales, respectively. The results of criterion-related validity showed a positive correlation between NA with anxiety (0.67), depression (0.50), and hostile affect (0.55). Furthermore, the correlation between hostile cognition and SI was 0.34.

Chinese version general self-efficacy scale

We used the Chinese version of GSES to evaluate self-efficacy of study participants. GSES is a 10-item psychometric scale that is designed to assess optimistic self-beliefs in coping with a variety of difficult demands in life. The scaled score for each question ranges from 1 (not at all true) to 4 (exactly true). Higher scores indicate stronger participant's belief in self-efficacy. The scale was originally developed by Jerusalem and Schwarzer [25], and Chinese version GSES also has good reliability and validity [26]. The internal consistency was 0.91.

The Taiwanese version of mini-international neuropsychiatric interview

In this study, the number of comorbid psychiatric disorders was evaluated by the Taiwanese version of the MINI. MINI is a short, structured diagnostic interview which is used as a tool to diagnose 16 axis I disorders and one personality disorder of *the Diagnostic and Statistical Manual of Mental Disorders, the Fourth Edition (DSM-IV)*. Its original version was developed by Sheehan and Lecrubier [27, 28], and was translated to Taiwanese [29].

Insight interview

Illness insight is a multidimensional phenomenon, which is collected through interviews. The collected data include awareness of illness, awareness of symptoms, the perceived need for treatment, and recognition of the social consequences of illness [30]. In our study, specialist psychiatrists assessed insight level according to criteria suggested in the textbook of psychiatry [31]. The degree of illness insight, including personal awareness and understanding of illness, is assigned a level of seriousness from 1 to 6:

- Level 1: Complete denial of illness
- Level 2: Slight awareness of being sick and needing help, but denying it at the same time
- Level 3: Awareness of being sick, but blaming it on others, on external factors, or on organic factors
- Level 4: Awareness that illness is caused by something unknown in the patient
- Level 5: Admission that the patient is ill and that symptoms or failure in social adjustment is caused by the patient's own particular irrational feelings or other disturbances without applying this knowledge to future experiences
- Level 6: Emotional awareness of the motives and feelings within the patient and important persons in his or her life, which can lead to basic changes in behavior.

Early recollections
Phase I

In our study, the participants were asked to give 3–5 recollections of events that occurred before they were 10 years old as much detail as possible. The first question is "What I want you to do is to think back as far as you can remember, and tell me your earliest memory." When the participants appeared to have completed the memory, we asked, "Is there anything else you can recall about the memory?"

The integration of sensorial experiences into the ER gathering process reduces reliance on intellectualizing and enhances the verbalization of feelings [32]. For further clarify memories, we ask the participants "Now I would like you to focus on the most vivid part of that memory. If you were able to take a picture of the most vivid part of that memory, what would it be?" Because feelings associated with participants are crucial in subsequent interpretations of the memory [33], we asked participants "What were your feeling at that moment?"

Phase II

After participants gave 3–5 ERs, they were further asked to complete three sentences based on the ERs they have made. The sentences began thus: (a) I am ..., (b) Others are …, (c) Life is …. We offered the prompt: "If all you knew about the life was what is in your ERs, how would you complete these sentences?"

Phase III

Finally, we asked, "How do you feel about your caregiver as a child? Do you feel a sense of belonging toward your caregiver?"

Categorization

According to the Adlerian perspective, individuals reports of ERs may be categorized into three types according to affect: Negative (characterized as uncomfortable, traumatic or discouraging), positive (characterized as enjoyable), and finally, ambiguous or confusing [18].

In our study, the "affect" category was concerned with the pleasantness or unpleasantness. Thus, we looked for the presence of negative affect or positive affect in each participant's ERs and used these dichotomous codes in the analyses. In addition, since the inability to belong or to connect with others results in pathology according to Individual Psychology [34], we also included the depressive patients' sense of belonging in this study.

In summary, we analyzed the ERs collected through the participants' sentence completion task and the answer to the question about caregiver. Based on their ERs and the sentence completions from the three questions ("I am, others are, life is"), participants were divided into positive or negative self-image groups. According to the answers to the question about caregivers, participants were divided into two groups: Those who do feel a sense of belonging toward their caregivers and those who don't. These judgments were made by a specialist psychiatrist with sufficient Adlerian training. Below is one of examples.

Miss Lin is a clean worker coming from a lower socioeconomic background. Her father was violent and abusive, and her mother was incompetent and could not protect her anymore. She has been severely neglected since she was a child. Miss Lin's ERs are as below:

Age five: When quarreling with my younger brother, my father did not ask the reason, and indiscriminately said that it must be my fault.

Age seven: I came home and found blood on the floor. I asked my mother "Did my father beat you?" Mom did not dare to answer, because Dad gave her a bad look.

Age eight: I was bullied by my classmates at school and dare not tell my parents after returning home. Hiding alone in the room, she held a Teddy bear crying.

Her belief was based on the analysis of ERs are: "I am a useless person, others are hostile and demanding, and life is hopeless."

Miss Lin's ERs were categorized to negative self-image and not feeling sense of belonging.

Statistical analysis

Type D personality scores, self-efficacy degree, illness insight level, and presence of psychiatric disorders were obtained by Taiwanese version DS-14, Chinese version GSES, insight interview, and MINI, respectively. The differences between the two affect groups (feeling belonging or not) and the two self-image groups (positive or negative self-image on the mentioned variables) were analyzed using independent t tests with alpha at 0.05 level. Cohen's d was calculated to measure effect size.

All the data were analyzed using the Statistical Package for the Social Science software version 17.0 (SPSS Inc., Chicago, Illinois, USA). The differences between the groups were considered significant if p-values were smaller than 0.05.

Results

A total of 80 participants completed our questionnaires and interview. The mean age of all participants was 47.6 years old ($M = 11.0$), and the average of number of years of education attained was 12.3 years ($M = 2.4$). Among those participants, 64 persons (80.0%) were female and 16 persons (20.0%) were male. Thirty-four persons (42.5%) were married, 16 persons (20.0%) were single, and 30 persons (37.5%) were widowed, divorced, or separated (Table 1).

Regarding the measure of sense of belonging, 39 persons (48.8%) were reported as not feeling a sense of belonging, and 31 persons (38.8%) were reported as feeling a sense of belonging, with 10 persons (12.4%) who were unable to categorize their sensations clearly. Regarding the beliefs about self-image, elicited with the "I am …" prompts, 38 persons (47.5%) had a negative self-image, 35 persons (43.8%) had a positive self-image, and 7 persons (8.7%) had beliefs that could not be categorized clearly. Regarding the results of the prompt "Others are …," 32 persons (40.0%) had a negative self-image, 31 persons (38.7%) had a positive self-image, and 17 persons' (21.3%) beliefs could not be categorized clearly. Regarding the results of the prompt "Life is …," 30 persons (37.5%) had a negative self-image, 26 persons (32.5%) had a positive self-image, and 24 persons (30.0%) beliefs that could not be categorized clearly.

Because a large proportion of participants could not be categorized by beliefs elicited from the "Others are…" and "Life is …" prompts clearly, we used categorical variables of

Table 1. The demographic data of all study participants

Variable	Total, n (%)
Age (years), mean ± SD	47.6 ± 11.0
Education (years), mean ± SD	12.3 ± 2.4
Gender	
Female	64 (80)
Male	16 (20)
Marital status	
Married	34 (42.5)
Single	16 (20.0)
Widowed	30 (37.5)

SD, standard deviation

the sensations of belonging toward their caregivers and the beliefs about "I am …" in analyses to assign groups. There was no significant difference between the two groups in sex, education,, and marital status.

Compared with participants who did feel sense of belonging (Table 2), those who did not feel a sense of belonging tended to have negative affectivity of Type D personality ($t = 3.1$), poor self-efficacy ($t = -2.6$), lack of illness insight ($t = -4.2$), and more comorbid psychiatric disorders ($t = 4.8$). The effect sizes ranged from 0.4 to 1.1. Compared with participants who had a positive self-image (Table 3), those who had a negative self-image tended to have negative affectivity of Type D personality ($t = 3.4$), poor self-efficacy ($t = -3.2$), lack of illness insight ($t = -5.7$), and more comorbid psychiatric disorders ($t = 3.8$). The effect sizes ranged from 0.4 to 1.3.

Discussion

Alfred Adler believed that through life experiences, people create beliefs in systematic ways which relate to their lifestyle [35]. Individuals look for experiences that validate their views of the world. Adlerians would state that ERs are a representation of memories that confirm people's perceptions of how they handle life's problems [18]. Depressive subjects report ERs in which the overall picture is negative [36]. Previous studies showed that the rôle of negative interactions with significant others forms a template for self-perception in adulthood, and negative representations of self and/or others make individuals vulnerable to depression [16, 17]. Our study (Tables 2 and 3) indicated that significantly more depressive patients expressed negative affect during the ER gathering process ($p < 0.05$). This finding is consistent with Adler's theoretical perspective.

Studies indicate that Type D individuals report performing fewer health-related behaviors and lower levels of social support than non-Type D individuals [9]. Type D personality has been associated with poor physical and mental health status and poor self-management of diseases [8] and is a vulnerability for general psychological distress that affects mental status [6]. The present study showed that individuals who stated negative affect, including not feeling belonging (Table 2) and having negative self-image (Table 3), were significantly higher in type-D personality traits ($p < 0.05$). Based on those results, we suggest that subjective ERs can be a useful tool in the clinical mental health treatment.

Previous studies indicated that individuals who score higher on measures of self-efficacy, show substantially fewer symptoms of depression [37], and self-efficacy mediates about 40% of the effect of dependent stressful life events on symptoms of depression [38]. People who demonstrate higher self-efficacy can act in ways that reduce their stress, make their environment more manageable and are more willing to pursue endeavors that contribute to better health [11]. For clinical practitioners, knowing how self-efficacy relates to depressive patients' lifestyles may help clinical practitioners identify patients who are more ready for therapeutic movement. Frequently, the qualitative level of an individual's self-efficacy is apparent in

Table 2. Summary of differences regarding sense of belonging

Variable	Mean ± SD		Cohen's d	t
	Feeling sense of belonging (n = 31; 38.8%)	Not feeling sense of belonging (n = 39; 48.8%)		
Type D personality				
Negative affectivity	17.0 ± 5.3	20.4 ± 3.9	0.7	3.1*
Social inhibition	10.4 ± 7.2	12.9 ± 6.0	0.4	1.6
Self-efficacy	21.7 ± 5.7	18.4 ± 5.1	0.6	−2.6*
Illness insight	3.8 ± 0.5	3.3 ± 0.6	0.9	−4.2*
Comorbid psychiatric disorders	1.2 ± 1.0	2.8 ± 1.8	1.1	4.8*

*$p < 0.05$, using t-test.
SD, standard deviation

Table 3. Summary of differences regarding the beliefs about ''I am …''

Variable	Mean ± SD		Cohen's d	t
	Positive self-image (n = 35; 43.8%)	Negative self-image (n = 38; 47.5%)		
Type D personality				
Negative affectivity	17.0 ± 5.1	20.6 ± 3.7	0.8	3.4*
Social inhibition	10.7 ± 7.4	13.0 ± 5.5	0.4	1.4
Self-efficacy	22.0 ± 5.5	18.2 ± 4.8	0.7	−3.2*
Illness insight	3.9 ± 0.6	3.2 ± 0.4	1.3	−5.7*
Comorbid psychiatric disorders	1.4 ± 1.4	2.7 ± 1.7	0.8	3.8*

*$p < 0.05$, using t-test.
SD, standard deviation

the context of one's lifestyle. One of our study findings (Tables 2 and 3) was that individuals who stated negative affect during an ER gathering process were significantly to have poor self-efficacy ($p < 0.05$). Subjective ER techniques could provide a way for assessing self-efficacy by ascertaining the positive or negative affect of depressive patients' memory. Stated another way, it means that depressive patients who do feel capable of handling for coming obstacles to be detected through ER.

Ghaemi et al. in 1994 indicated that lack of insight is a clinical problem in affective disorders [22]. The same group of investigators in 2000 reported that an association exists between a lack of insight and a poor outcome [23]. Based on previous research data, insight is an important factor which influences compliance with treatment and outcome of depressive disorder [23]. Another finding of the present study (Tables 2 and 3) was that individuals who stated negative affect during the ER gathering process were also significantly not to have insight ($p < 0.05$). This means that ER can provide a keen means for evaluating the level of insight and help clinical practitioners identify those who are ready for therapeutic movement.

Bartholomew and Horowitz have emphasized the importance of early experiences for creating lasting vulnerabilities that contribute to depression. People internalize early experiences with caregivers and thus form cognitive schemes of relationships [39]. These cognitive schemas influence the kinds of relationships they have with others throughout life. In Adler's conception, a neurotic individual retreats from performing life tasks due to what he/she interprets as failure [40]. Understanding subjective early interpersonal

experiences may help us understand the mechanisms that account for their vulnerabilities [17]. Our study (Tables 2 and 3) showed that individuals who stated negative affect during the ER gathering process had significantly more comorbid psychiatric disorders ($p < 0.05$).

The clinical implications for clinical practitioners is that we can look for the presence of negative affect or positive affect in patients' early life experiences through subjective ER. The dichotomous coding system is simple and has a close correlation with Type D personality, self-efficacy, illness insight, and comorbid psychiatric disorders. This information is important for clinical practitioners when they arrange treatment plans for depressive patients.

Study limitations

The readers are cautioned not to over-interpret the study results, because our study has three potential limitations.
- We had more female participants than male participants in our study.
- Caution should be taken when interpreting some results from the present study.
- All study participants were major depressive inpatients from a psychiatric hospital. The results cannot be extrapolated to the depressive patients in the community. Future studies could include more diverse groups, such as male patients and patients in community.
- Level of depression might influence type D personality trait, self-efficacy and illness insight. Future studies could include evaluation of the severity of depression to explore its related effects.

Study summary

Based on ERs collected through the participants' sentence completion task and the answers to the question about caregiver, depressive patients who stated negative affect were higher in Type-D personality traits, poor self-efficacy, lack of illness insight and more comorbid psychiatric disorders. Our study confirms that ER could function as a window through which depressive patients' inner lives can be viewed thoroughly. Thus ER to be considered an important part of clinical assessment methods for depressive patients in clinical practice.

Financial Support and Sponsorship

None.

Conflicts of Interest

The authors declare no potential conflicts of interest in writing this report.

References

1. Lim GY, Tam WW, Lu Y, et al.: Prevalence of depression in the community from 30 countries between 1994 and 2014. *Sci Rep* 2018; 8: 1-10.
2. Rouillon F: Epidemiology of mood disorders. *Rev Prat* 2008; 58: 361-5.
3. Murray CJ, Vos T, Lozano R, et al.: Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012; 380: 2197-223.
4. Lépine JP, Briley M: The increasing burden of depression. *Neuropsychiatr Dis Treat* 2011; 7: 3-7.
5. Bolger N: Coping as a personality process: a prospective study. *J Pers Soc Psychol* 1990; 59: 525-37.
6. Mols F, Denollet J: Type D personality in the general population: a systematic review of health status, mechanisms of disease, and work-related problems. *Health Qual Life Outcomes* 2010; 8: 9.
7. Denollet J: DS14: standard assessment of negative affectivity, social inhibition, and type D personality. *Psychosom Med* 2005; 67: 89-97.
8. Mols F, Denollet J: Type D personality among noncardiovascular patient populations: a systematic review. *Gen Hosp Psychiatry* 2010; 32: 66-72.
9. Williams L, O'Connor RC, Howard S, et al.: Type-D personality mechanisms of effect: the role of health-related behavior and social support. *J Psychosom Res* 2008; 64: 63-9.
10. Bandura A: Self-efficacy *the Corsini Encyclopedia of Psychology*. Vol. 10. Hoboken, New Jersey, USA: John Wiley & Sons, Inc., 2010; 1-3.
11. Bandura A: Health promotion by social cognitive means. *Health Educ Behav* 2004; 31: 143-64.
12. Cervone D: Thinking about self-efficacy. *Behav Mod* 2000; 24: 30-56.
13. Avagianou PA, Zafiropoulou M: Parental bonding and depression: Personality as a mediating factor. *Int J Adoles Med Health* 2008; 20: 261-9.
14. Bellino S, Patria L, Paradiso E, et al.: Major depression in patients with borderline personality disorder: a clinical investigation. *Can J Psychiatry* 2005; 50: 234-8.
15. Diehl AS, Prout MF: Effects of posttraumatic stress disorder and child sexual abuse on self-efficacy development. *Am J Orthopsychiatry* 2002; 72: 262-5.
16. Carnelley KB, Pietromonaco PR, Jaffe K: Depression, working models of others, and relationship functioning. *J Pers Soc Psychol* 1994; 66: 127-40.
17. Zuroff DC, Fitzpatrick DK: Depressive personality styles: implications for adult attachment. *Pers Individ Dif* 1995; 18: 253-65.
18. Kern RM, Belangee SE, Eckstein D: Early recollections: a guide for practitioners. *J Individ Psychol* 2004; 60: 132-40.
19. Fakouri ME, Hartung JR, Hafner JL: Early recollections of neurotic depressive patients. *Psychol Rep* 1985; 57: 783-6.
20. Allers CT, White J, Hornbuckle D: Early recollections: detecting depression in the elderly. *J Individ Psychol* 1990; 46: 61-6.
21. Bruhn AR: Using early memories as a projective technique: the cognitive perceptual method. *J Pers Assess* 1985; 49: 587-97.
22. Ghaemi SN, Pope HG: Lack of insight in psychotic and affective disorders: a review of empirical studies. *Harv Rev Psychiatry* 1994; 2: 22-33.
23. Ghaemi SN, Boiman E, Goodwin FK: Insight and outcome in bipolar, unipolar, and anxiety disorders. *Compr Psychiatry* 2000; 41: 167-71.
24. Weng CY, Denollet J, Lin CL, et al.: The validity of the Type D construct and its assessment in Taiwan. *BMC Psychiatry* 2013; 13: 1-9.
25. Jerusalem M, Schwarzer R: *The General Self-efficacy Scale*. Berlin, Germany: Freie Universität, 1979.
26. Zhang JX, Schwarzer R: Measuring optimistic self-beliefs: a Chinese adaptation of the General Self-Efficacy Scale. *Psychologia* 1995; 38: 174-81.
27. Lecrubier Y, Sheehan DV, Weiller E, et al.: The Mini International Neuropsychiatric Interview (MINI). a short diagnostic structured interview: reliability and validity according to the CIDI. *Eur Psychiatry* 1997; 12: 224-31.
28. Sheehan D, Lecrubier Y, Sheehan KH, et al.: The validity of the Mini International Neuropsychiatric Interview (MINI) according to the SCID-P and its reliability. *Euro Psychiatry* 1997; 12: 232-41.
29. Si T, Shu L, Dang WM, et al.: Evaluation of the reliability and validity of Chinese version of the Mini-International Neuropsychiatric Interview in patients with mental disorder. *Chin Ment Health J* 2009; 23: 493-7.
30. David AS: Insight and psychosis. *Br J Psychiatry* 1990; 156: 798-808.
31. Sadock BJ, Sadock VA, Ruiz P: *Comprehensive Textbook of Psychiatry*. Philadelphia: Lippincott Williams and Wilkins, 2000.
32. Cosgrove SA, Ballou RA: A complement to lifestyle assessment: using Montessori Sensorial Experiences to enhance and intensify early recollections. *J Individ Psychol* 2006; 62: 47-58.
33. Clark AJ: Early recollections: a humanistic assessment in counseling. *J Humanist Counsel Educ Dev* 2001; 40: 96-104.
34. Shifron R: Adler's need to belong as the key for mental health. *J Individ Psychol* 2010; 66: 10-29.
35. Adler A: *Understanding Human Nature* (*Psychology Revivals*). London: Routledge, 2013.
36. Allers CT, White J, Hornbuckle D: Early recollections: detecting depression in college students. *J Individ Psychol* 1992; 48: 324-9.
37. McFarlane AH, Bellissimo A, Norman G: The role of family and peers in social self-efficacy: links to depression in adolescence. *Am J Orthopsychiatry* 1995; 65: 402-10.
38. Maciejewski PK, Prigerson HG, Mazure CM: Self-efficacy as a mediator between stressful life events and depressive symptoms: differences based on history of prior depression. *Br J Psychiatry* 2000; 176: 373-8.
39. Bartholomew K, Horowitz LM: Attachment styles among young adults: a test of a four-category model. *J Pers Soc Psychol* 1991; 61: 226-44.
40. Abramson Z: The meaning of neurosis according to Adler. *J Individ Psychol* 2015; 71: 426-39.