

Accuracy of retrospective memory and covariation estimation in patients with obsessive–compulsive disorder

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Abstract

Assessment methods relying on biased or inaccurate retrospective recall may distort knowledge about the nature of disorders and lead to faulty clinical inferences. Despite concerns about the accuracy of retrospective recall in general and in particular with obsessive–compulsive disorder (OCD) patients, the accuracy of retrospective recall for one's own symptoms assessed in vivo is unknown in this population. This study used a prospective ecological momentary assessment (EMA) methodology to create a criterion against which to assess recall accuracy in OCD patients. Although results indicated that patients' retrospective recall of OCD symptoms was fairly accurate, they consistently overestimated the magnitude of OCD symptom covariation with non-OCD facets (e.g., sleep duration, contemporaneous stress level, etc.). Findings suggest that even when recall of OCD symptoms is accurate, patients may be inaccurate in estimating symptom covariation. The findings have implications for the research, case conceptualization, and assessment of OCD, and may extend to other disorders.

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Accurate clinical case conceptualization frequently relies on a client's ability to retrospectively recall behavioral dimensions of problems. Clinical interviews and questionnaires presuppose that a client's recall is reasonably accurate, although research has questioned this assumption. For example, data collected in vivo and patients' retrospective recall have shown discrepancies for estimates of pain intensity (Stone, Broderick, Shiffman, & Schwartz, 2004), frequency of eating behaviors (Stein & Corte, 2003), use of coping behaviors (Stone et al., 1998), frequency of panic attacks (de Beurs, Lange, & Van Dyck, 1992), timing of smoking lapses

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(Shiffman et al., 1997), and presence of anxious cognitions (Marks & Hemsley, 1999). Inaccurate patient recall has the potential to negatively influence treatment planning and compromise treatment efficacy (Haynes, Leisen, & Blaine, 1997).

No studies to date have assessed recall accuracy of ideographic and ecologically valid symptoms in patients with obsessive–compulsive disorder (OCD). This is problematic for several reasons. First, some laboratory studies have documented memory biases in patients with OCD (e.g., Deckersbach et al., 2002; Fontenelle, Mendlowicz, Mattos, & Versiani, 2006; Savage et al., 1996; Zitterl et al., 2001). Such deficits have been hypothesized to contribute to the maintenance of this disorder. However, not all studies have found evidence of memory deficits (Jelinek, Moritz, Heeren, & Naber, 2006; Moritz, Jacobsen, Willenborg, Jelinek, & Fricke, 2006). Based on extant studies, it appears as if recall accuracy varies as a function of experimental methodology and type of memory assessed (for a review see Muller & Roberts, 2005) and may be moderated by depressive symptoms (Wilhelm, McNally, Baer, & Florin, 1997). Second, metamory, or the trustworthiness and fallibility of one's own memory, may mediate performance (MacDonald, Antony, McLeod, & Richter, 1997; Tolin et al., 2001), although an increasing number of studies have failed to find dysfunctional metamemory in OCD patients (Cabrera, McNally, & Savage, 2001; Moritz et al., 2006, 2007). Third, because the accuracy of retrospective recall degrades as a behavior increases in frequency (Menon & Yorkston, 2000), the high frequency of some OCD behaviors (especially obsessions) suggests that these patients would have greater difficulty accurately recalling their behaviors compared with other disorders. Finally, the accuracy of retrospective recall may be impaired by attentional and encoding biases present in mood and anxiety-disordered patients (Barlow, 2002). Assuming that the accuracy of autobiographical memories is dependent on the quality of initial encoding, accuracy of retrospective recall may reflect deficiencies in cognitive processing prior to storage.

A caveat to interpreting the extant literature is that previous laboratory studies have employed standardized, rather than personally relevant stimuli. One exception is the study of Tolin et al. (2001) in which participants recalled objects after six 10-s presentations, which they had rated as safe, neutral, or unsafe. In this study, participants with OCD recall accuracy of the presented objects did not differ from anxious and non-anxious controls, but did differ with respect to lower confidence in their memory. The ecological validity of this study was limited, however, because the participants remained in the laboratory. Ecologically valid studies in which participants interact with their natural environment are needed to test the generalizability of laboratory results, especially with regard to accuracy in recall of clinically relevant autobiographical behavior. To date, the accuracy of ecologically valid retrospective recall has been investigated primarily with regard to overt behaviors (e.g., smoking, drinking, purging, etc.). The relative accuracy of retrospectively obtained reports of latent processes (e.g., thoughts, emotions, moods, etc.) is less precisely understood. This is troubling given that many theories of anxiety and mood disorders posit a central role for cognition as a causal or maintaining factor (e.g., Beck & Emery, 1985).

If the accuracy of recalled behavioral intensities, frequencies, and durations are compromised, it is also possible that patients inaccurately estimate covariation of different behaviors assumed to maintain the disorder. For instance, the common clinician inquiry as to what factors may exacerbate a target problem requires patients to judge covariance of symptoms, mood, and environmental stimuli. Possible examples range from the general “What makes your symptoms better?” to specific items on assessment instruments such as “How much distress do your obsessive thoughts cause you?” (Yale-Brown Obsessive–Compulsive Scale (Y-BOCS); Goodman et al., 1989). To our knowledge, no studies have directly examined clinical participant's accuracy in estimating covariations of one's own symptoms. Other lines of research suggest, however, that patients will have difficulty accurately reporting covariation of their own behavior. For example, using a non-clinical population O'Brien (1995) presented advanced clinical psychology graduate students hypothetical self-monitoring data of a patient's target behaviors (e.g., headache frequencies, durations, and intensities) and hypothesized controlling factors (e.g., stress level, number of arguments, sleep duration, and number of pain killers taken) and asked them to estimate variable intercorrelations. Students overinflated estimations of weak relationships while underestimating the strength of strong relationships. O'Brien's findings were consistent with other research on illusory correlation (de Jong, Merckelbach, Bögels, & Kindt, 1998; Pauli, Montoya, & Martz, 2001; Tomarken, Mineka, & Cook, 1989) and basic studies on judgment (Kahneman, Slovic, & Tversky, 1982; Nisbett & Ross, 1980), which has shown that humans are largely inaccurate when estimating

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