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Invited Editorial

The Challenges of Measuring Symptoms of Depression in Disability Healthcare

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Depression is a psychiatric construct, most commonly operationalised as a sustained period of low mood and/or loss of interest/pleasure in activities (APA, 2013). Depression is considerably overrepresented among people living with physical illness, long-term disability and mobility-impairing conditions, with the prevalence of major depressive disorder (MDD) consistently 2-3 times higher than in the general population (Moussavi et al., 2007; Read et al., 2017). Conditions involving significant functional impairment, such as spinal cord injury, stroke or loss of limbs, are associated with an especially high prevalence of depressive symptoms and other mental health difficulties (Arnaud et al., 2022; Merlo et al., 2024; 2025a, 2025b; Senra & McPherson, 2021; Silvestro et al., 2025; Villa Castaño et al., 2024). The estimated prevalence of 'clinically significant' depressive symptoms ranges 20-45% depending on the condition (Liu et al., 2023; Singh et al., 2024; Williams & Murray, 2015). Depression remains one of the leading global causes of disability (World Health Organisation, 2023) and among the top contributors to global disease burden worldwide (Vos et al., 2020). Indeed, the issue of multimorbidity – the co-occurrence of two or more chronic conditions – is considered a major challenge for health care systems (Read et al., 2017; Van Blarikom et al., 2023). Given the bidirectional relationship of depression and chronic health conditions (Costa et al., 2023; Katon, 2011), developing appropriate measures of and interventions for depression is of fundamental importance.

Before considering measurement instruments, it is important to interject that the psychiatric category of depression is itself marked by longstanding concerns of its validity and reliability (Myles, 2021; Scull, 2021). These critiques have called for alternative methods for conceptualising mental health difficulties (Scull, 2021), which we believe it is likely will see increasing prominence in the coming years. Nevertheless, the current psychiatric diagnostic system forms the framework within which clinical research and practice are currently conducted. Therefore, this editorial will be written within the context of that philosophical framework.

A large number of tools exist to measure depression (Fried et al., 2022). The 9-item Patient Health Questionnaire (PHQ-9) has seemingly emerged as a forerunner within mental health services in the UK and Europe (Almeida et al., 2015; NICE, 2022). This trend is also evident in physical health settings, gradually replacing the fore-leading Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) and the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). Indeed, the PHQ-9 is endorsed by clinical guidelines for several disabling conditions, including spinal cord injury (Bombardier et al., 2021) and stroke (Wei et al., 2025). The PHQ-9 is itself designed as a screening and severity measure, with items that correspond to each of the 9 symptoms of MDD from the DSM-5 (Kroenke et al., 2001; Somma et al., 2025). Shorter derivatives, such as the 2-item PHQ-2 also demonstrate sensitivity for convenient screening purposes, in settings such as spinal cord injury (Abdulsalam & Krassioukov, 2025), chronic pain (Vancampfort et al., 2025) and chronic kidney disease (Alsaleh et al., 2019). Although performance appears robust when used as a screen, this still requires careful clinical assessment which runs risks of misclassification.

At a systems level, the increasing unification of patient-reported measurement across clinical contexts can have a range of benefits, such as integration of care, improving communication between services and enabling population-level research (Snowdon et al., 2023). These advantages are particularly salient in the context of depression, given it is a significant source of disability and comorbidity in people with physical health conditions. Yet, it is essential to be aware of what may be lost in translation when the same measures are applied to different contexts with their own unique challenges. At the item level, measurement properties may be compromised by different interpretations across contexts. For example, the face validity of items within the PHQ-9 may be poor within specific disability contexts when used to screen specifically for depression. Item 3, *"Trouble falling asleep or sleeping too much,"* might be confounded with the unfamiliar and often communal sleeping environments of inpatient hospital wards or those with limited access to stimulating activity during the daytime. Items 7 and 8, *"Trouble concentrating[…]"* and *"Moving or speaking so slowly[…],"* might be confounded with secondary health complications, such as cognitive difficulties, medication use and/or physical recovery.

Item 9, the designated 'risk screening' item, *"Thoughts that you would be better off dead, or of hurting yourself in some way,"* has received notable criticism for its lack of directness with regards to plans, intention or ideation of suicidal or non-suicidal self-injury (Mournet et al., 2021). By framing the question around "thoughts" rather than explicit suicidal thinking, the item risks capturing ruminations about loss, existential distress or perceived burdensomeness rather than suicidal intent. This is especially unhelpful in newly acquired disability contexts, wherein patients commonly feel profound changes in identity, purpose, enjoyment of daily activities and future expectations (Al Syifa & Hadi, 2023; Diop, 2021; Gómez-Tabares et al., 2024).

How we reconcile the costs and benefits of generalised versus specific depression measurement across health contexts remains a valuable discussion. Cautious and thoughtful application of measures is always a necessity, as individual items may not be interpreted as intended within certain contexts. Importantly, in line with health guidance recommending the use of such measures, they should be interpreted in the context of clinical formulation and in the idiographic context of the patient. When considering physical disability, items pertaining to movement, cognitive function and interpretation of one's circumstances warrant particular consideration, due to the confounding ways their condition may impact these facets, rather than depression per se. Additionally, patient involvement in measurement development, which may involve discussions concerning the development of idiographic outcome measures with each patient (e.g., Hill & Watts, 2024; Myles, 2025; Myles & Jones, 2024), through to larger-scale qualitative or quantitative analysis, could assess the face validity and differential item functioning of standardised measures within specific presentations.

To conclude, harmonising the measurement of depression across physical health and disability services continues to offer benefits for integration, quality improvement, joining up of care pathways and wider research. Yet, these benefits may only be actualised if guidelines and service protocols explicitly account for the interpretive imitations of the measures used. Although this naturally arouses caution for clinicians and researchers, it may also be recognised as an opportunity to understand the item-level functioning of measures, adapt measures to be tailored for specific contexts and perhaps even capture the validity of depression measurement across the trajectory and life course of experiences of disability.

Conflict of Interest Statement

The authors declare the absence of any potential conflict of interest.

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