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Measurement of depression and anxiety problems has not kept up with theory and evidence

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I am concerned that the measurement of depression and anxiety problems is falling behind the theory and evidence. This is a central concern because measurement fundamentally shapes conceptualisation, research and clinical practice. This letter is a call to re-start the scientific cycle again so that current knowledge regarding depression and anxiety problems once again closely underpins endeavours to measure these constructs. To illustrate my point, I present four examples by which depression and anxiety problem measurement has generally not kept up with theory and evidence.

First, a common, very reasonable, but usually untested assumption, is that respective measures of depression or anxiety problems – give or take some error – have fairly equal content validity. However, this assumption seems to be unsound. For example, although there are a multitude of self-report depression measures, evidence repeatedly indicates that these do not measure depression equivalently[1]; and when different scales do measure the same depression domains (e.g., somatic, cognitive), they often weight those domains unequally due to differing numbers of items.[1] The same situation is apparent in the measurement of anxiety problems. This issue is obviously best-addressed at the scale development and validation stage, but it also highlights the need for researchers and clinicians to consider commensurability between measures when selecting, interpreting and comparing existing scales.

Second, psychiatric diagnoses are based on a combination of psychiatric symptoms and their associated distress and consequences (ie impairment). However, many commonly used self-report measures of depression or anxiety problems (eg,[2]) do not assess functional impairment, meaning that valuable clinical and diagnostic information may be missed. Symptoms and impairment both need to be routinely assessed and monitored; an editorial requirement that

new self-report and clinical interview measures assess functional impairment in addition to symptoms, cognitions, etc, would go some way to addressing this issue.

Third, depression self-report measures that assess suicidality usually assess only suicidal desire and ideation.[3] Whilst these are of clinical concern, they are more depressotypic, whereas resolved suicide plans and preparations are far more important indicators of dangerousness across psychological problems, including but not limited to depression.[3] Researchers and clinicians need to be careful when selecting depression measures if they hope to ascertain an accurate measurement of suicide phenomenology and risk.

Finally, there is an extensive psychometric literature demonstrating that shared and non-overlapping symptom dimensions underlie depression and the anxiety disorders.[4] This research suggests that differential diagnosis and assessment can be enhanced by focusing on specific symptom clusters and deemphasizing nonspecific manifestations of distress/negative affect. However, most of the commonly used measures do not (and cannot) describe and explain the complex structural relationship between depression and anxiety problems. In fact, to the author's knowledge, the expanded version of the Inventory of Depression and Anxiety Symptoms[5] is the only measure currently capable of assessing the distinct facets of depression and separate anxiety problems. Assessment and measurement will both be improved if researchers and clinicians become more aware of the complex structural relationship between depression and the anxiety disorders, and how to assess this.

Author contributions

The researcher has no conflicts of interest. A.P. Siddaway is the sole author of this article and is responsible for its content.

Declaration of interests

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