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Development of a Depression Scale for Veterans and War Widows

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We developed and evaluated a brief measure of depression for use within a population of older Australian war veterans and war widows. Derived from the Geriatric Depression Scale (GDS), the 12-item GDS–Veterans is designed to include items that most closely represent the thoughts and feelings of older veterans in relation to their war experiences. The scale was administered to 1,620 veterans and widows concurrent with the 36-item Medical Outcomes Study Short Form (MOS SF–36) quality of life measure. Of those surveyed, 13.5% indicated that they often or always worry about things that happened during the war, indicating that this item tapped an important dimension for many of the veteran population. Scores on the GDS-Veterans were strongly correlated with the Mental Health subscale (–.72) and the Mental Health Component Summary Score (–.68) of the MOS SF–36 quality of life measure.

Key words: depression, aged, war veterans, scale development

Although clinical depression defined according to the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association, 1980) is less common among the elderly than younger adults, the prevalence of depressive

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symptoms increases with age (Weissman et al., 1985). It is estimated that around 1% of older people in the Australian community suffer major depression (Henderson et al., 1993) and that 20% to 30% of community-dwelling elderly experience depressive symptoms (Blazer, Burchett, Service, & George, 1991). However, in many cases depressive symptoms in the elderly are unrecognized, and therefore depression is underdiagnosed (Livingston, Manela, & Katona, 1997), particularly among elderly men (Garrard et al., 1998).

Undiagnosed depression and depressive symptoms can have negative consequences for individuals, their families, and the community (Gurland, Copeland, Kuriansky, et al., 1983; Henderson et al., 1993; Kay et al., 1985). The most serious consequences of these depressive feelings are reflected in the high rates of suicide among people over 65 years of age (Burdekin, 1993). Elderly people who experience depressive symptoms also are among the highest users of health care services (Druss, Rohrbaugh, & Rosenheck, 1999; Livingston et al., 1997; Simon, von Korff, & Barlow, 1995). Woods (1996) confirmed this assertion, stating that the increased service use associated with depression may overload professionals, thus reducing the effectiveness of the service itself.

Given that depressive symptoms are common, potentially serious, and underdiagnosed in the elderly, a brief assessment of depressive symptomatology would be useful as part of comprehensive geriatric assessment (Carpenter, 1996). In Australia, the Commonwealth Department of Veterans' Affairs is developing a home-based geriatric assessment for community-dwelling older people, which includes the assessment of depressive symptoms as a necessary component of the intervention (Byles, Harris, Nair, & Butler, 1996).

For war veterans and their widows, depressive symptoms may take on another dimension. When veterans returned from war they were expected to readjust to work, marriage, and families, and this adjustment and the subsequent appearance of psychological malfunctioning initiated detailed postwar research (Elder & Clipp, 1989). The results of this detailed research concluded that war veterans experienced chronic impairment 20 years after their return from World War II; their symptomatology was continual and increased with time.

Memories and emotions associated with combat events that individuals suppress and downplay in order to fulfill a "normal life" can reemerge in later life and lead to depressive symptoms (Elder & Clipp, 1989). The triggers include losses such as the death of a spouse, siblings, and friends (particularly friends through war service). These losses leave the surviving elderly person with a diminished social support network. Other relevant losses may include the loss of health and physical ability and retirement from employment (Elder & Clipp, 1989). The coping mechanisms that the aging person has relied on may weaken, increasing the impact of these losses and exposing the person to a greater risk of depression.

The effect of war in later life has not been examined sufficiently. Investigation is necessary so that undetected depression among war veterans can be managed ef-

fectively, especially because war veterans may hold a greater risk of experiencing depressive symptomatology.

Assessment and classification of depression in older people can be difficult (Snaith, 1987). Older people manifest fewer of the somatic symptoms of depression, and depressive symptoms may be masked by comorbidities (Kendall, 1976). The Geriatric Depression Scale (GDS) originated in 1983 (Yesavage et al., 1983) as a scale to measure depressive symptoms in an elderly population. The questions focus on sad mood, lack of energy, positive mood, agitation, and social withdrawal. Higher scores reflect more depression. The GDS originally consisted of 30 items but was later shortened to provide a more concise 15-item scale suitable for use by health professionals.

Versions of the GDS have been used extensively in clinical and research settings and have been shown to have good reliability and validity. The 30-item version has been shown be internally consistent (Cronbach's a = .94), interrater reliability has been recorded at .85, and test–retest reliability coefficients range from .86 to .98 for periods of 1 hr to 10 to 12 days (McDowell & Newell, 1996). GDS scores correlate with the Hamilton Rating Scale—Depression (.62–.82), the Beck Depression Inventory (BDI; .85), Montgomery Asberg Depression Rating Scale (MADRAS; .82), and the Centre for Epidemiological Studies—Depression (.82 with stroke patients). The 15-item version correlates well with the 30-item version (coefficients range from .66 to .89). When the Structured Clinical Interview was used as the gold standard, the optimal sensitivity of the 15-item version for major depression was 92% and the specificity was 81%. The corresponding values for the 30-item version were 100% and 84% (Lyness et al., 1997). Other research has established that the GDS is appropriate for use in clinical and community settings (McDowell & Newell, 1996) and can be used to detect depression in patients with dementia (Lichtenberg, Marcopoulos, Steiner, & Tabscott, 1992).

Ease of comprehension is an important consideration when choosing a depression screening scale for the elderly. The GDS has a format such that questions do not rely on the participant's memory. "Are you," "do you," and "how often" form the question structure, placing emphasis on the recognition of "now," and removing demand from memory function. The Hamilton Depression Rating Scale, for example, requires both memory function and descriptive expression of recent experiences and feelings (Lichtenberg et al., 1992). When available depression scales are compared, the GDS and the BDI are comparable, showing the highest levels of reliability and validity (McDowell & Newell, 1996). Length and time needed for administration may be the only tangible difference between the two scales: The GDS is quicker in administration time and therefore was a more appropriate scale to use in this study.

To allow recognition of war-related thoughts and concerns, we created a modified 12-item GDS. This modification of the original 30-item GDS followed the conduct of three focus groups involving men (two groups) and women (one

group). These groups provided an "insiders' view" of those factors considered to be important for the quality of life for older veterans and war widows. As a result, items from the GDS deemed least suitable for use with Australian veterans and war widows were excluded (n = 19). Disturbance by thoughts about war-related events was evident from the group discussions, and a single specific item was included to cover these ideations. Therefore, a final scale was developed consisting of 12-items that were most closely related to the findings of the veteran focus group discussions.

After pilot testing with 58 veterans and widows, the response options were expanded to a 5-point categorical scale to allow greater discrimination of responses. To discourage acquiescence bias, approximately half of the items were positively worded and the rest were negatively worded. In this article we present data on the validation of this modified 12-item scale (the GDS–Veterans) and the prevalence of symptoms within a sample of Australian veterans and war widows age 70 years and older.

METHODS

Validation of the checklist was undertaken as part of the Preventive Care Trial funded by the Australian Commonwealth Department of Veterans' Affairs. The Preventive Care Trial aims to evaluate the benefits of regular home visits to identify veterans' health care needs and to meet these needs through primary health care and other relevant health and community services. The home visits are undertaken by a trained health professional, using a structured checklist developed specifically for the trial. The areas covered by the checklist include hearing, vision, dental, vaccinations, medications, nutrition, smoking, foot care, continence, mobility, cognitive function, sleep, community services, social support, depression, and home safety. For each area, needs are recorded, discussed with the veteran, and also reported to the person's local medical officer. Obviously, the process includes an expectation of effective treatment or intervention. However, frequently only minimal assistance or intervention is required, and the needs may be more for social and instrumental support or aids rather than medical intervention.

Sample

Potential participants were selected randomly from the Department of Veterans' Affairs database of entitled veterans and war widows. To be eligible for inclusion in the sample, veterans had to be at least 70 years old and had to live in selected postal areas in 10 geographical regions in two Australian states (6 regions in New South Wales and 4 regions in Queensland). Half the areas in each state were from urban

zones; the other areas were zoned rural or remote. Within each area, selection was stratified to allow equal representation of men and women and overrepresentation of older people (85 years and over).

The Department of Veterans' Affairs mailed randomly selected veterans and widows an invitation to participate in the 3-year trial of home visits. A thank you/reminder card was mailed to all veterans and widows 1 and 3 weeks after the original invitation. Interested veterans and widows completed and returned a consent form, providing contact details for the baseline telephone survey.

Telephone Survey

Consenting veterans and widows were surveyed using the computer-assisted telephone interview (CATI) system. The telephone survey took an average of 30 min per participant. The questions included the 36-item Medical Outcomes Study Short Form (MOS SF–36) quality of life measure, the 11-item Duke's Social Support Index (DSSI), the GDS–Veterans, items about hospital and nursing home or hostel admission, and other health and community service utilization in the past 12 months.

The MOS SF–36 is a widely used and well-validated measure of health-related quality of life (Ware & Sherbourne, 1992). The validity of the MOS SF–36 for use with elderly populations also has been established in Australia (McCallum, 1995; McHorney, Ware, Lu, & Sherbourne, 1994; Pitt, Schurink, Nair, Byles, & Heller, 1996) as has its validity for the depressed elderly (Beusterien, Steinwald, & Ware, 1996). The instrument provides an eight-scale health profile and two component summary scores representing physical and mental health. The scales measure physical functioning; bodily pain; role limitations due to physical health problems; general health perceptions; vitality, energy, or fatigue; general mental health, covering psychological distress or well-being; role limitations due to emotional problems; and social functioning. The DSSI (Koenig et al., 1993) consists of two subscales. The first measures social interaction including the number of people who can be relied on, the number of social contacts, and participation in group activities. The second subscale involves subjective evaluation of the quality of the social interaction available. The full scale has been validated for use with older people in Australia (Goodger, Byles, Higginbotham, & Mishra, 1999).

Analysis

Baseline data collected by CATI were analyzed as follows. For the modified GDS, negatively worded items were recoded so that a high score related to a more negative affect. Total GDS scores then were calculated for each participant by adding to-

gether his or her responses across the 12 items. Item analyses were performed including the percentage endorsement of each item and inter-item and item-total correlations.

We checked the internal consistency of the scale by using Cronbach's alpha and we undertook exploratory and confirmatory factor analyses by using principle components analysis with varimax rotation (Stata Statistical Software, Stata Corporation, College Station, TX). The factor loadings were used to weight item scores for further analysis.

Univariate and multivariate analyses (analysis of variance) were conducted to assess the correlation between the weighted GDS scores and the MOS SF–36 and to identify other factors associated with high scores (age, sex, urban or rural zone, service use, DSSI, education, occupation, marital status). MOS SF–36 scores were calculated as recommended by its developers (Ware, Kosinksi, & Keller, 1994), and Australian population norms were used to calculate component scores (Australian Bureau of Statistics, 1995).

All results were weighted to correct for oversampling of people aged 85 years and older.

RESULTS

Of the total sample of 5,354 veterans, 26 were ineligible (dead, in nursing home, too young, or out of area), and 10 were not at the address listed. Of the remainder, 1,967 (37%) agreed to participate in the study, and 1,620 were successfully interviewed. Others either refused at the time of interview (n = 142), could not be contacted for the interview (n = 73), or were not contacted because the required sample size for the trial had been exceeded (n = 132).

Of those interviewed, 54% were men (n = 876) and 46% were women (n = 744). Stated ages ranged from 64 to 97 years. In comparison with the 1996 census (Australian Bureau of Statistics, 1996), participants were representative in terms of education level and occupational status. Married women were greatly underrepresented (4%), because "war widow" is the main entitlement category for women under Department of Veterans' Affairs criteria. Of the men, 74% were married, which is much higher than census data for Australian men of the same age but comparable to the veteran population (data provided by Australian Commonwealth Department of Veterans' Affairs, 1999).

On each of the GDS–Veterans items, the responses were well distributed across the range of options. However, positively worded items were less frequently endorsed at the depressed end of the scale than negatively worded items (see Table 1).

Inter-item correlations were acceptable (.2–.3, n = 22), moderate (.3–.4, n = 21), or high (>0.4, n = 16). Item-total correlations were all greater than 0.5 except for "Worry about things that happened during the war" (correlation = .4).

TABLE 1
Response to Items in the Modified Geriatric Depression Scale

	Endorsement (%)	
	Males[a]	*Females*[b]
Positively Worded Items and Response Options		
Are you basically satisfied with your life?		
Always	49	47
Often	27	33
Sometimes	20	16
Seldom	2	3
Never	2	1
Are you in good spirits?		
Always	37	43
Often	42	44
Sometimes	18	12
Seldom	2	1
Never	1	0
Do you think it is wonderful to be alive now?		
Always	74	64
Often	14	18
Sometimes	8	14
Seldom	3	3
Never	1	1
Are you hopeful about the future?		
Always	44	42
Often	21	23
Sometimes	20	22
Seldom	10	8
Never	5	5
Do you enjoy getting up in the morning?		
Always	60	54
Often	19	20
Sometimes	13	17
Seldom	5	5
Never	3	4
Negatively Worded Items and Response Options		
Do you feel your life is empty?		
Never	48	50
Seldom	22	19
Sometimes	21	24
Often	7	5
Always	2	2

(Continued)

TABLE 1
(Continued)

	Endorsement (%)	
	Males[a]	*Females*[b]
Negatively Worded Items and Response Options		
How often do you get bored?		
Never	32	47
Seldom	31	26
Sometimes	24	20
Often	11	6
Always	2	1
How many activities or interests have you dropped?		
None	49	65
1 or 2	17	18
Some	14	7
Most	14	8
All	6	2
How often do you feel helpless?		
Never	35	31
Seldom	25	30
Sometimes	28	30
Often	9	7
Always	3	2
How often do you prefer to stay at home rather than go out and do new things?		
Never	7	15
Seldom	12	20
Sometimes	36	40
Often	31	18
Always	14	7
Are you bothered by thoughts you can't get out of your head?		
Never	42	49
Seldom	21	19
Sometimes	26	24
Often	8	7
Always	3	1
How often do you worry about things that happened during the war?		
Never	38	52
Seldom	17	20
Sometimes	27	20
Often	13	6
Always	5	2

[a]$n = 876$. [b]$n = 744$.

All the items were retained in the scale. Cronbach's alpha indicated high levels of internal consistency (.85 for men and .83 for women).

Exploratory factor analysis revealed one main factor and a smaller secondary factor related to negatively worded items (eigenvalues = 4.65, 1.27). These two factors explained 48% of the varience.

The distribution of the total scores is presented in Figure 1 for 1,542 veterans and widows who provided responses to all items. The percentage of missing data was low; endorsement of iems ranged from 100% response ("How often do you get bored?") to 97.23% ("Are you hopeful about the future?"). The scores ranged from a minimum of 7.4 to a maximum of 33.6 (60 was the highest possible score). The mean score was 14.75 (SD = 5.5). The total score demonstrated a high correlation with MOS SF–36 subscale scores, particularly the Mental Health subscale (–.72) and the Mental Health Component Summary Score (–.68) (see Table 2). These correlations are negative because a higher score on the GDS–Veterans scale indicates more depressive thoughts and feelings, whereas a higher score on the MOS SF–36 subscales indicates a more favorable health-related quality of life profile.

Univariate analyses revealed that the GDS–Veterans was significantly associated with urban or rural zone ($p = .002$), marital status ($p = .01$), sex ($p = .001$), total DSSI score ($p = .0001$), and use of community services ($p = .001$). Multivariate analyses found that the GDS–Veterans score was significantly associated with the use of community services ($p = .02$) and negatively associated with social support (those with more support had less depression; $p = .001$). Urban versus rural zone of residence, age, sex, marital status, and past occupation were retained in the model

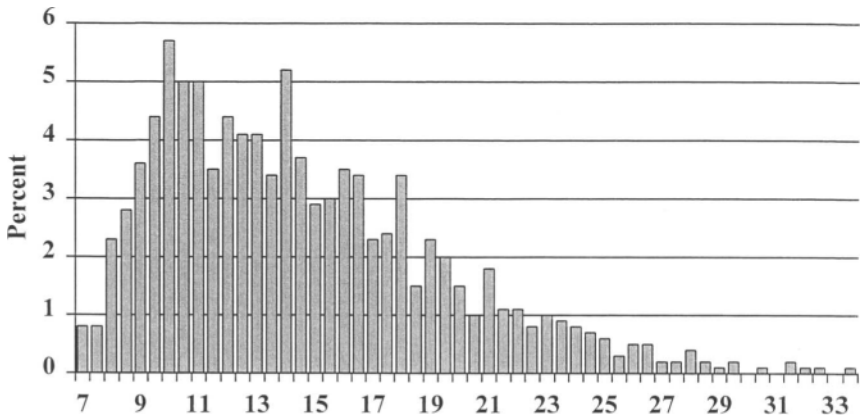

FIGURE 1 GDS–Veterans' scores ($N = 1,542$).

TABLE 2
Correlation Between Modified GDS Scores and SF–36 Subscales

Subscale	*Pearson Correlation Coefficient*
Mental Health	–.72
Role Emotional	–.48
Social Functioning	–.52
Vitality	–.61
Mental Health Component Summary Score	–.68
General Health	–.57
Bodily pain	–.4
Role Limitations Physical	–.42
Physical Functioning	–.45
Physical Health Components Summary Score	–.29

but were not significantly associated with the GDS–Veterans score. The full model explained 31% of the variance in scores.

DISCUSSION

The GDS–Veterans scale applied in this study has demonstrated acceptable levels of validity for use as a measure of depressive symptoms within the veteran population. Evidence of scale validity is shown by the high correlation between the GDS–Veterans scores and the MOS SF–36 Mental Health subscale. The Mental Health subscale has been reported to be useful in measuring depression in elderly populations (Beusterien et al., 1996) and is therefore a suitable comparison for assessing validity. In our analysis, the GDS–Veterans scores correlated most highly with the MOS SF–36 Mental Health subscale and the mental health component summary score. These correlations were of higher magnitude than Beusterien et al. (1996) observed in a comparison of the MPS SF–36 Mental Health subscale and the Hamilton Depression Scale score.

The distribution of depression scores for participants in the Preventive Care Trial shows that most people scored at the lower end of the scale (not depressed). Participants in this study, however, are likely to underrepresent depressed elderly, who may be less likely to participate in research of this type. The consent rate of 37% limits the extent to which the results can be generalized to all Australian veterans and widows.

A small number of veterans (n = 78) taking part in the survey did not complete all items comprising the GDS–Veterans scale. Using a case-wise deletion method, we dropped these respondents from further analysis. To increase the validity of the scale for these people, other standard approaches to missing data, such as mean substitution, may need to be employed. Otherwise the validity of the scale is limited to those people who are able to answer all items.

For veterans within the trial, the scale seems able to discriminate between various levels of depressive symptomatology. Although there is no clear cutoff for deciding if an individual is depressed, the higher the score the greater the reporting of depressive symptoms. In the absence of other indicators, the 90th percentile (22/60) provides one useful benchmark for those at the extreme end of this continuum who should be more closely evaluated for depression.

Although several groups such as the U.S. Preventive Services Task Force (1996) and the Canadian Task Force on the Periodic Health Examination (1994) conclude there is insufficient evidence to support screening for depression, evaluation of depression is explicitly listed as a component of comprehensive geriatric assessment (Carpenter, 1996). Other researchers have shown that the use of screening tests can increase detection of depression (Linn & Yager, 1980; Magruder-Habib & Zung, 1990; Moore, Lilimperi, & Bobula, 1978; Zung et al., 1983), and treatment of depression in the elderly by using cognitive therapy as well as medication has been shown to be effective in randomized controlled trials (e.g., Old Age Depression Interest Group, 1993; Shea et al., 1992) Also, because depression can be a side effect of other therapies (e.g., beta-blocker medication), a thorough clinical assessment and medication review form the foundation of therapy.

Mental symptoms experienced by elderly populations are more likely to result in medical rather than mental health treatment (Druss et al., 1999), suggesting that assistance for the elderly presently is focused in a medical–biological framework that bypasses the psychological cause for the complaints. The potential contribution of war-related events to current psychological functioning needs to be considered further and may provide important avenues for effective psychotherapeutic strategies for this population.

Our modification of the GDS scale arose from recognition of the relevance of war-related experience to veterans' current mental state. Focus group discussions with older Australian veterans and war widows suggested that thoughts and feelings about the war may feature prominently in veterans' daily lives. Of the men in the study, 11% were often or always bothered by thoughts they "could not get out of (their) head," and 18% often or always worried about "things that happened during the war" (13.5% of participants overall). The additional item regarding the war was significantly correlated with the depression total, although it was the most weakly correlated of all 12 items in the scale.

In Australia, people currently in their 70s and 80s belong to a culture that derived a strong part of its identity from the national contribution to two world wars (Walker-Birckhead & Davison, 1995), and these events retain their significance particularly for those who personally experienced the conflict.

It is important to understand the current physical and emotional state of older people in this context (Walker-Birckhead & Davison, 1995) and to acknowledge that war-related issues may affect the current lives of older veterans and war wid-

ows. To date, very little research has been done to understand how these experiences affect people as they age (Walker-Birckhead & Davison, 1995).

War-related psychiatric symptomatology has been shown to be significant and persistent over long periods of time (Archibald & Tuddenham, 1965). Sutker and Allain (1996) reported prevalence of major depression over a lifetime for World War II and Korean Conflict prisoner of war survivors and combat veterans as high as 42%. Within the Australian population of Vietnam veterans, about half of those veterans who have ever had posttraumatic stress disorder (PTSD) still have it today (Creamer, Morris, Biddle, & Elliott, 1999).

More recently a phenomenon has been described whereby war-related conditions such as anxiety, depression, insomnia, alcoholism, and PTSD are experienced for the first time in older adult life (Elder & Clipp, 1989). These symptoms and conditions may be triggered by traumatic current events including the onset of ill health or retirement (Van Dyke, Zilberg, & McKinnon, 1985). Retirement also may mean the loss of occupation and distraction previously used to fend off intrusive thoughts and depressive symptoms. Furthermore, memories are known to play an important role in the process of aging (Coleman, 1986), and traumatic memories may be more prominent at this time of life.

In European countries, not only military veterans have been observed to suffer late-onset symptoms related to their war experience but also concentration camp survivors, resistance members, and civilians whose lives and homelands were disrupted by combat and occupation (Hovens, Falger, Opden Velde, et al., 1992). For example, Hovens et al. (1992) found that 56% of resistance veterans suffered from PTSD. Similarly, Robinson et al (1990) reported that 75% of holocaust survivors suffered from one or more symptoms such as hypermnesia, depressive moods, nightmares, and anxiety. Thus, although the prevalence of war-related psychiatric symptoms among older people is unknown, it is likely that a very large number of older people are affected.

Although this study concentrated on depression, other psychiatric symptoms also may be important for this population. Other studies have reported on the prevalence of PTSD and other symptoms of depression and anxiety (Long, MacDonald, & Chamberlain, 1996), and worry about "things that happened during the war" may be better correlated with PTSD. However, Hyer, Stanger, and Boudewyns (1999) reported that depression, not PTSD, was more related to health status and social support in a group of elderly male combat veterans, hence our selection of depression as the most relevant psychiatric condition to assess in this population. In terms of the screening methodologies employed in the Preventive Care Trial, the modified 12-item GDS–Veterans proved adequate in identifying veterans with war-related concerns for further follow-up and referral.

If screening for depressive symptoms among the elderly is to be adopted, then specific questioning about war-related experience should be included, particularly among war veterans. Without more general acknowledgment of the impact of

symptoms and the importance of the social context and life experience, these people's symptoms are likely to be unrecognized, misdiagnosed, and poorly treated. More accurate assessment could lead to better treatment and support for a large proportion of older people experiencing depressive symptoms, thus significantly improving the quality of their experience of aging.

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