Gender Disparities in the Treatment of Late-Life Depression: Qualitative and Quantitative Findings From the IMPACT Trial

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Objectives: The objectives of this study were to examine gender differences in recruitment, depression presentation, and depression treatment history in a large effectiveness trial; and to use qualitative data to generate hypotheses about reasons for observed gender differences. Methods: Data from IMPACT, a multisite trial of a disease management program for late-life depression in primary care were used to examine gender differences quantitatively. Qualitative interviews were conducted with 30 key informants from IMPACT (referring physicians, depression care managers, and study recruiters) to learn more about challenges in recruiting and treating depressed older men and then analyzed thematically. Results: Compared with older women, older men were significantly less likely to be referred to IMPACT, to endorse core depressive symptoms, and to have received prior depression treatment. Gender differences in prior depression treatment persisted after adjustment for covariates. Qualitative themes identified as important contributors to gender disparities included 1) how men experience and express their depression, 2) traditional masculine values, and 3) the stigma of chronic mental illness. Conclusion: This study provides further evidence of the gender gap in depression care, identifies possible contributing factors, and suggests avenues for future research. (Am J Geriatr Psychiatry 2006; 14: 884–892)

Key Words: Gender, late-life depression, treatment

Depression is a common and disabling condition in late life that often goes undertreated in primary care settings, where most older adults receive their medical care.¹⁻³ Epidemiologic studies have found depression to be more common in women,⁴ although this gender difference is less pronounced in older adults⁵ and certain ethnic groups.⁶⁻⁸ Depressed men have significantly lower rates of treatment than...
women. For example, a recent survey of 9,585 adults from 60 U.S. communities found that clinically depressed men had significantly lower rates of treatment compared with women. Ethnic minority older men are at particularly high risk for not receiving depression care. In primary care settings, men’s depression is less likely to be recognized.

Because older men have higher rates of completed suicide (31.8 per 100,000 in men age 65 and older compared with 4.1 per 100,000 in older women), gender disparities in depression diagnosis and treatment are of considerable public health importance. Yet, the reasons for gender disparities in depression care among older adults are poorly understood. Prior research has found that men have more negative attitudes toward help-seeking for mental health problems, lower disclosure rates of depressive symptoms, lower rates of health service utilization, and more “atypical” presentations of depression. Provider bias may also play a role in generating gender disparities in depression care. Prior qualitative studies have also highlighted the role of gender role identity and masculinity in shaping men’s expression of depression and reluctance to seek help or accept treatment.

In this article, we use quantitative and qualitative data from the IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Depression) study, a large primary care-based depression treatment trial. We examine gender differences in referrals to the IMPACT study, presentation of depression among patients screened for study eligibility, and history of depression treatment in persons who enrolled in the trial. An analysis of individual, semistructured qualitative interviews with key informants is used to illuminate the quantitative findings and to generate hypotheses about factors that may contribute to gender gaps in depression care. Qualitative methods may be useful in effectiveness trials as a way of identifying processes that may help explain observed patterns and outcomes.

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**METHODS**

**Quantitative Study**

The methods for IMPACT, a multisite trial of a disease management program for late-life depression in primary care, are described in detail elsewhere. In this article, we use IMPACT recruitment and baseline data for our quantitative analyses. IMPACT participants were older (i.e., age 60 and above) adults with major depression or dysthymic disorder from 18 participating primary care clinics affiliated with eight healthcare organizations nationwide. Participants were recruited using two methods: 1) 2,190 older adults were referred (usually by their primary care physicians) and 2) 32,908 older adults were systematically screened for depression with a two-item depression screener adapted from the Prime MD. Patients referred to the study or who endorsed one or more screening items were invited to participate in a study eligibility interview conducted by trained lay interviewers at each site. The eligibility interview included the Structured Clinical Interview for DSM-IV (SCID) to assess whether patients met research criteria for major depression or dysthymia. The interview also screened for exclusion criteria, including bipolar disorder or schizophrenia, severe cognitive impairment, and acute suicide risk. A total of 2,102 patients who met study criteria were invited to enroll in the study and 1,801 (86% of those eligible) agreed to participate, completed written informed consent, and completed a baseline interview. Three Veterans’ Administration (VA) sites are excluded from the data reported because nearly all VA participants are men, making a meaningful comparison of men and women at this site impossible. The analyses reported in this article are based on data from the remaining 15 sites, including 1,613 enrolled subjects.

Trained lay interviewers conducted baseline interviews using structured computerized interviews at each study site. The interviews included sociodemographic characteristics, social support, prior use of health services, and prior depression treatment (i.e., any antidepressant use in the past three months, any specialty mental health visits or psychotherapy in the past three months, any depression care in the past three months, any lifetime depression care). Based on prior work, we also derived an indicator of “potentially effective” recent depression treatment defined as at least two months of an antidepressant medication or at least four sessions of counseling or psychotherapy during the prior three months.

For the quantitative analyses, we examined data from screening and referrals, eligibility interviews, and baseline interviews. We compared numbers of
men and women recruited to the IMPACT trial by screening and referral and examined gender differences in the likelihood of enrolling in the trial. We also compared the clinical presentation of depression in men and women by studying data from 3,714 completed eligibility interviews. Finally, we compared demographic and clinical characteristics and prior depression treatment experiences among men and women who enrolled in the trial (N = 1,613). We used t tests for numerical variables and chi-squared tests for categorical variables. Multiple logistic regressions were used to assess gender difference on depression treatment controlling for variables associated (p < 0.10) with gender in the bivariate analysis, including being married or living with partners, minority status, two or more prior episodes of depression, thoughts of suicide, positive on cognitive impairment screener, general health status, mean SCL-20 depression score, and sites. To show effect sizes, standardized predictions for rate of treatment among men and women are presented for each treatment indicator. Variables examined in this study had item-level missingness rates of less than 2%. Sensitivity analyses\(^ \text{31,32} \) that imputed missing data (not reported here) produced similar results. To correct for multiple comparisons, a significance level of p < 0.01 was used in these analyses.

**Qualitative Study**

Qualitative data included interviews with: 1) primary care physicians who referred participants to IMPACT, 2) depression care managers who provided IMPACT depression care,\(^ \text{33} \) and 3) lay recruiters who screened patients for study participation. All interviews were audiotaped, transcribed, and then entered into a qualitative software package, NVIVO (QSR Nvivo 2.0).

*Interviews With Primary Care Providers.* After the completion of IMPACT, a convenience sample of eight primary care physicians (six men and two women, all family practice physicians or internists) who referred patients to the IMPACT study were identified at two of the participating study sites (two Kaiser sites in Northern California and one in San Diego, CA). Semistructured qualitative interviews were conducted in participants’ offices (six interviews) or by telephone (two interviews). An interview guide was developed and standard techniques for qualitative interviewing were used.\(^ \text{34} \) Topics included physician training and background, challenges faced in care of depressed older men, perceptions of gender similarities or differences in depression care, and experiences in referring older men for the IMPACT study. Interviews lasted 30–60 minutes and were tape recorded and later transcribed.

*Interviews With Depression Care Managers.* All 11 active IMPACT depression care managers were interviewed by telephone during the treatment phase of the project.\(^ \text{33} \) All were women, including nine with nursing degrees and two psychologists. The 60–90-minute qualitative interview focused on an array of issues related to performing the role of care manager for older depressed adults in primary care settings. A section of the interview focused on patient characteristics, including gender, and their relationship to identification and treatment of depression. Open-ended questions in this section explored how age affects the way a person answers questions about depression symptoms, how gender affects a person’s answers to such questions, and what care managers might have noticed about communication styles among patients that might influence whether their depression gets recognized. Responses pertaining to gender-specific factors in recognizing and treating late-life depression were examined for this article.

*Interviews With Lay Recruiters.* Qualitative telephone interviews were conducted with 12 of 13 active lay recruiters across all IMPACT sites (one refused), but one interview was not usable because of sound quality. Among other questions, recruiters were asked whether issues relating to language, ethnicity, gender, or the age group of potential participants influenced the recruitment process.

*Qualitative Analysis.* Transcribed interviews were analyzed thematically using standard qualitative data analysis techniques.\(^ \text{35} \) The goal was to identify repeating patterns (i.e., themes) relevant to clinicians’ experience of diagnosing and treating older depressed older men. Initial analyses included open coding of interviews to identify themes related to challenges and barriers in the care of older men. Initial coding was done by each of the authors independently to generate a list of themes. These themes were discussed among the team in a series of meetings until a consensus emerged with respect to the major themes. Our research team identified three themes we felt were most strongly supported by the
data (i.e., achieved saturation). Next, a definition of each theme was developed by the research team. Finally, the first author systematically coded these themes in all interviews using NVIVO (QSR NVivo 2.0) to index the data and facilitate the retrieval and analysis process. Illustrative examples for each theme were reviewed and discussed by the research team. The three major themes are described in the “Results” section.

Written, informed consent was obtained from all study subjects and the study was approved by the Internal Review Boards at Kaiser, the University of California–Los Angeles, and the University of California–Davis.

RESULTS

Quantitative Results

After excluding the VA sites, the 15 participating clinics in Project IMPACT had a total of 1,613 enrolled subjects, 28% (N=453) of whom were men. IMPACT participants were enrolled by screening (N=802) and primary care physician referral (N=811). Men represented 32% (N=255) of the sample enrolled by screening but only 24% (N=198) of the referral sample ($\chi^2 = 10.88$, p <0.001). Refusal rates did not differ significantly by gender (results not reported).

Among the 3,689 older adults with complete data from the study eligibility interview, we found several significant differences in the presentation of depressive symptoms and other clinical characteristics. Men were significantly less likely than women to endorse depression symptoms such as feeling depressed or down (39% men versus 47% women, $\chi^2 = 21.24$, p <0.001) and having lost interest or pleasure in things they usually enjoy (37% men versus 42% women; $\chi^2 = 7.14$, p = 0.008). Men were also less likely than women to report fatigue (62% men versus 67% women; $\chi^2 = 7.49$, p = 0.006) and appetite problems (34% men versus 41% women; $\chi^2 = 14.36$, p <0.001).

Among older adults with major depression or dysthymia who enrolled in the study, men were significantly more likely to be married, less likely to have two or more prior depression episodes, and reported lower overall depression severity as measured by the 20-item HSCL-20 (Table 1). Table 2 shows rates of depression care in older men and women after adjusting for variables associated with gender at the p <0.10 level. As shown in Table 2, women had significantly higher odds of depression treatment in four of the five indicators of depression care. Adjustment had little effect on the magnitude of gender disparities.

Qualitative Results

In this section, we describe three interrelated and overarching themes that emerged from our analysis of key informant perspectives on challenging aspects of diagnosing, treating, and referring older men with depression: 1) how men experience and present their depression, 2) traditional masculine values, and 3) the stigma of depression. Each theme is now described drawing examples from the interviews.

How Men Experience and Express Their Depression

Our key informants emphasized that older men experience and express their depression in ways that do not fit well with diagnostic criteria, making diagnosis more difficult in two respects: depression is more difficult to recognize and men are more resistant to the diagnosis because they do not identify with the label. Depression is more difficult to recognize because older men were viewed as less likely to present their depression in emotional terms such as feeling depressed or sad and more likely to focus their depression in other ways such as through somatic symptoms or a focus on interpersonal stress. As one physician told us: “Women in general are much more likely to present with mood symptoms saying they are feeling depressed or feeling anxious or nervous. I think men in general, especially older men, are much less likely to mention those red flag kind of words.”

To explain gender differences, some informants speculated that older men might have more difficulty accessing and recognizing their feelings. Others, however, perceived men as actively trying to conceal or mask their depression. For example, a primary care provider, when asked if men present their depression in a different way, responded:
“They try to hide it basically whereas women are more open and they come and talk . . . Because it is their nature for some reason.”

Because older men tend not to endorse depressed mood or sadness, they were often viewed as more reluctant to accept the diagnosis of depression and the treatment recommendations. As one primary care physician put it: “They [men] just do not go with the labels. They’ll say, no I’m not sleeping well, I have aches and pains. It seems to be a leap for them to accept depression treatment for that. The men recognize the symptoms, but they still do not think it is them.” Thus, engaging men in a discussion of their depression diagnosis and getting them to ‘buy in’

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### TABLE 1. Characteristics of Study Participants

<table>
<thead>
<tr>
<th>Subject demographic characteristics</th>
<th>Overall (N = 1,613)</th>
<th>Male (N = 453)</th>
<th>Female (N = 1,160)</th>
<th>Statistic&lt;sub&gt;df&lt;/sub&gt;, p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 60–64</td>
<td>381 (23.62)</td>
<td>111 (24.50)</td>
<td>270 (23.28)</td>
<td>(x^2_{[2]} = 0.57), 0.75</td>
</tr>
<tr>
<td>Age 65–74</td>
<td>664 (41.17)</td>
<td>180 (39.74)</td>
<td>484 (41.72)</td>
<td>(x^2_{[2]} = 0.57), 0.75</td>
</tr>
<tr>
<td>Age 75 and above</td>
<td>568 (35.21)</td>
<td>162 (35.76)</td>
<td>406 (35.00)</td>
<td>(x^2_{[2]} = 0.57), 0.75</td>
</tr>
<tr>
<td>Married or living with partners</td>
<td>715 (44.11)</td>
<td>284 (62.83)</td>
<td>431 (37.22)</td>
<td>(x^2_{[1]} = 86.39), &lt;.001</td>
</tr>
<tr>
<td>Minority</td>
<td>335 (20.85)</td>
<td>81 (17.96)</td>
<td>254 (21.97)</td>
<td>(x^2_{[1]} = 3.17), 0.075</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td>(x^2_{[1]} = 4.34), 0.227</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>1272 (79.15)</td>
<td>370 (82.04)</td>
<td>902 (78.03)</td>
<td>(x^2_{[1]} = 3.17), 0.075</td>
</tr>
<tr>
<td>Black</td>
<td>196 (12.20)</td>
<td>43 (9.53)</td>
<td>153 (13.24)</td>
<td>(x^2_{[1]} = 3.17), 0.075</td>
</tr>
<tr>
<td>Hispanic</td>
<td>88 (5.48)</td>
<td>24 (5.32)</td>
<td>64 (5.54)</td>
<td>(x^2_{[1]} = 3.17), 0.075</td>
</tr>
<tr>
<td>Other</td>
<td>51 (3.17)</td>
<td>14 (3.10)</td>
<td>37 (3.20)</td>
<td>(x^2_{[1]} = 3.17), 0.075</td>
</tr>
<tr>
<td>At least high school graduate</td>
<td>1311 (81.45)</td>
<td>372 (82.30)</td>
<td>939 (81.09)</td>
<td>(x^2_{[1]} = 0.32), 0.574</td>
</tr>
</tbody>
</table>

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### TABLE 2. Adjusted Percent of Participants With Depression Care by Sex

<table>
<thead>
<tr>
<th>Depression Care Measure</th>
<th>Analytic N</th>
<th>Male Percent (SE)</th>
<th>Female Percent (SE)</th>
<th>OR (95% CI)</th>
<th>Wald (x^2_{[1]})</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any antidepressant use in the past three months</td>
<td>1567</td>
<td>37.73 (2.37)</td>
<td>46.14 (1.50)</td>
<td>1.42 (1.12–1.81)</td>
<td>8.40</td>
<td>0.0038</td>
</tr>
<tr>
<td>Any specialty mental health visits or psychotherapy in the past three months</td>
<td>1566</td>
<td>9.00 (1.48)</td>
<td>8.84 (0.82)</td>
<td>0.98 (0.63–1.52)</td>
<td>0.01</td>
<td>0.9205</td>
</tr>
<tr>
<td>Any depression care in past three months</td>
<td>1567</td>
<td>40.98 (2.42)</td>
<td>49.65 (1.51)</td>
<td>1.43 (1.13–1.81)</td>
<td>8.77</td>
<td>0.0031</td>
</tr>
<tr>
<td>Any lifetime depression care</td>
<td>1567</td>
<td>50.61 (2.36)</td>
<td>71.24 (1.37)</td>
<td>1.74 (1.35–2.23)</td>
<td>18.89</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Potentially effective depression treatment in past three months</td>
<td>1556</td>
<td>21.00 (1.99)</td>
<td>30.65 (1.39)</td>
<td>1.69 (1.28–2.24)</td>
<td>13.69</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

**Notes:** Values are mean (standard deviation) for continuous variables and N (%) for categorical variables. Because of missing data, the analytic sample sizes are varied from 1,596–1,613.

**Note:** Results were based on multiple logistic regressions adjusting for married or living with partners, minority status (i.e. white non-Hispanic versus other), two or more prior episodes of depression, thoughts of suicide, positive on cognitive impairment screener, general health status, mean SCL-20 depression score, and sites.

OR: odds ratio; CI: confidence interval; SE: standard error.
was widely viewed as among the most problematic aspects of the care of older depressed men. Some men avoided the use of the term depression altogether; as one clinician put it, the label of depression carries too much “emotional baggage.”

Difficulties in getting older men to accept the label of depression also complicated the process of referral to IMPACT or to specialty mental health providers. Asked about his experience in referring older men and women to IMPACT, one primary care provider told us: “Women accept this [referral] more easily compared to men to go for the study and to accept that they are depressed and from there on to go into the study program [IMPACT].” The comments of this primary care physician were echoed by other clinicians and highlights resistance to diagnosis as an explanation for the lower referral rates of men to IMPACT.

Traditional Masculine Values

A subgroup of older men, often referred to as “old school” or the “John Wayne type,” were viewed as difficult to diagnose and treat because they perceived the cultural meaning of depression to be in conflict with their own view of themselves as men (i.e., their masculinity). For this subgroup, depression connotes “vulnerability” and “weakness” and is in direct conflict with an image of men as self-sufficient, tough, and stoic. For example, one physician told us: “I think especially older men have grown up in a culture in which they have been told to buck up and make the best of a situation and that depression is viewed as a weakness, a fallibility, a loss of moral strength and character.”

As a result of this dissonance between the cultural meanings of depression and this more traditional view of masculinity, the diagnosis of depression may trigger in men feelings of shame or a sense of failure. Referring to older men, one depression care manager told us: “there’s more shame associated with admitting to symptoms of depression, admitting to failure.” These set of associations help to explain the tendency of some men to reject the diagnosis of depression and to attempt to conceal or mask symptoms of depression.

Clinicians made a direct connection between more traditional views of masculinity and difficulties with diagnosis and referral to specialty mental health or IMPACT. For example, one primary care physician observed: “The bigger they come with the John Wayne attitude the harder they fall when they finally come to accept that they have a problem [depression].” This clinician went on to say that “giving up” these core masculine values was from her perspective an important step in the treatment process. Reflecting on a particularly challenging case of a suicidal, depressed older male patient he had tried to refer to a psychiatrist, one physician told us: “They just do not think that tough guys go talk to psychologists or psychiatrists, and fool around with that type of monkey business.” A male recruiter for IMPACT observed: “As far as barriers, with my being male, I’m less likely to get male patients in. I do not know if they’re just less likely to talk about it. I get mostly Marlboro-type men who fall into that ‘Yeah, you get down but then you pick yourself back up.’”

Stigma of Chronic Mental Illness

Although not as pervasive as the previously noted themes, several clinicians viewed cited the association of depression with severe mental illness, or “craziness,” as a barrier to care. For example, one depression care manager cited stigma as an explanation for the greater tendency of men to express their depression in somatic rather than emotional terms: “Sometimes I think they’re not as forthcoming because of the stigma. They will not say, ‘I feel sad’ or ‘I feel depressed.’ They’ll say ‘I have a stomach ache.’” Stigma-related concerns also influenced men’s willingness to accept the diagnosis of depression. As another depression care manager told us, men are more “fearful” of the term “depression” because it may lead to “someone thinking they’re crazy or it is all in your head versus the medical aspect of it.” The stigma of severe mental illness also hindered referral to mental health specialists. For example, one primary care physician described a depressed and psychotic older man who was expressing suicidal thoughts but was unwilling to see a psychiatrist because of fears that it would “mark him as crazy. He was something like an iron worker. His history was really macho . . . I think that it is the stigma of being crazy. I think it is true for the older population more and particularly older men.” This informant and several others expressed the view that men of lower...
socioeconomic status may be more traditional in their views of masculinity and thus more likely to view depression in a highly stigmatizing way.

**DISCUSSION**

This study has found further quantitative evidence of gender disparities in depression care and has identified qualitative themes that help to explain these disparities. Depressed men enrolled in IMPACT were less likely to have received prior treatment on four of five indices of depression care, even after adjusting for multiple covariates. Although gender disparities in depression care were modest for most indices, they are significant in view of the burden (i.e., frequency) of depression in older men and its association with increased risk of suicide. One possible explanation for these findings, supported by both our quantitative and qualitative results, is that men express their depression more “atypically.” Statistical comparison of symptom patterns in men and women revealed that men less often endorsed core symptoms of depression such as depressed mood and anhedonia. Key informants in our qualitative study also emphasized that men more often presented “atypically,” making depression more difficult to recognize and hence to diagnose and treat. Our findings are consistent with prior literature on male psychology that emphasizes that depressed men often express their distress through alternative idioms such as anger, rage, and risky behavior.15,36

Our qualitative data, based on the perspectives of those who provide care to older depressed men, also suggests that the cultural meanings of depression (the label’s “emotional baggage”) may create barriers to care for some older men, particularly those who view their own masculinity in more traditional terms. From the perspective of these clinicians and recruiters, the depression label is discrediting and potentially stigmatizing. To avoid this stigma, our data suggests some older men may express their depression using alternative idioms of distress and resist formal diagnosis and possibly treatment. This finding is consistent with a larger literature on the men, depression, and help-seeking.14,19,36 as well as recent qualitative work in this area.22,23 Thus, a major challenge for clinicians was negotiating a way of talking to patients about their diagnosis that facilitated rather than impeded treatment. Our qualitative data suggest that patient and clinician concerns about labeling may also have contributed to lower referral rates of older men to IMPACT.

Consistent with others, we found stigma to be an important issue in geriatric depression care.37 Our qualitative findings suggest that depression’s stigma may result not only from its association with “vulnerability” or “weakness,” but also from its association with severe mental illness or “craziness.” We view these as theoretically separable sources of stigma for older men. As a result, depressed older men may be vulnerable to “double stigma” and amplification of their suffering.38

These findings suggest future avenues for education and intervention. Standard psychoeducational approaches with more traditional older depressed men may need to be tailored to directly address attitudinal barriers identified in this study. Initially, such approaches might de-emphasize professional labels and place more emphasis on symptoms and stressors. In our study, providers also noted a number of strategies to overcome these barriers, including using an open-ended interview style, using less direct or clinical (i.e., threatening) language to discuss depression with patients to help neutralize stigma, and involving family in all phases of treatment. A more in-depth description of provider coping styles is beyond the scope of this article but will form the basis for future reports. These strategies might also help to inform interventions that target primary care physicians with the goal of improving their ability to diagnose and treat depression in older men.

In terms of methodology, combining qualitative and quantitative methods is not common in geropsychiatry research, but may be useful when examining services-related problems such as disparities in mental health care. Whereas conducting qualitative research in conjunction with effectiveness trials requires the addition of a social scientist familiar with this mode of scientific inquiry, if well focused, it may yield insights and hypotheses to guide additional research.26 Another methodological contribution of this article is our focus on the experiences and perspectives of clinicians.

This article has several important limitations. First,
qualitative findings reflect the perspectives of clinicians and lay recruiters rather than the views of older depressed men themselves. The perspectives of these informants may be influenced by their own gender stereotypes as well as their experiences in working with older men and women. Although IMPACT included a representative sample of depressed older adults from eight diverse healthcare organizations, we cannot assume that participants are representative of all depressed older adults or that the men who participated in this depression treatment study are representative of all men with depression. Physicians participating in the qualitative study are a convenience sample drawn from two of 18 IMPACT sites and were predominantly men; further research with a more representative and gender-balanced sample would be important. Finally, our qualitative results should be considered as exploratory and hypothesis-generating because of the modest number of interviews conducted. An expanded study of this nature with a more representative sample of clinicians and patients would be likely to deepen our understanding of the themes we have presented and to identify other important factors.

The public health importance of improving care for depression among older men is clear. Older men experience higher rates of completed suicide than any other age and gender group (approximately eight times higher than older women) and in this study were more likely than women to endorse suicidal ideation. Because depression is one of the most important suicide risk factors, elucidating gender-specific aspects of depression care has the potential to reduce this disparity, close the gender gap in depression treatment, and lessen the enormous burden of suffering for older adults and their families caused by depression in older men.

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References

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