Chapter 6
HIV/AIDS and Other STDs among Adults over 50

Men and women over the age of 50 now account for more than 15% of all new HIV/AIDS cases and are becoming infected at rates four times higher than young adults. More than half of all people living with HIV/AIDS will be aged 50 and older within the next decade.

Health care providers can no longer afford to regard HIV and AIDS as a disease of youth and young adulthood. According to the Centers for Disease Control (CDC, 2008a), approximately 15% of all new HIV/AIDS cases in the USA occur among men and women over the age of 50. The rise in documented cases of HIV/AIDS and the increasing incidence of other STDs among adults over the age of 50 is unprecedented. Two distinct populations emerge upon examination of older adults with HIV: middle-aged and older adults who contract HIV/AIDS and other STDs for the first time at that point in their lives and middle-aged and older adults previously infected with HIV who are now living into midlife and beyond. Each of these groups must cope with unique age-related risk factors for infection and treatment, as well as underlying medical, economic, social, and psychological stressors including stigma and discrimination.

Relevant Statistics

New HIV/AIDS Diagnoses

According to the Centers for Disease Control and other experts, approximately 15% of all new HIV/AIDS diagnoses are made among adults over the age of 50 (CDC 2008b; Linley et al. 2007). Rates of HIV/AIDS infection are increasing nearly four times faster among older than young adults, and the primary means of infection among older adults is through sexual contact (Chiao et al. 1999). Notable disparities also exist in terms of ethnic differences in diagnoses. Older adults of color are at

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increased risk of infection. Specifically, older African-Americans are 12 times more likely than older Whites to be diagnosed with HIV infection, and older Latinos are 5 times more likely to receive an HIV diagnosis than older Whites. Put another way, the incidence rate of HIV/AIDS for White US citizens over the age of 50 is 4.2/100,000 people. For older Latino citizens it is 21.4/100,000, and for older Blacks it is 51.7/100,000 (CDC 2008b; Linley et al. 2007).

Specific areas of the country that draw retirees in greater numbers, such as Florida, California, and Arizona, also report substantial increases in numbers of HIV and AIDS cases. In Florida, approximately 17% of all new AIDS cases were among adults over the age of 50. Of those newly diagnosed, 74% were male, and 26% were female. Nearly two-thirds of the infected women and nearly one-half of the infected men were Black. For both men and women, the primary mode of transmission was sexual contact (including 25% of infections among older men via heterosexual contact), followed by IV drug use (Florida Department of Health 2007). In California, 16% of all new HIV/AIDS cases and 40% of the current population of people living with HIV and AIDS (PLWHA) are over 50 (Foster 2011). In New York City, 17% of all new HIV infections and 37% of PLWHA are over the age of 50. In addition, increasing numbers of older women in New York City are being diagnosed with HIV/AIDS each year (NYC Department of Health and Mental Hygiene, 2010).

Despite the wealth of information we now have about HIV among older adults, it is unclear how many adults currently living with HIV remain undiagnosed and untreated. For example, symptoms of HIV infection may be different between older and younger adults. Early symptoms of AIDS among older adults often include memory loss, poor attention, and confusion, which can be misdiagnosed as Alzheimer's disease or simply dismissed as "normal" signs of aging. Although the symptom presentation can vary significantly, the cognitive changes that may accompany HIV infection are often referred to as HIV-associated dementia, AIDS dementia complex, or HIV/AIDS encephalopathy. CDC statistics also are likely to underestimate the actual numbers of HIV-infected adults over the age of 50 due to underreporting (e.g., family members often ask that their physician identify a non-AIDS related cause of death on their relative's death certificate), misdiagnosis, and the exclusion of older adults who may be asymptomatic except for the cognitive changes associated with HIV-induced dementia.

Older People Living with HIV and AIDS

Current estimates suggest that 1 in 3 PLWHA are over the age of 50 (CDC 2008a), with the numbers of older PLWHA increased by more than 75% between the years of 2001 and 2005 (CDC 2008a). With the improved effectiveness of antiviral medications, notably highly active antiretroviral therapy (HAART), infection with HIV is no longer viewed as an imminent death sentence. Many PLWHA and their health care providers now consider life with HIV much like living with a chronic illness.

In response to both the increased number of new HIV diagnoses, as well as the effectiveness of HAART, estimates suggest that that within the next decade more than 50% of every two PLWHA will be over the age of 50 (CDC 2008b).

This significant increase in HIV infection among older adults is often referred to as the graying of the AIDS epidemic (Gorman 2006), and it poses significant implications for not just the USA but global health (Emlet 2006a, 2006b, 2006c). AIDS represents the 15th leading cause of death among men and women over the age of 65 (Kaye and Markus 1997). More older US adults have now died of AIDS than the number of American GIs killed in the Vietnam War, and more than one-third of all people who currently die from AIDS are over the age of 50 (CDC 2007). Clear ethnic disparities also appear in which nearly half of all older PLWHA in the USA are Black (CDC 2008b). The health disparities involved in treatment of older adults with HIV, particularly those who are from a low SES or minority group status, cannot be ignored.

Increased Incidence of Additional STDs

Although the highest incidence of STDs among older adults is that of HIV/AIDS, significant increases in other STD diagnoses have emerged in relation to Chlamydia, syphilis, and gonorrhea (Jena et al. 2010), as well as the sometimes sexually transmitted Hepatitis C (Institute of Medicine 2010). For older men, the incidence of Chlamydia is 11 per 100,000 and the incidence of syphilis is 3 per 100,000, with significant increases in the last 5 years. Among older men and women combined, the incidence of syphilis is 1 out of 100,000 and approximately 10 out of 100,000 for gonorrhea (CDC 2001). Although overall prevalence rates for STD infection among adults over 50 remain lower than those of young adults, the incidence rates of STDs among this older age group are on the rise (Calvert 2003).

Some unique symptom presentations and diagnostic issues appear in relation to STDs in people over the age of 50. Diagnosis and treatment of Chlamydia is vital, as untreated it can cause significant infection of the cervix and urethra (Calvert 2003). Syphilis is more likely to be diagnosed in the secondary and tertiary stages of the disease among adults over 50, with symptoms often emerging 5–20 years after the initial infection. Symptoms commonly reported at the time of a syphilis diagnosis include stroke, dementia, deafness, and reduced vision (Calvert 2003) as well as cardiovascular-related symptoms including aortic aneurysms (Swartz et al. 1999). Many older adults receive their initial diagnosis when a routine screening for syphilis is initiated upon hospitalization for stroke (Calvert 2003). Symptoms of gonorrhea among older adults may include a rash on the extremities (present in nearly 2/3 of all infected) as well as arthritis (Calvert 2003).

Up to 25% of adults over 50 may be infected with the sexually transmitted herpes simplex virus (HSV), with increased age serving as a significant risk factor. Incidence rates for herpes infection also are higher among Mexican (40%) and African-Americans (60%; Fleming et al. 1997). The incidence and prevalence of genital

warts, otherwise known as human papillomavirus (HPV), among older adults is generally unknown. Among older women, greater concerns generally exist regarding HPV-related cervical cancer. Although the frequency at which older women should have a pap test is greatly contested (Calvert 2003), findings indicate that approximately 25% of all new cases of cervical cancer occur among women over the age of 65 (Cornelison et al. 2002).

Up to two-thirds of individuals diagnosed with Hepatitis C are over the age of 50. Many individuals in this age cohort contracted the disease decades ago, when using or experimenting with IV drug use. Up to 75% of those infected with Hepatitis C do not know they have the virus, as its symptoms may remain dormant for up to 30 years. The virus is transmitted through blood, which can occur during high-risk or unprotected sexual activity. In addition, older adults with HIV infection or other STDs face increased risk for contracting Hepatitis C due to already compromised immune systems. Although detection of the Hepatitis C virus involves a simple blood test, few physicians order such tests for their older adult patients or ask about related risk factors (Institute of Medicine 2010).

Age-Related Risk Factors

At the beginning of the AIDS epidemic in 1980, older adults were at greater risk than younger adults to contract HIV through infected blood products. Older adults were more likely to undergo lengthy operations that required transfusions (e.g., knee and hip replacements), open heart surgeries, and exploratory surgeries for internal bleeding after car accidents than their younger peers. Fortunately, as a result of increased safeguards and routine testing introduced to the US blood supply in 1985, the number of new HIV/AIDS cases due to infection via tainted blood products has essentially dropped to zero (Goodnough et al. 2003).

Unfortunately, many older adults and health care providers themselves are unfamiliar with the age-related factors that *currently* place older adults at increased risk for HIV infection. For example:

- Older adults are less likely to use condoms than younger adults for a variety of reasons, including diminished concerns about pregnancy, lack of familiarity with condoms (including how to put them on and use them correctly), and discomfort with condom negotiation
- Due to decreases in estrogen levels and related thinning of the vaginal wall and a decrease in naturally produced lubrication, post-menopausal women are more likely to experience micro- and macroscopic tears of the vagina during intercourse, allowing the HIV virus easier access to the bloodstream. Like most younger adult women, the majority of older adult women are not even aware that sexual intercourse is often accompanied by such trauma to the vaginal wall because these tears are often painless and generally undetectable after intercourse.
- Decreased levels of immune function, typically associated with increased age, make older adults more susceptible to infection, per exposure, when compared to younger adults.

- Older adults have never been the target of any national campaigns about STD prevention, and many assume that HIV/AIDS only affects young, gay, or IV drug users.
- No national programs exist that are specifically tailored for HIV prevention among minority group elders. As noted, older Black and Latinos are at increased risk for HIV infection compared to their White counterparts.
- Health care providers are significantly less likely to discuss issues related to HIV/AIDS with their older patients than their younger patients and least likely to discuss sexual issues with older female patients (Lindau et al. 2006).
- Older adults are unlikely to know that oil-based lubricants are not safe for use with condoms (Hillman 2008a, b). For example, older adults may believe incorrectly that baby oil and hand lotion are safe to use with condoms, and do not realize the need to use only water-based lubricants (e.g., KY-jelly; Astroglide).
- With older age cohorts displaying rising rates of separation and divorce, increasing numbers of older adults are finding themselves dating for the first time in years and may engage in related unprotected sex.
- Viagra and other drugs for the treatment of erectile dysfunction (ED) allow more older men to engage in intercourse than ever before. Physicians are not required to discuss STDs with their patients who take such performance-enhancing drugs, leading to increased risk of high-risk behavior. Older men who use drugs for ED, including widows, are 50% more likely to have HIV than those who do not use such medication (Jena et al. 2010; Smith and Christakis 2009).
- Despite common societal views that older adults are asexual, older men and women can and do engage in high-risk behaviors such as IV drug use and sex with multiple partners and prostitutes. The oldest person to have a documented case of HIV infection was an 88-year-old White widow. She is believed to have contracted HIV through sexual activity with her husband, a recreational IV drug user (Rosenzweig and Fillit 1992). The use of illicit substances also has been increasing among older adults, including the use of intravenous drugs such as heroin.
- The use of alcohol and drugs, including crack cocaine, is known to impede effective decision making for participation in safer sex practices. For older adults, who typically process alcohol and other drugs less effectively than younger adults due to age-related declines in liver function, impaired judgment after even one drink can increase risk.
- Older women face increased risk for HIV infection. Coupled with the general decrease in immune system functioning with age, an increased risk of vaginal trauma, and lower rates of condom use, an older adult woman has a higher risk of contracting HIV through each act of heterosexual intercourse than her younger adult, female counterpart.
- Men are more likely than women to influence whether a condom will be used during sexual intercourse, and older adult males are the least likely age group to use a condom,
- Many older adult clients do not even consider heterosexual contact as a risk factor for HIV, particularly if they are widow and widower who assume that their respective partners were involved in a long-term monogamous relationship.

Women and men over the age of 50 are significantly less likely to use condoms than their younger counterparts, particularly when a female partner is postmenopausal. In fact, only 25% of both men and women over the age of 50 have reported using a condom during casual sex. In contrast, teenagers between the ages of 14 and 17 report using condoms 80% of the time during casual sex (Schick et al. 2010). When asked about their use of condoms during sexual relations, one 69-year-old female client laughed and responded, "Oh, my. You know that I don't have to worry about a baby on the way! But that is flattering that you would think about me being so young to even ask. You are so sweet."

Other patients have responded to questions about condom use with some variant of, "Oh, that's just for people who are dirty, you know what I mean? My Reggie and I have been together for over a year. I don't have to worry about anything. He's squeaky clean." When asked to elaborate upon what it means to be "squeaky clean," it was revealed that this statement was based upon her visual examination of her boyfriend's genitals, and not any kind of medical examination or result. This client had also never discussed condom use with her boyfriend, out of fears that he would reject her for "being a hussy, because only dirty girls need to use condoms in the first place." When asked about condom use with her boyfriend, another 52-year-old female patient responded simply, "I just don't like to think about it. I'm over 50 now. What are the odds of me catching something, anyway?" Significant psychoeducation and therapeutic work need to take place in order for older adults to acknowledge and realistically assess their risk factors.

Cultural Factors

Various cultural factors can pose unique risks for HIV/AIDS infection among adults over 50. In some Black cultures, for example, men having sex with men (MSM) is not labeled as gay or homosexual, and those MSM may not believe that HIV/AIDS prevention messages are relevant to them. In traditional Latino culture, the concepts of machismo and marianismo, gender roles that devalue education for women, and subscription to certain Catholic beliefs that prohibit condom use may contribute significantly to increased rates of HIV/AIDS infection. As noted, older Latinos are five times more likely to be diagnosed with HIV/AIDS than older Whites (CDC 2008b.)

Machismo dictates that Latino men possess a vigorous sex drive that they are typically unable to satisfy or control. In traditional culture, Latino men are virtually expected to engage in promiscuous sex with a variety of partners. Within the context of STD infection, it is important to note that it is acceptable for Latino men to have both male and female sex partners. Male partners are those who are discussed as being "on the down low." Latino men are likely to have more than one partner at a time, even if they are married (Beaulaurier et al. 2009; Gonzalez et al. 2009).

Machismo also dictates that Latinos serve as a sole provider and that they are dominant in their household. Conversely, Latino culture also has a female role of

marianismo, defined by submission, dependence, and lack of freedom (Rios-Ellis et al. 2005). A Latina is expected to be submissive to her father and then later to her husband. For a Latino woman to even ask her husband or boyfriend about his sexual activity is viewed as brazen and shocking, and Latino women who ask their significant other to use a condom are typically viewed as promiscuous themselves (Gonzalez et al. 2009). If a man is macho enough, the expectation is that his partner will be too fearful to even ask him to wear a condom (Rios-Ellis et al. 2005).

Marianismo also views education for women as superfluous and even selfish, as a woman's primary role is to remain at home to care for her husband and family. Limited formal education is certainly associated with lesser knowledge about physical and sexual health. Findings from a recent community-based study revealed that half of the older Latino participants were unaware that HIV could be passed through vaginal, anal, and oral sex. Results from the study also revealed that the majority of older Latinas were unaware of their risk for contracting HIV/AIDS, and that more than half feared that asking a macho partner to use a condom would damage their relationship (Hillman 2008a, b).

The Need for a Correct and Timely Diagnosis

One of the most intriguing aspects of the case of the oldest woman to be diagnosed with HIV/AIDS (Rosen and Fillit 1992), who also happened to be White and middle-class, is that she was a widow. This woman was first diagnosed with AIDS 7 years after the death of her husband. It took careful risk assessment and sensitive questioning by open-minded clinicians to arrive at the appropriate conclusion and provide appropriate treatment, as older women typically tend to be overlooked by health care professionals in relation to potential HIV infection (Zablotksy 1998).

Current studies show that only 25% of adults between 55 and 64 have been tested for HIV (Beaulaurier et al. 2009). For adults aged 65 and older, only 12% have ever received testing (CDC 2008c). Although Medicare pays for HIV tests, the CDC only recommends routine HIV testing for individuals only up to the age of 64 (CDC 2006). Unfortunately, most older adults who receive a diagnosis of HIV do so while they are hospitalized and not as part of routine medical care. Older adults also are more likely to receive their initial diagnosis after they have already developed AIDS (Mugavero et al. 2007).

The implications for an incorrect or a delayed diagnosis of HIV among older adults are insidious. Such errors postpone the delivery of appropriate medical, psychological, and psychosocial interventions and result in significant decreases in quality of life and ultimately in increased mortality (Linsk 1994). Unfortunately, due in part to a natural decline in immune system functioning with age, adults over 50 who contract HIV are likely to die sooner than their younger counterparts, even if both people are diagnosed and treated at the same time. Current CDC reports indicate that more than half of individuals who are first diagnosed with HIV when they are 50 or older develop full blown AIDS or die from AIDS-related illnesses

within 1 year of their initial diagnosis (Linley et al. 2007). It also is important to note that of all racial groups, older Black women and men have the shortest length of time reported between their initial diagnosis and death from AIDS (CDC 2001). Significant health disparities persist in terms of both HIV detection and treatment for older adults of color.

Individuals with an HIV infection in mid and late life also are more likely to suffer from complications from chronic diseases commonly associated with advanced age such as heart disease and diabetes. The drugs associated with HAART can introduce negative side effects such as high cholesterol, high blood sugar, and insulin resistance (Silverberg et al. 2007; Wigfall et al. 2010). Unfortunately, it remains unclear to what extent individuals who were being treated for HIV when they were young or middle-age adults (when drug regimens were less sophisticated and caused greater side effects) are likely to age well into older adulthood. It also remains unclear to what extent older adults being diagnosed and treated initially with HAART will be able to live into advanced age without significant side effects and increased mortality from other chronic illnesses.

HIV-Associated Dementia

Like syphilis, HIV can cause significant neuropsychological dysfunction that often present in the form of cognitive impairment or dementia. Autopsy studies suggest that up to 80% of individuals who contract AIDS will develop HIV-associated dementia complex (HADC; American Academy of Neurology AIDS Task Force 1991). Clinical studies also suggest that more than one-third of all people currently infected with HIV will meet diagnostic criteria for dementia (Buckingham and Van Gorp 1988). Recognizing the causal relationship between such a sexually transmitted disease and a debilitating dementia is particularly important among older adults, whose symptom presentations of HADC may mimic, and subsequently be mistaken for, Alzheimer's disease. Another concern is that older individuals with HIV-associated cognitive deficits are significantly less likely to remain compliant with their HAART medication (Barclay et al. 2007). Older adults with HIV infection also are likely to show initial cognitive declines in attention and processing, which may impair their ability to drive a car or pilot an airplane safely (Hardy and Vance 2009).

Although many reviews of the cognitive deficits associated with HIV dementia among young adults are available, significantly fewer (e.g., Hardy and Vance 2009; Morgan et al. 2011) provide comprehensive summaries that differentiate between the symptoms associated with HADC in older as compared to younger adults. Such symptoms among older adults include but are not limited to cognitive changes such as impaired attention, impaired concentration, poor short-term memory, confusion, and impaired abstract thinking; affective symptoms such as apathy, indifference, and social withdrawal; and behavioral symptoms such as psychomotor slowing, diminished coordination, unsteady gait, difficulty with writing, impaired occupational functioning, and a significantly decreased ability to engage in activities of daily living. It

Table 6.1 Differences between HIV-associated dementia and Alzheimer's dementia

Symptoms	HIV-associated dementia	Alzheimer's dementia
Onset	Acute	Gradual
Progression	Rapid	Gradual
Time until acute stage	6 months–1 year	More than 1 year
Affect	Appropriate	Labile
Mood	Apathy, mania, depression	Depression
Use of language	Intact	Impaired (aphasia)
Short-term memory	Impaired	Impaired
Encoding	Intact	Impaired
Psychomotor speed	Significant slowing	Minor impairment
Tremor	Common	Rare
Gait	Impaired	Intact
Opportunistic infections	Common	Rare
Cerebrospinal fluid	Elevated protein levels	Average
T-cell count	Below average	Average

Note: These characteristics represent a summary of typical symptoms. Each client's symptom presentation is unique, and deviations from typical patterns must be expected

is important to note that unlike Alzheimer's dementia, HADC typically includes both cognitive and psychomotor impairment. The American Academy of Neurology AIDS Task Force (1991) also identifies HIV-Associated Minor Cognitive Motor Disorder (MCMD) as a neurological syndrome in which an individual does not yet meet criteria for dementia, but exhibits mildly or moderately impaired functioning along with psychomotor slowing and tremor.

Practitioners must be aware that the symptoms of HADC often mimic various symptoms of Alzheimer's disease. Table 6.1 summarizes the similarities and differences typically observed in their respective symptom presentations. Both disorders present with a debilitating picture, in which patients display significantly diminished social and occupational functioning, and short and long-term memory loss. However, some vital distinctions can be made between the typical presentations of HADC and Alzheimer's dementia. Regarding onset, HADC tends to be sudden, whereas recognizable onset of Alzheimer's dementia typically is gradual. HIV-induced dementia often has a rapid, aggressive progression over a period of 6 months to 1 year, whereas Alzheimer's dementia has a gradual progression of symptoms, often over many years. Language impairment, such as aphasia (an inability to speak), is not a part of the typical HADC presentation, unlike the typical presentation of Alzheimer's dementia. No pronounced language deficits are observed in HADC, until its very end stages.

Although short-term memory is significantly impaired in both HADC and Alzheimer's dementia, patients with HIV-induced dementia, unlike their counterparts with Alzheimer's, appear to maintain their ability to encode and learn new information. For example, although most patients with HADC and Alzheimer's dementia display impairment in their recall of a list of words, even after numerous repetitions, the patient with HADC would be more likely to recognize certain words

as part of the original list (indicating that she or he was able to encode the new information, but was unable to retrieve it without cuing).

Patients with HADC, compared to those with Alzheimer's disease, also appear to have significant impairment in psychomotor speed. When asked to connect thought with action, a patient with HADC is expected to display significant difficulty. Additionally, patients with HADC often display other symptoms of AIDS, such as low-grade fevers, depressed mood, skin lesions, opportunistic infections (e.g., pneumonia, shingles), diarrhea, headache, night sweats, sudden weight loss, and incontinence. Neuropsychological testing can also show a relatively large "scatter" or dispersion of scores on test batteries for older PLWHA when compared to older adults with Alzheimer's disease (Morgan et al. 2011). Clinicians, clients, and their significant others and family members should recognize that reduced sex drive, depressed mood, memory impairment, and incontinence are *not* a normal part of healthy aging, and should be explored as a sign of underlying pathology or illness, whatever form that might take.

Adults Over 50 Living with HIV/AIDS

Stigma and Isolation

For older PLWHA, the potential stigma and discrimination related to HIV/AIDS from peers, health care providers, and society at large poses significant challenges. As a result, recent studies based upon HIV-positive adults over 50 in the New York area suggest that more than one-third of older PLWHA suffer from symptoms of clinical depression. Loneliness, social stigma, and cognitive impairment (e.g., early symptoms of HIV-associated dementia) also accounted for a significant role in explaining the older participants' depressive symptoms (Grov et al. 2010). Because the New York City metropolitan area serves as the base for a number of national HIV/AIDS, LGBT, and older adult HIV/AIDS service programs, and participants in the study were already linked with various social service agencies, the numbers of older PLWA with depressive symptoms are likely to be significantly higher for those who live outside such a large urban area.

Another contributing factor in depression among older PLWHA is that of the side effects often associated with HAART. Although HAART has significantly improved the quality of life for HIV-infected individuals, older adults are more likely than younger adults to encounter side effects and are more likely to be taking multiple drugs with various interactive effects. One side effect not commonly discussed among health care providers and their older patients living with HIV/AIDS is that of diarrhea. Studies suggest that nearly one-third of middle-aged and older adults being treated with HAART experience periods of debilitating diarrhea and fecal incontinence (Siegel et al. 2010). Due to fears of having an accident in public,

many older PWLA in the study reported that they became homebound, which significantly limited their social interactions with others. Still other study participants expressed fears that the presence of diarrhea meant that they would lose weight quickly (i.e., wasting), indicating that they were approaching the end stage of the disease. Still other older PLWHA with diarrhea felt consistently ashamed, embarrassed, helpless, humiliated, and "dirty," contributing to further depressive symptoms and social withdrawal.

A consistent theme that emerges from all studies of older PLWHA is that of social isolation, brought on primarily through social stigma and fears of triggering such stigma (e.g., Emlet 2006b; Grov et al. 2010; Siegel et al. 2010). Anxiety, chronic stress, and depression appear to be closely linked. Qualitative analysis of responses from older HIV-positive men and women suggests that these middle-aged and older adults face a "double threat" of stigma associated with aging and HIV status if White (e.g., Emlet 2006c), and if they are of color, a "triple threat" of stigma associated with aging, HIV status, and minority group status (e.g., Haile et al. 2011). Older PLWHA in these studies also report that they experienced stigma and discrimination from both peers and health care professionals. Examples of such discrimination by professionals ranged from hostile and unkind remarks, to lapses in care, to the unethical and illegal breach of confidentiality regarding the older person's HIV-positive status (Emlet 2006c). One can only image the devastation brought upon an older PLWHA when their own health care providers single them out for hostility and rejection.

Secondary Prevention

Studies of self-reports by older PLWA indicate that they continue to engage in sexual activity with relatively high frequency (Illa et al. 2008). Many lay people do not realize that safe sex practices are recommended for HIV-positive individuals, even when both partners are HIV positive, in order to help prevent them from reinfecting each other and to avoid passing different strains of HIV to each another. Unfortunately, estimates suggest that significantly more than one-third of older PLWA engage in unprotected vaginal and anal sex, with gay men having lower rates of condom use than both heterosexual men and lesbian and heterosexual women (Golub et al. 2010). The use of drugs and alcohol before sex, as well as limited knowledge of HIV/AIDS, is also associated with unprotected sex and other high-risk activities (Cooperman et al. 2007; Lovejoy et al. 2008). Greater fear of stigma is also associated with a decreased likelihood of even sharing their HIV-positive status with current or potential sex partners.

In the first study of its kind, Golub and colleagues (2011) sought to discover what individual factors were associated with older HIV-infected adults' proactive use of condoms during sexual activity—and focus upon risk reduction. This group of researchers discovered that various aspects of psychological well-being, including

one's sense of personal growth and potential, of having quality relationships with others, and of having control over one's life, were positively associated with condom use during sexual activity. Even when the older HIV-positive participants reported using substances, the potentially negative effect of drugs and alcohol upon condom use appeared to be overridden when psychological well-being was high.

Golub et al.'s (2011) study is important because their findings highlight the value of personal psychological resources among older HIV-infected individuals, and it suggests that therapeutic and social support interventions may serve as preventive health measures. Empirical studies have demonstrated consistently that both group therapy and interpersonally based support groups are very effective in reducing depressive symptoms among older PLWHA (Heckman et al. 2011), as well as increasing condom use when combined with condom negotiation skills (Illa et al. 2010). Because such studies suggest that group interventions are just as effective as individual interventions for older HIV-positive individuals, organizations and communities with limited resources can feel more confident about providing more typically cost-effective group interventions. Consistent with the value of social support for reducing feelings of social isolation and symptoms of depression, the contact information for various organizations available to assist both adults over 50 and their practitioners in coping with HIV/AIDS are provided in the appendix at the end of the chapter.

Knowledge Among Practitioners

Limited attempts have been made to explore health care providers' knowledge and attitudes about HIV among older adults. One such study employed a sample of physician assistants, psychologists, and nurses at a large mental health facility with specialized geriatric units (Hillman 1998). The results showed that these health care providers correctly identified gay men and IV drug users as among the top risk groups for HIV transmission among adults over the age of 50. However, although a significant number of the health care workers in the study were aware of the increase in HIV transmission among heterosexual older adults, the vast majority remained unaware of the increased risk of HIV transmission via intercourse in post menopausal women. They incorrectly estimated that an older adult woman who was date-raped by an HIV-infected rapist had the same chance of contracting HIV as a young adult woman raped by the same assailant.

Contrary to expectation, exposure to various patient populations including adults over the ages of 50 and 70 and work with patients who were HIV positive were not associated with more accurate knowledge of HIV or its transmission among adults over 50. Also contrary to expectation, specialized training in HIV, geriatrics, neuropsychology, and human sexuality was not associated with greater knowledge of HIV/AIDS or HIV-associated dementia among aging adults. It is unclear whether any of the training that these health care providers received broached the subject of HIV and aging specifically. It also is interesting to note that in debriefing after

the study, various participants spontaneously remarked that they had never ever considered that one of their older patients might have HIV, and that they never received any formal or informal education about HIV and aging. It is clear that as practitioners, we must correctly educate ourselves and our clients.

Issues in Assessment

Questions at Intake

Agism is evident when health care providers fail to ask, or even consider, whether their older adult clients are at risk for contracting HIV/AIDS or other STDs. To make an accurate diagnosis, it is vital that clinicians ask their middle-aged and older clients candidly and directly about a variety of issues including (see Hillman and Stricker 1998, for a review):

- Sexual history, including extramarital affairs and multiple partners.
- Current sexual behaviors, including vaginal, oral, and anal intercourse.
- Partner selection, including heterosexual and LGBT.
- Recreational drug use, particularly IV drug use.
- Sharing of needles for insulin or other prescription medications.
- Major operations and blood transfusions that occurred before 1985.
- Use of blood products for hemophilia, before 1985.
- Caregiving for HIV/AIDS patients.
- Sexual abuse or assault.
- Changes in mental status such as apathy and confusion.
- Physical symptoms such as swollen glands, loss of appetite, night sweats, weight loss, and a nagging cough or cold.

Health care providers should never assume that an older client is free from the risk factors associated with HIV transmission. The potential emotional discomfort associated with asking older adults about their sexual activities and sexual history is well worth the effort if it reveals a possible link to an HIV/AIDS or other STD diagnosis and to timely, appropriate treatment. It also is vital that clinicians remember that a 4- to 7-year window may pass between infection with the HIV virus and overt symptoms. Thus, sexual history remains a vital part of any intake assessment, regardless of a patient's age, marital status, or current sexual abstinence. Recall that the oldest patient to have a documented case of HIV infection was an 88-year-old woman who had been widowed and sexually abstinent for more than 7 years.

We know that middle-aged and older adults, as well as younger adults, use IV drugs, have affairs, employ prostitutes, and are survivors of sexual assault. It is essential to ask older adults about their numbers of sex partners, and if they have engaged in unprotected sex with both male and female partners. Another salient item for investigation regards caregiving activities for individuals with HIV/AIDS,

particularly for adult children who may be living at home and receiving nursing care from an older parent, or older adults who may be caring for grandchildren with HIV/AIDS. Although these topics may be difficult subjects to broach, the information gained is invaluable.

The Presence of Family Members

Due to the sensitive nature of these questions, particularly for some older adults who may not be socialized to openly discuss their sexual activities, it is advisable to speak to an older client without their spouse, significant other, or children being present for the entire interview. For better or worse, many older adults come to an initial interview with a spouse, a caregiver, or children. Additional information from family members can provide important information that might otherwise be lost, particularly if the older person has some cognitive issues, and their presence allows the clinician to observe family dynamics firsthand. However, it is advisable to discuss at the beginning of the intake that some time will be allotted to speak to the designated patient alone. Many clients, as well as their family members, spouses, partners, and concerned friends, become noticeably more relaxed about the procedure when they are simply told that it is standard procedure.

It also can be helpful to preface questions about a client's sexual history and high-risk behaviors by telling him or her that these are standard questions asked of every client at every interview. It is important to inform patients and clients that whatever information they reveal will be confidential, and that this information will not be disclosed to other family members without their expressed, written, informed consent, with the exception of mandatory reporting for danger to self or other, and elder abuse as mandated in some states. (One should not assume that all older adults are familiar or fully understand all HIPPA rules and regulations.) Normalizing the discussion of such typically private matters as sexual behavior and drug use often allows clients to speak freely and to express additional concerns (e.g., Hillman and Stricker 1998). It also is important that clinicians use the same sexual terms as the ones used by their patients. For example, if older clients use the term rubbers instead of condoms, one should follow their lead.

Queries about Caregiving

Many middle-aged and older adults find themselves assuming the role of caregiver for their adult children (or grandchildren) who are infected with HIV or AIDS. With the increasing number of AIDS patients in this country, difficulties with medical insurance coverage, an inability to acquire hospital or hospice care, and a lack of other available caregivers, many older parents, particularly older mothers, are providing daily nursing care for adult children with AIDS. Some of these parents

describe having a positive experience, in which they are able to show their children that they love them, even to the bitter end. Other older clients in this caregiving role have spoken about acknowledging and accepting their child's LGBT lifestyle for the first time and about forgiving their child for turning to drugs as a way to deal with their problems. Other older patients have been more reluctant caregivers and have voiced concerns about who will care for them when they are sick and in need of care. Still others have discussed how preoccupied they are with keeping the nature of their child's illness a secret from friends and family members. They fear the stigma significantly, predicting that no one will visit them or want to socialize with them once their child's HIV-positive status is known.

The Benefits of a Team Approach

Regardless of the clinician's degree status, professional title, or proscribed role on a treatment team, each mental health professional should take personal responsibility to ensure that a potential HIV diagnosis is examined and, ideally, ruled out. The use of a team approach can provide a professional cohort to discuss and work through any feelings of discomfort regarding the discussion of high-risk behaviors and potential HIV status with a patient. Just as we often inform patients that we often have little control over how we feel, but that we are responsible for how we manage those feelings and our behavior, it is vital that team members remain respectful of other professionals' feelings, even if they appear negative, ambivalent, or anxious. However, once such feelings have been aired and processed within the group, team members typically are better able to manage those feelings so that they do not interfere with the assessment and treatment of patients. Often the team member who has the greatest rapport with the patient, or the team member who has the greatest comfort with discussions about sexuality can play the role of mediator and patient educator, with favorable results.

The Importance of Follow-Up

Even after assessment takes place, it remains vital that clinicians remember that adults over 50 are the least likely group to be targeted for educational interventions regarding HIV/AIDS and its transmission. In most cases, client education is as important as proper assessment. Despite agist stereotypes, client of all ages should be educated about the risks associated with unprotected sex and other high-risk activities. Among older adults, particularly those who may have postmenopausal female or who have same-sex partners, the fear of conception is absent. Thus, this older age group is least likely to engage in safer sex because their associations with condoms are typically for prevention of pregnancy. Older adults may not even know how to use a condom properly. Still other older IV drug users may not be aware of

the use of bleach and the avoidance of needle sharing to minimize viral transmission. Older adults also are less likely to be aware of universal health precautions. Such information is critical, particularly when an older adult may provide nursing care for an adult child or grandchild with HIV/AIDS.

Case Examples

Marsha

Marsha was a 58-year-old woman enrolled in a geriatric day hospital program. Marsha was admitted on the recommendation of her adult daughter who was concerned that no one was available to help her mother manage her obsessive-compulsive disorder and keep up with her activities of daily living. Marsha's daughter is her only child from her first marriage, which ended more than 20 years ago in divorce. Marsha arrived on time each day for the program and was always dressed and groomed neatly for someone of her size. Marsha reports that she gained over 75 pounds in the last 5 years; she is obese. She also appeared to demonstrate some difficulties with attention and concentration.

Although she agreed readily to participate in group psychotherapy, Marsha had significant difficulty avoiding her compulsions, even under the influence of appropriate medication. During group sessions, she would only be able to sit for a few minutes at a time before she would feel compelled to walk seven steps forward, three steps backward, turn 180°, and repeat the procedure in varying degrees. She also whispered to herself as she counted numbers in a complicated pattern. It initially was unclear how much Marsha would benefit from the day program's group therapy and milieu therapy because of the severity of her symptoms. Her daughter reported that they intensified about 5 years ago, when she also changed her eating habits and began to gain a significant amount of weight. Neither Marsha nor her daughter could identify a precipitating incident.

Three months into the program, Marsha experienced a breakthrough. She had begun to socialize with two elderly single women who had also been secretaries who enjoyed big band music. Marsha began to eat lunch with these women and to be able to stave off some of her compulsions long enough to talk with them in brief conversation. During a group therapy session, one of these women discussed how vulnerable she often feels in her own home, because her late husband is no longer there to look after her. Marsha, who had been whispering to herself, gave her new companion a sideways glance and began to rock back and forth and hum loudly. The group leader paused to ask Marsha how she was doing, and Marsha began to cry. She admitted that about 5 years ago, a maintenance man she had hired to do some chores around the house suddenly became violent and raped her. She swore that she would never tell anyone about the attack because she felt so ashamed and afraid. Marsha received overwhelming support from other group members, and was able to

discuss the event more openly over the next few weeks. She learned that it was not her fault about what happened, and that it was normal for her to feel angry, embarrassed, and upset. Marsha also was able to explore the relationship between her desire to control her environment via her compulsions and her attempts to feel comforted and reassured with the consumption of food.

Despite the positive response that Marsha received in group therapy among her elderly peers, the treatment team did not demonstrate such cohesion when Marsha's group therapist suggested that Marsha be informed about the risks of contracting HIV and other sexually transmitted diseases and to assist her in scheduling an AIDS test. The initial response among team members was that it was just "water under the bridge." Marsha's individual therapist asserted that she did not want to broach the subject of HIV testing because it would only retraumatize her patient and lead to a resurgence of binging and compulsive behavior. After all, this happened more than 5 years ago!

A lengthy discussion ensued in which many team members were able to discuss their anger and discomfort about the thought of a gentle and innocent older woman contracting HIV through a senseless and violent acquaintance rape. When the team leader asked how they would proceed if Marsha were a 25-year-old woman who had been raped, they quickly recognized their conscious and unconscious desires to deny the entire unfortunate incident. Many of the team members also acknowledged their implicitly held stereotype that "well, elderly women just don't get AIDS."

In a parallel process like that observed in the patients' group therapy session, in which group members were able to rally around Marsha after she aired her secret about the rape, the treatment team was then able to support Marsha's group therapist in her need to discuss the issue openly. The team agreed that it was vital to speak sensitively but frankly with Marsha about the rape and about her subsequent risks for contracting HIV. Because one of the nurses on staff had a particularly good relationship with Marsha, she volunteered to meet with her to address specific medical questions and the hospital's policy regarding HIV test results.

Gerald

Gerald was an 83-year-old man who was brought to the geriatric assessment unit of a hospital after having a serious fall at home. Concerned neighbors in the apartment complex called the police when they had not seen Gerald for a few days. Gerald appeared malnourished and unkempt, and he presented with a low-grade fever and swollen glands. On admission he was confused and apathetic when staff members tried to communicate with him. He preferred to spend his time on the unit alone, curled up on his bed. After being contacted by the staff social worker, Gerald's estranged son agreed to go to his father's apartment to gather his pajamas and toiletries. While at his father's apartment, Gerald's son discovered a large collection of empty liquor bottle, and vials of white and brown powder. The treatment team concluded that Gerald was suffering from major depression and substance abuse,

and suggested that he enroll in an inpatient treatment program for drug abuse. The team physician ordered a series of chest X-rays and considered using antibiotics to treat a probable case of pneumonia. The treatment team did not even consider HIV as a possible diagnosis, even when Gerald admitted to engaging in intravenous drug use, a clear high-risk behavior.

Florence

Florence was a 75-year-old widow who exhibited symptoms of depression and dementia. Her niece insisted that she enroll in a day hospital program in order to help lift her spirits, and Florence reluctantly agreed. Florence arrives at the day program each day, dressed appropriately and neatly. She is eager to make friends with other patients in the program and quickly acquires a close knit circle of five female companions for breakfast, lunch, and conversation between group sessions. During group therapy, Florence is eager to participate. She responds supportively to patients dealing with a variety of problems, yet can also gently challenge their denials and cognitive distortions. Before long, most patients in the day program clamor to sit with Florence, to hear her tell a humorous story or to offer a kind word. Although Florence is reluctant to discuss her own problems in group therapy, her depression appears to lift, and her mood brightens. She tells the group that she has been doing more cleaning and baking at home. She even brings a loaf of her special apple bread to share with her group of friends.

About 1 month into the program, it became obvious that Florence was having trouble remembering things. She often forgot to take her hat home, or forgot to bring an umbrella when it was raining. She sometimes lost track of what people were saying in group therapy, but could use her sense of humor to smooth over any rough spots. Her primary therapist asked for a neuropsychology consultation to rule out dementia, and Florence agreed to participate. The neuropsychology intern said that Florence was superficially cooperative, but that she became very frustrated when she couldn't trace a series of lines, remember a series of words, or recite parts of a story. The official report suggested that Florence had mild to moderate dementia, with unknown etiology; the pattern was not entirely consistent with Alzheimer's or vascular dementia. The test report also contained suggestions that Florence use a notepad to help remind her about daily medications and physicians' appointments, and that she retested within 6 months to see if she would benefit from instrumental assistance around the house. Florence did not take the news well, and insisted that, of course, she forgot things once in a while, but that she was "as fit as a fiddle."

About 2 months into the program, Florence failed to arrive on time for the morning session. Because she had not called in sick, her primary therapist called her home and initially thought she had dialed a wrong number because a younger woman answered the phone. The therapist was surprised because Florence had told her that she was a widow of more than 15 years who lived alone. The woman on the

phone said that she was Florence's daughter, and that Florence was taking a little longer than usual to help her with her morning routine. Florence herself refused to discuss the issue over the telephone, and said that she would come to the program at the regular time on the following day only if her therapist promised that they would discuss the issue "in private."

When asked about her situation at home, Florence admitted that her daughter was dying of AIDS. She implored her therapist to keep it a secret from the other patients, and only reluctantly accepted that this information would be shared (in confidence) among the treatment team members, as per the usual agreement for acceptance into the program. Florence said that it was her duty as a mother to take care of her daughter, but that things were very difficult for her. When asked why she never talked about this serious problem behavior, she said that she didn't want to burden others with her problems or "waste time crying over spilled milk." Despite her therapist's urging, Florence felt strongly that there was no need to discuss this problem with others in group therapy, because it would probably just make others upset.

Although she never had formal nursing training, Florence was proud that she learned how to help her daughter with her catheter, change her dressings (she apparently had open wounds that were not properly healed), and help her eat, bathe, and go to the bathroom. She said that she was faring much better with this daughter than with her son, who died of AIDS 5 years previously, also under her care. When asked how her two children contracted the virus, Florence tersely replied that they had turned to "dirty street drugs." Although Florence never provided a wealth of details, it also appears likely that her daughter turned to prostitution to finance her drug habit, and that she also could have contracted HIV through unprotected heterosexual sex. Florence failed to mention whether or not she wore latex gloves and goggles when taking care of her daughter and son, or that she even knew how to properly dispose of potentially contaminated medical waste.

Within the treatment team, concerns were raised that Florence was unaware of the basic universal precautions required for caring for someone with AIDS, and that even if universal precautions were explained to her, her dementia would prevent her from employing them accurately and consistently. However, the treatment team was reluctant to discuss universal precautions with Florence, much less ask her to consider an HIV test for herself. Some staff members admitted openly that the topic of HIV and AIDS made them uncomfortable, and that they simply did not want to "put Florence through that with everything else she has been through."

Staff members also argued about whether Florence should be encouraged to discuss her situation with her peers. Many staff members expressed fear that the older adults in the program would ostracize her and even engage in a mass exodus from the program in order to avoid contracting the disease. Heated discussions also arose about whether staff members and patients alike should take universal precautions when dealing with Florence on a daily basis. Ultimately, Florence agreed to have a visiting nurse help with some of her daughter's caregiving. She refused to take an HIV test and never disclosed to her peers that her daughter had AIDS.

A Call for Prevention and Advocacy

The development of primary prevention programs for HIV/AIDS among older adults represents one of the most proactive steps we can take to guard against agist decision making. An essential weapon against the inaccurate diagnosis of HIV and HIV-associated dementia is available through both practitioner and patient education. To complicate matters, of all age groups older adults are less likely to be targeted for HIV prevention strategies, and are less likely to be knowledgeable about the nature, transmission, and progress of the disease (Orel et al. 2004). Studies suggest that even healthy, independent, community-living older adults are generally unaware of the age-related risk factors associated with HIV/AIDS (e.g., postmenopausal women experience thinning of the vaginal walls; older adults die sooner of AIDS than their younger counterparts), and some even maintain incorrectly that HIV can be passed via public toilets, mosquito bites, and blood transfusions (Hillman 2007, 2008a).

Older adults also are less likely to be cognizant of the significant time that may pass between initial infection with HIV and the emergence of symptoms, as well as the overall risk of infection in their age group (e.g., CDC 2000). Thus, adults over 50 may be more likely to unknowingly pass the virus to their partners and loved ones through sexual contact and IV drug use. Few educational programs about HIV and its transmission exist for older adults (e.g., Orel et al. 2010). Among health care providers, only a handful of training programs in academic and on-the-job settings incorporate geriatric issues, much less specific issues about HIV among older adults, into their required curriculum. No national educational programs exist regarding HIV/AIDS education among adults over 50.

Fortunately, some new statewide initiatives for HIV/AIDS prevention among older adults have appeared in New York and Florida. New York City's most recent educational program, sponsored by the New York State Health Department, features posters with the slogan, "Age won't protect you from AIDS," along with various facts about HIV prevention (e.g., HIV prevention is a lifelong job) and a phone number for additional information and questions. Variations on a theme are available as these posters offer various options, including close-ups of women and men from various ethnic groups, as well as one of a large birthday cake with multiple lit candles. It also is notable that all of these materials are available in English and Spanish (New York Department of Health 2011). The Senior HIV Intervention Project in Florida's West Palm Beach and Broward Counties trains peer educators, often referred to as "safe sexperts," and "condom grandmas," to educate older adults about condom use and to convince them to seek out HIV testing (Gearon 2008). As noted, the CDC only mandates HIV testing in medical settings for adults up to the age of 64 (CDC 2006). Asking health care providers to advocate for changes to this policy could have life-saving impact.

Summary

The rise in documented HIV/AIDS cases among older adults is unprecedented. The rates of infection are increasing nearly four times faster among older adults than among young adults. The primary means of infection among older adults include homosexual contact, heterosexual contact, and intravenous drug use. Despite the wealth of information that we now have about HIV among older adults, it is unclear how many older adults currently suffering from HIV and HADC remain undiagnosed and untreated. It also remains unknown how well equipped clinicians are to make differential diagnoses regarding HIV-associated dementia and Alzheimer's dementia. Practitioners must guard against falling victim to their own agist beliefs and stereotypes; dealing with older adults and HIV can be a daunting but necessary task.

The development of educational primary prevention programs, and of group interventions designed to help combat the stigma, social isolation, and depression often faced by older PLWHA are some of the most proactive steps we can take. It is vital to guard against agist and inappropriate diagnostic decision making. We also need to highlight the needs of the rapidly growing population of men and women over the age of 50 living with HIV/AIDS in terms of minimizing stigma, reaching minority group members, reducing social isolation, and celebrating psychological well-being and resilience. An essential weapon against the inaccurate diagnoses of HIV/AIDS and HIV-associated dementia, and the discrimination sometimes unfortunately associated with such a diagnosis, is available through both practitioner and patient education.

Appendix

Resources for older adults and professionals regarding HIV/AIDS and aging

American Association of Retired Persons (AARP)
601 East Street NW
Washington, DC 20049
(202) 434-2260
www.aarp.com

AARP has a Social Outreach and Support *(SOS)* division that provides links to various referral services.

Health Watch Information & Promotion Services
589 Eight Avenue, Sixth Floor
New York, NY 10018
voice: (212) 564-7199
fax: (212) 564-7189
www.hwatch.org

Offers Community HIV Information/Education for Seniors (CHIEFS): A training for providers to assist them in training seniors to become peer educators, and Seniors & HIV/AIDS: Serving African-Americans Over 50, a training to assist healthcare and social service providers in understanding the needs of African-Americans 50 and over with HIV/AIDS and to integrate service models that promote access to and retention in care.

HIV/AIDS in Aging Task Force
425 East 25th Street
New York, NY 10010
(212) 481-7670
http://www.thetaskforce.org/issues/health_and_hiv_aids

Arranges educational seminars and conferences for health care providers.

HIV Wisdom for Older Women.
Founded by Jane Fowler
http://hivwisdom.org/index.html

Provides educational presentations, typically by an older woman living with HIV.

National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20850
1-800-458-5231
http://www.cdcnpin.org/

Provides information about local resources and access to free government publications.

National AIDS Hotline
1-800-342-AIDS
1-800-344-SIDA
for Spanish 1-800-AIDS-889 (TTY)

This hotline is manned 24 h a day, 7 days a week. It can provide referrals to local programs and general information about the disease.

NAHOF: New England Association of HIV over Fifty
23 Miner St, Ground floor
Boston MA 02215
http://hivoverfifty.org/en/

Offers training and annual conferences

New York Association on HIV over Fifty, Inc.
J. Edward Shaw, Chairperson
119 West 24th Street
New York, NY 10011-1913
(212) 367-1009
http://www.nyahof.org/mission.htm
e-mail: info@nyahof.org or ednys2003@yahoo.com

Seniors in a Gay Environment (SAGE)
305 7th Avenue, 16th Floor
New York, NY 10001
(212) 741-2247
http://www.sageusa.org/index.cfm

SAGE offers referral services and HIV/AIDS information primarily to older lesbian, gay, bisexual, and transgender adults

Social Security Administration
1-800-SSA-1213
Social Security provides two different disability programs for eligible AIDS patients.