HIV AND OLDER ADULTS

Although HIV infection tends to be most common among people younger than 50 years of age, older people are also at risk. Their risks, however, are largely ignored by health care providers, HIV prevention campaigns, and society at large, partly because of the widespread misconception that older adults do not engage in HIV risk behaviors. Likewise, many older adults do not perceive themselves to be at risk and lack adequate HIV prevention education. This issue of PERSPECTIVES examines the reasons why some older adults are at risk for HIV infection and strategies for effectively counseling older clients.

Research Update

A prevailing cultural image of older adults is that they are not sexually active and do not engage in behaviors that put themselves at risk for HIV. In 1999, however, the age of diagnosis for 11 percent of AIDS cases in the United States was 50 years or older (see page 2, “Defining Older Adults”).1 People age 60 and older accounted for 25 percent of these cases, and people age 70 and older accounted for 4 percent of cases.2

Prevention efforts aimed at older adults are particularly important because between 1991 and 1996, new AIDS diagnoses increased by 22 percent in people age 50 and older compared to a 9 percent increase in people between the ages of 13 and 49.3

Areas in the United States where older adult populations are more highly concentrated, such as Florida, California, and Arizona, have reported higher percentages of AIDS diagnoses among older adults compared to the national average. For example, in Palm Beach County, Florida, a popular retirement location where 40 percent of the population is age 50 or older,4 15 percent of AIDS diagnoses occur among this age group.5 In Los Angeles County, where 22 percent of the population is age 50 or older,6 approximately 18 percent of people currently living with an AIDS diagnosis are 50 or older.7

According to the 1990 census, 25 percent of the U.S. population was age 50 and older; it is estimated that the 2000 census will indicate this rate to have risen to 28 percent. The percentage of people age 65 and older is estimated to be 13 percent in 2000, the same as it was in 1990.8

With the recent introduction of antiviral therapy, the length of time between HIV infection and death has increased, thus allowing people who were infected later in life to live into their senior years. With more HIV-positive people living longer, it is possible that an increased pool of both infected and uninfected people who have had limited HIV prevention education will come into contact and engage in risky behavior.

It is difficult to accurately estimate rates of HIV infection among older adults because very few people age 50 and older routinely test for HIV antibodies.9 A 1999 national study found that 47 percent of younger adults (between the ages of 18 and 49) had tested for HIV, while only 27 percent of older adults had done so.10 The reason for not testing appears to be two-
Older adults are often unaware of their risks for HIV infection, and health care providers rarely discuss HIV risk factors with older clients. Older adults have also traditionally been excluded from national HIV prevention campaigns, which usually target younger populations. A national survey found that 10 percent of older adults had at least one risk factor for HIV infection. The survey also found that older adults at risk for HIV were one-sixth as likely to use condoms during sex and one-fifth as likely to have been tested for HIV than a comparison group of at-risk people in their twenties. Research also indicates that between 1991 and 1996, heterosexual transmission of HIV among older women in the United States increased by 106 percent, and transmission resulting from injection drug use increased by 75 percent. Older adults are less likely to use condoms than younger people largely because they assume they are not at risk for HIV and other sexually transmitted diseases (STDs), and this may be an accurate assumption for many people who are involved in long-term, monogamous relationships. Also, for many older adults, HIV disease was not a concern in their younger years of initial sexual exploration because it was not yet known to exist. Thus, many older adults may be unaware of the ways in which they might be susceptible to HIV infection.

Despite cognizance of their own behaviors and histories, older adults may accept the prevailing societal assumption that they are not at risk for HIV infection due to their age. Similarly, older people may assume that potential partners are not infected because of their age. Many sexually active older people perceive a partner who “looks clean” or “is a nice person” as someone who could not possibly be infected with HIV.

Health care providers and HIV educators are similarly unlikely to perceive a need for HIV prevention interventions for older people. In a random survey of 30 HIV educators, not one reported providing primary prevention intervention to older communities. Among their reasons were insufficient resources, uncooperative senior center directors, and failure to perceive older adults as being in need of these services. Likewise, a study by the Centers for Disease Control and Prevention (CDC) found that only 15 percent of older adults who had seen their doctors in the previous five years had discussed HIV with them, and 72 percent of these discussions occurred at the patient’s urging. The study also found that when

### Defining Older Adults

Although most gerontologists define older adults using the social security designation of age 65, the convention for current research on older adults and HIV is to focus on people age 50 and older. The Research Update of this issue of PERSPECTIVES adopts this convention, but the Implications for Counseling section focuses on clients over the age of 60 because this is closer to the age at which lifestyle differences relevant to HIV test counseling generally emerge.
Related Issue: Viagra

Many older men experiencing impotence, or erectile dysfunction, are being treated with the drug Viagra. Recent studies indicate that Viagra, which helps fill the penis with enough blood to induce an erection, is effective in 60 percent to 80 percent of men with erectile dysfunction.\textsuperscript{27}

Increased sexual behavior among older men can contribute to increased risk for HIV infection and other sexually transmitted diseases (STDs).\textsuperscript{28} Media reports suggest that Viagra has enabled older men to rejuvenate their sexual activity and that it is common for some of these men to hire sex workers, which can increase risk for HIV infection, especially if the sex is unprotected. Nevada sex industry workers have anecdotally reported an increase in the number of male clients between the ages of 66 and 96 since the introduction of Viagra.\textsuperscript{29}

In addition to potentially leading to behaviors that increase risk for HIV infection, Viagra use can cause side effects for HIV-infected men who take protease inhibitors. Pfizer Inc., the manufacturer of Viagra, reports that taking Viagra in conjunction with protease inhibitors, particularly ritonavir, may raise the concentration of Viagra in the bloodstream. This may increase the likelihood of side effects associated with Viagra such as color distortion, dizziness, facial flushing, headaches, low blood pressure, and increased heart rate. As a result, taking Viagra with protease inhibitors can increase the risk of heart attacks. In response to these findings, Pfizer has altered the Viagra dosing recommendations for people taking protease inhibitors.\textsuperscript{30}

Transmission, Infection, and Treatment

The physical and mental deterioration associated with advanced age may increase risk for HIV infection. In women, for example, vaginal tissue becomes thinner and less resilient with age, which reduces natural lubrication and increases the likelihood that the tissue...
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Implications for Counseling

The challenges that tend to emerge when counseling older clients relate to communication. Under ideal circumstances, an older client testing for HIV would be matched with an older counselor, but this often does not occur. There may be a wide gulf in experience, background, and orientation to social, political and spiritual issues between a client over the age of 60 (see page 2, “Defining Older Adults”) and a counselor who is several generations younger. For any number of reasons, older clients may be reluctant to discuss details of their personal lives with counselors, especially those who are much younger than them. In such instances, it may be constructive for the counselor to acknowledge the situation, for example, by saying, “I imagine it can be a little unsettling for you to talk about these things with a complete stranger who is quite a bit younger than yourself. What is this like for you?” It may also be useful to reassure the client that the counselor is well-trained and experienced, adding that the focus of the session is HIV prevention.

Discussing sex or drug use with a complete stranger can be an unsettling experience for which clients—particularly those who are over the age of 60—may be unprepared. It can be especially difficult to discuss these topics with a client who is uncomfortable doing so. In these cases, it may be productive to keep the session educational rather than personal: rather than exploring the client’s sexual behaviors or drug use, educate the client about...
HIV transmission and prevention. Similarly, it may be less intimidating for clients to discuss in general terms issues that are common for their age group rather than issues specific to the client’s circumstances. As the session proceeds, the client may ask questions about specific behaviors. When this happens, answer these questions in a way that continues to afford the client safety by not making the inquiry personal.

In the same way that it may be difficult for a younger counselor to establish rapport with an older client, it may be a challenge for the counselor to discuss sexual behaviors or needle sharing behaviors with a client who is about the same age as his or her parents or grandparents. Counselors who are unaware of their biases or assumptions about older people may miss important opportunities to help older clients reduce their HIV risks. For example, a counselor who incorrectly assumes that injection drug use is not a possible risk factor for older people may fail to assess this risk when working with older injection drug-using clients.

Many older people are not aware that they may be at risk for HIV infection. The fact that an older client appears in a testing clinic, however, indicates that this client has probably given some thought to the issue of HIV risk. A good way to begin a session with an older client is to briefly explore the client’s reasons for testing, for example, by asking, “What brings you in today to test for HIV?” It can also be useful for the counselor to praise the client for testing.

To help assess a client’s understanding of HIV, use open-ended questions or statements, for example, “Tell me what you know about your risk for HIV.” The counselor can then validate the client’s knowledge, add to it, and correct misinformation. This part of the session also presents an opportunity to educate the client about sexually transmitted disease (STD) transmission and prevention. Older clients may be more familiar with STDs other than with HIV because HIV is a much newer disease. Keep in mind, however, that the term “STD” is also relatively new, and some clients may be more familiar with the older term, “venereal disease.”

**Suddenly Single**

Clients who have been in long-term monogamous relationships with partners who are now deceased may suddenly find themselves to be single. Although abrupt change can affect anyone at anytime, adjusting to being single may be especially difficult for older people. People who have been in monogamous relationships for 20 years or longer have probably been sheltered from concerns about HIV. As a result, such clients may not consider HIV to be a risk as they start dating again and may genuinely be in the pre-contemplation stage of behavior change related to HIV. In addition, they may have little or no experience negotiating for safer sex or may not perceive the need to do so.

A client who is beginning to date after being in a long-term, monogamous relationship may too readily believe that a new partner has been and will be monogamous. Begin by acknowledging the client’s need and desire for monogamy. The counselor and client can then explore what would happen if the client or the client’s partner were to seek sex outside of the relationship. How would that be handled in the relationship with regard to transmission of HIV or other STDs? These are sensitive issues that people in relationships generally do not discuss with their partners. It is, therefore, critical for the counselor to approach such a discussion with tact and sensitivity while remaining within the context of HIV prevention.

**Educating the Client**

When working with pre-contemplative clients, it is important for counselors to use interventions that help clients to recognize their risks for HIV infection. However, before attempting to educate a client about HIV, an empathic comment can help establish rapport for what may be an uncomfortable situation. For example, the counselor may say, “Wow! You’ve been married for 20 years and now, all of a sudden you are looking at dating. What is this like for you?” Or, “I understand that this is the first time you are testing for HIV. We may be talking about things that you have never talked about before. I can appreciate how this may be uncomfortable for you. I will do my best to be respectful as...”
we talk about these things.”

A counselor may need to educate older clients about the importance of negotiating for safer sex because this may be a new concept for them. The counselor may then proceed with the session by asking a series of open-ended questions: “I know this is all new for you, so I’m wondering what it may be like for you to bring up the topic of HIV during a date. What could you say to your partner? How would you feel about bringing up the topic of condoms? If you weren’t going to use condoms, what might you do to reduce your risk?” To help the client with the last question, it may be necessary to explain that different sexual behaviors have different levels of risk associated with them.

Some clients who feel unable to talk about condom use for anal or vaginal sex may be willing to discuss their preference for oral sex with their partners. In this way, clients may reduce their risk, because oral sex poses a lower HIV risk than unprotected anal or vaginal sex. It would be useful to educate clients in detail about how to minimize the risks of engaging in oral sex, for example, by avoiding taking ejaculate into the mouth or by avoiding oral sex when there are cuts or open sores in the mouth, when the receptive partner has a sore throat, or soon after flossing or brushing.

**Sex and Aging**

With age comes changes in hormone levels and sexual functioning. Men lose the potency of the erections they once had, making it difficult or impossible to use condoms. In women, the vagina loses its ability to lubricate, and the vaginal walls lose their elasticity. As a result, using condoms can become uncomfortable, and older clients may not consider condom use to be a viable option. Some options may make condom use more attractive, for example, the use of Viagra for men. When making suggestions for medical or pharmaceutical interventions, discuss with male clients how they would feel about bringing up Viagra with a physician (see

**References**

Case Study

Laura is a 68-year-old woman who was referred for HIV testing by her doctor because of an undiagnosed decline in her health. For the past six years, Laura has been widowed. Several years after her husband’s death, she and two of her friends started traveling together around the world. On one of her trips, she met a man in Europe, whom she is now dating. They have been seeing each other four to six times a year for the past two years. Laura had never considered herself to be at risk for HIV. She had previously used condoms only as prevention for birth control, but “That was too many years ago to remember.” Laura does not use condoms or any other form of birth control because she is no longer ovulating. She is visibly anxious and says she feels uncomfortable talking about things she never really talked about with anyone before.

Recognize that being referred by a doctor for HIV testing can cause anxiety for many clients, and ask Laura how she feels about this before beginning the risk assessment. Acknowledge and support her feelings before moving on.

Explain the risk assessment to Laura in the context of prevention with reassurances about anonymity or confidentiality, depending on the nature of the setting, and ask how she feels about the process. If Laura is significantly older than the counselor, consider asking how she feels about the age difference. If it is a source of discomfort for her, it may be helpful to refer her to a counselor closer to her age, if an older counselor is available. This may help Laura feel more at ease and more able to discuss her HIV risk.

Discuss HIV transmission in terms with which Laura would feel comfortable, and assess her knowledge. Because this is her first time testing for HIV, her knowledge may be limited, and it may be productive to keep the session educational, which could make talking about sex less personal and less threatening.

During the session, Laura may begin to realize that she has, indeed, placed herself at risk for HIV. This would mean that the counselor has effectively helped her move from the pre-contemplation to the contemplation stage of behavior change. Such progress is usually accompanied by an emotional reaction from the client. Help Laura acknowledge the reaction by bringing her attention to it, for example, by saying, “We’ve been talking about HIV transmission, and I believe you are starting to realize your own potential for risk. I’m wondering if you can talk about what it is like for you to suddenly realize that you may have been at risk for HIV.”

To move the session in the direction of risk reduction counseling, the counselor may ask Laura, “I’m wondering if there is anything you can do to lower your risk for HIV.” Explore with Laura her options and help her decide which ones are the most realistic for her. It may be that she is not ready to take action to reduce her risk for HIV. She may need time to assimilate the shift from being naive about her risk to being informed. The counselor can support future action to reduce HIV risk by offering Laura a referral for further counseling so that she can continue to integrate prevention education into her life.

Be aware that older clients may use the services of sex workers and that these encounters may be unprotected. Older male clients, whether they are gay or heterosexual, may believe that they are unable to compete in a youth-dominated culture. They may also prefer to have sex with a younger sex worker rather than with someone closer to their own age.

It may be difficult for older clients to openly discuss their interactions with sex workers because they may feel shame or other uncomfortable emotions about the subject. Many people consider their use of sex work services to be a private matter, and it may be difficult or impossible for test counselors to discuss this subject with some clients.

It is best to bring up the topic of sex work gently, simply, and without judgment. For example, a counselor may ask, “Tell me, do you use prostitutes (or hustlers, if the client is a gay man)?” It is essential for the counselor’s tone to remain neutral in these situations. A client who detects any judgment in the counselor’s voice will most likely not share this information, and the counselor will miss an important opportunity to work with the client on reducing risk.
Test Yourself

Review Questions

1. People age 50 and older represent what percent of all AIDS diagnoses in the United States? a) 2 percent; b) 11 percent; c) 40 percent; d) 80 percent.

2. True or False: Many older adults are unaware of the ways HIV is transmitted.

3. True or False: It is common for health care providers to routinely discuss HIV prevention with clients age 50 and older.

4. Which of the following illnesses prevalent among older people have symptoms that are similar to those of HIV infection? a) cancer; b) Alzheimer’s disease; c) diabetes; d) all of the above.

5. True or False: Sexual communication skills among older adults may be poorly developed due to more sexually restrictive societal influences during the era in which they grew up.

6. Viagra may increase risk for HIV infection among older men because of which of the following effects? a) prolonged erection; b) increased sperm count; c) increased frequency of sexual episodes; d) delayed ejaculation.

7. Which of the following conditions common among older women increases susceptibility to HIV infection during unprotected sex with an infected partner? a) Alzheimer’s disease; b) vaginal tissue thinning; c) osteoporosis; d) diabetes.

8. True or False: Because of the increased frequency at which older adults generally receive medical check-ups, it is likely that most have tested for HIV antibodies.

Review Questions

1. How can a test counselor initiate a discussion about HIV risk behavior with an older client who is reluctant to talk about such personal issues?

2. When counseling an older client, how can a relatively young counselor determine if it would be beneficial to refer the client to an older counselor?

3. How can counselors prepare themselves for working with clients who are significantly older than themselves?

4. What are some generalizations and assumptions about older people that may hinder a counselor’s effectiveness during a session?

5. How can counselors identify and be aware of local referrals that may be useful for older clients?

6. What are some strategies counselors can use to establish rapport with older clients?

Answers

1. b.

2. True.

3. False. Studies indicate that most health care providers fail to ask older adults about HIV risk behavior.

4. d.

5. True.

6. c.

7. b.

8. False. Most older adults have not been tested for HIV, which is partially due to being unaware of their risk for HIV infection.
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