Older Adults

Seniors (age 55+)

(**Table 1 and Table 2**) In 2011, 106 people age 55 and older were newly diagnosed with HIV in Houston/Harris County. This equates to 8.5% of all new HIV diagnoses in that year. When compared to all new HIV diagnoses in Houston/Harris County in 2011 regardless of age, larger proportions of newly diagnosed seniors (1) were White (19.8% v. 14.3%) and (2) reported injection drug use (13.2% v. 5.3%). In addition, newly diagnosed seniors were more evenly distributed between MSM and heterosexual contact than were all new HIV diagnoses in 2011 in Houston/Harris County. The same demographic trends can be seen in new HIV diagnoses in seniors in the Houston EMA.

SENIORS (age 55+) TABLE 1-New Diagnoses of HIV and Persons Living with HIV in *Houston/Harris County* by Sex, Race/Ethnicity, and Risk[a]

	New HIV Disease[b]		Persons Living with HIV[c]	
	Cases	%	Cases	%
Total Seniors	106	100.0%	3,096	100.0%
Sex				
Male	83	78.3%	2,446	79.0%
Female	23	21.7%	650	21.0%
Race/Ethnicity				
White	21	19.8%	1,232	39.8%
Black/African American	56	52.8%	1,338	43.2%
Hispanic/Latino	27	25.5%	481	15.5%
Other/Multiple Races	2	1.9%	45	1.5%
Risk Category[d]				
Male-to-male sexual activity (MSM)	46	43.4%	1,518	49.0%
Injection drug use (IDU)	14	13.2%	484	15.6%
MSM/IDU	¶	¶	170	5.5%
Heterosexual contact	46	43.4%	920	29.7%
Perinatal transmission/other	¶	¶	4	0.1%
Total All Ages	1,249	100.0%	20,022	100.0%

[a]Source: Houston/Harris County eHARS
[b]HIV Disease = People diagnosed with HIV, regardless of AIDS status, with residence at diagnosis in Houston/Harris County in 2011
[c]PLWH at end of 2010 = People living with HIV disease, regardless of AIDS status, in Houston/Harris County at the end of 2010
[d]Patients with no risk reported were recategorized into standard categories using the multiple imputation or risk program of the Centers for Disease Control and Prevention (CDC)
¶Data has been suppressed to meet cell size limit of 5

Of all persons living with HIV in the Houston EMA, people age 55 and older comprise 16.8% at 3,641 persons. When compared to all people living with HIV in the Houston EMA in 2011 regardless of age, larger proportions of HIV positive seniors (1) were again White (39.0% v. 24.6%) and (2) reported injection drug use risk, either IDU alone or in combination with MSM (21.1% v. 16.0%). However, prevalence rates among seniors remain highest in African Americans at 940 per 100,000 population.

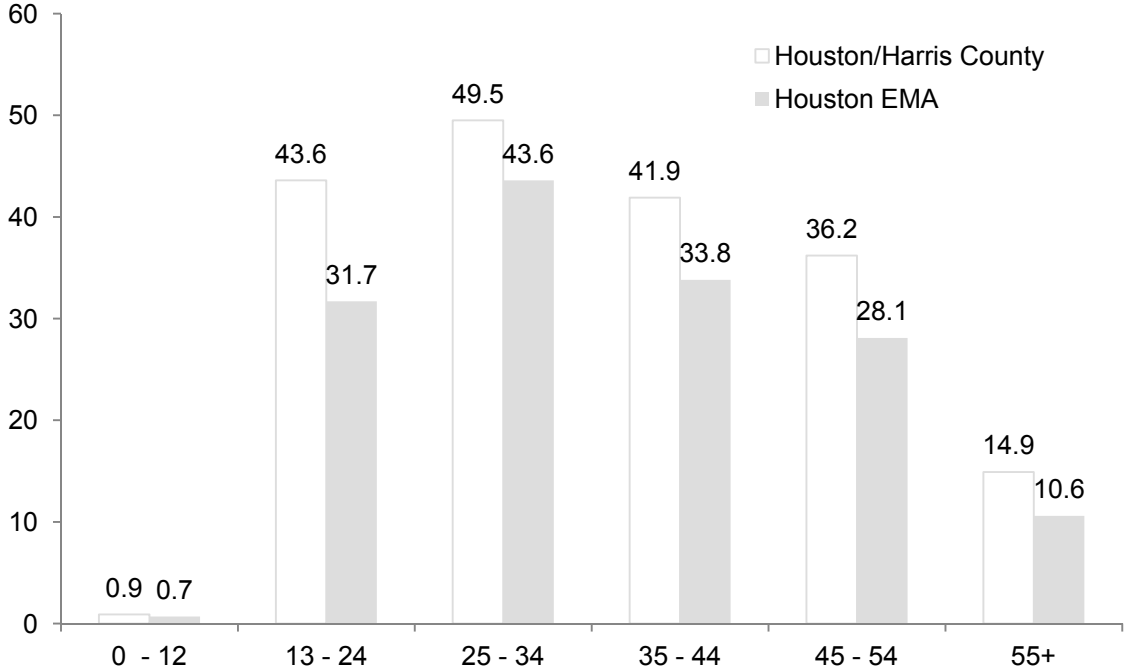
SENIORS (age 55+) TABLE 2-New Diagnoses of HIV and Persons Living with HIV in the *Houston EMA* by Sex, Race/Ethnicity, and Risk[a]

	New HIV Disease[b]			Persons Living with HIV[c]		
	Cases	%	Rate[d]	Cases	%	Rate[d]
Total Seniors	104	100.0%	10.6	3,641	100.0%	370.3
Sex						
Male	79	76.0%	17.1	2,843	78.1%	614.8
Female	25	24.0%	4.8	798	21.9%	153.2
Race/Ethnicity						
White	20	19.2%	3.7	1,420	39.0%	264.3
Black/African American	55	52.9%	32.9	1,573	43.2%	939.9
Hispanic/Latino	28	26.9%	15.2	593	16.3%	322.8
Other/Multiple Races	¶	¶	¶	55	1.5%	58.0
Risk Category[e]						
Male-to-male sexual activity (MSM)	41	39.4%	*	1,738	47.7%	*
Injection drug use (IDU)	16	15.4%	*	564	15.5%	*
MSM/IDU	¶	¶	¶	206	5.7%	*
Heterosexual contact	46	44.2%	*	1,126	30.9%	*
Adult other risk	¶	¶	¶	7	0.2%	*
Total All Ages	1,334	100.0%	24.5	21,664	100.0%	397.6

[a]Source: Texas eHARS. Living HIV cases as of 12/31/11
[b]HIV Disease = People diagnosed with HIV, regardless of AIDS status, with residence at diagnosis in the Houston EMA
[d]PLWH at end of 2010 = People living with HIV disease, regardless of AIDS status, in the Houston EMA at the end of 2010
[e]Rate per 100,000 population. Source: DSHS Center for Health Statistics 2011 Population Projection: http://www.dshs.state.tx.us/chs/popdat/detailX.shtm
[f]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification
*Population data are not available for risk groups; therefore, it is not possible to calculate rate by risk
¶Data has been suppressed to meet cell size limit of 5

(**Graph 1**) Rates of new HIV diagnoses by age in Houston/Harris County and in the Houston EMA follow a general bell curve, with a peak among people age 25 to 34 in both jurisdictions. For people age 55 and older, the rate of new HIV diagnos es is highest in Houston/Harris County at 15 new HIV cases for every 100,000 seniors in the jurisdiction. In the Houston EMA, there are 11 new HIV cases for every 100,000 seniors.

SENIORS (age 55+) GRAPH 1-Rate[a] of New HIV Diagnoses in the Houston EMA[b] and Houston/Harris County[c] by Age as of December 31, 2011



[a]Source: DSHS Center for Health Statistics 2011 Population Projection: http://www.dshs.state.tx.us/chs/popdat/detailX.shtm
[b]Source: Texas eHARS. Living HIV cases as of 12/31/11
[c]Source: Houston/Harris County eHARS

http://www.cfah.org/hbns/2013/half-of-at-risk-older-adults-arent-getting-routine-hiv-screening-

HEALTH BEHAVIOR NEWS SERVICE

Half of At-Risk Older Adults Aren't Getting Routine HIV Screening

Release Date: January 29, 2013 | By Sharyn Alden, HBNS Contributing Writer
Research Source:

KEY POINTS

- Nearly half of an at-risk population of older adults visiting a public health venue was not screened for HIV/AIDS in the past year.
- Older adults who had a mistrust of the government or believed in HIV/AIDS conspiracy theories were more likely to be tested in the past year.

One in four people with HIV/AIDS is over 50, yet older adults are more often diagnosed at a late stage than younger people. Despite this, nearly half of older adults visiting a public health clinic where HIV/AIDS is prevalent were not screened for the disease in the past 12 months, finds a study in The Gerontologist.

"It is concerning that none of the participants in the study were automatically tested," said Chandra L. Ford, Ph.D., MPH, MLIS, assistant professor in the department of community health sciences at the University of California at Los Angeles. "In the venues where we recruited patients, they provide HIV testing and HIV/AIDS care, and yet, the CDC guidelines, which have been in effect since 2006, are not being followed for older adults, even for those who are considered higher risk such as injection drug users, and sexually transmitted disease patients," she said.

The cross-sectional study sought to examine whether misinformation and government mistrust played a role in the decision to be screened. The study included 226 adults of various racial and ethnic backgrounds, over 50-years-old who had participated in the LA VOICES study in Los Angeles. All of the adults were patients at public health venues, including needle-exchange sites and STD clinics, and none had been diagnosed with HIV.

About 72 percent of the adults surveyed had high levels of mistrust of the government. Interestingly, thirty percent of participants believed that AIDS was a man-made disease designed to wipe out targeted groups of people. However, people who believed in conspiracy theories like these were more likely to have gotten tested for AIDS in the past year, suggesting that testing that is done early and often gives people the opportunity to avoid or control their fears.

Richard Birkel, Ph.D., senior vice president for health at the National Council on Aging in Washington, D.C. said this type of study is good for generating questions for future research. “While it is clear that HIV/AIDS is a serious public health problem among older adults and that many are not availing themselves of opportunities to be tested, the study does not provide clear direction for practice or policy change. For example, many people who mistrusted the government did get tested—what accounts for that difference? Is it feelings of hopelessness or the belief that one can make a difference by taking action?”

Ford added it is crucial that health care providers not overlook screening opportunities to diagnose HIV early, especially among vulnerable adults. “Otherwise, when HIV infection finally is diagnosed, the disease will be more advanced, more difficult to manage and more costly for HIV patients as well as for taxpayers.”

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For More Information:

Reach the Health Behavior News Service, part of the Center for Advancing Health, at (202) 387-2829 or hbns-editor@cfah.org.

The Gerontologist, published since 1961, is a bimonthly journal (first issue in February) of The Gerontological Society of America. GSA Press Room: http://www.geron.org /About%20Us/press-room

Ford, C. et al. (2013). Belief in AIDS-Related Conspiracy Theories and Mistrust in the Government: Relationship with HIV Testing among At-Risk Older Adults. *The Gerontologist*.

Tags for this article:
Disease Screening Get Preventive Health Care Aging Well

AIDS InfoNet www.aidsinfonet.org Fact Sheet Number 616

OLDER PEOPLE AND HIV

HOW MANY OLDER PEOPLE HAVE AIDS?

About 29% of all people with AIDS in the United States are age 50 or over. In 2001, this proportion was 17%. In some cities, as many as 37% of people with AIDS are older than 50.

The number of older people diagnosed with AIDS is increasing. There are three types of older people with HIV: people who have been living with HIV for many years; older HIV-infected people who are just learning their HIV status; and older people newly infected with HIV. About half of the older people with AIDS have been infected for one year or less.

The rates of HIV/AIDS among older people are 12 times higher for African-Americans and 5 times higher for Hispanics compared with whites.

Many people don't consider age 50 to be "old." However, age 50 is being used more often to keep statistics on "older people" with HIV and AIDS.

WHY ARE OLDER PEOPLE GETTING INFECTED?

There are several reasons:

- Health care providers may not test older people for HIV infection
- Older people may lack awareness of the risk factors for getting HIV (see Fact Sheets 150 and 152)
- Many older people are newly single. They get divorced or lose their mates. While they had a partner they may have ignored HIV prevention messages
- Very little HIV prevention education is targeted at older people
- Many older people believe that HIV only affects younger people
- Most older people get no training in safer sexual activities (see Fact Sheet 151)
- Drug use accounts for more than 16% of infections of people over 50
- Unprotected sexual activity. This may be heterosexual or homosexual sex. Viagra and other drugs that help men get and maintain an erection may contribute to increased rates of sexual activity and sexually transmitted diseases among older people, as they do for younger people.
- Physicians may not diagnose HIV infection in older people. Some early symptoms of HIV disease may appear to be signs of normal aging.
- The stigma of having HIV/AIDS may be worse for older people. This can result in hiding their infection from family and friends.

IS HIV DISEASE DIFFERENT FOR OLDER PEOPLE?

The first studies of HIV in older people were done before strong anti-HIV drugs were available. Most of them showed that older people got sicker and died faster than younger people. This was thought to be due to the weaker immune systems of older people. Also, older people usually have health problems in addition to HIV.

Recent research shows that older people respond well to antiretroviral treatment. Most older patients, unless they are drug users or have mental problems, take their medications more regularly than younger patients. They have better adherence (see Fact Sheet 405.)

IS HIV THE SAME IN OLDER PEOPLE?

CD4 cell levels (see fact sheet 124) do not recover as quickly in older patients as in younger patients. Unfortunately, we don't have good information on older people because they were usually not included in clinical trials of new drugs.

Treatment side effects (see fact sheet 550) may not be any more frequent in older people. However, changes caused by aging can resemble or worsen treatment side effects. For example, older age is a major risk factor for heart disease (see fact sheet 652) and for increasing fat in the abdomen. Some older people without HIV lose fat that looks similar to the changes caused by lipodystrophy (see fact sheet 553.)

Recent research suggests that many of the health problems of older people progress faster in people with HIV. Inflammation (see fact sheet 484) is a major factor in several diseases of aging.

WHAT OTHER HEALTH PROBLEMS ARE COMMON?

As people age, they develop health issues that continue for the rest of their lives. These can include heart disease, depression (see fact sheet 558,) osteoporosis (see Fact Sheet 557), high blood pressure, kidney problems (see fact sheet 651,) arthritis, diabetes, Alzheimer's disease and various forms of cancer.

Older people often take many different medications to deal with their health problems. This can make it more difficult for a doctor to choose anti-HIV drugs because of interactions with other medications.

MENTAL PROBLEMS

Older people may have more problems with thinking and remembering than younger people. These symptoms can appear the same as HIV-related mental problems. Fact Sheet 505 has more information on HIV and nervous system problems.

These problems, sometimes called dementia, are less severe than they were before the use of strong anti-HIV drugs. It is difficult to know what is causing mental problems in older people with HIV. Is it normal aging, or is it HIV disease? Research studies have linked both age and higher viral load (see Fact Sheet 125) to mental problems.

Rates of depression and substance use haven't been well studied in older people. However, these problems may be related to HIV disease, aging, or both. They need to be diagnosed and treated correctly.`

THE BOTTOM LINE

The number of people over 50 with HIV or AIDS is growing rapidly. About 29 % of people with AIDS in the United States are over age 50.

Older people get HIV the same way as younger people. However, they may not be aware that they are at risk of HIV infection. They also may not know how to protect themselves from HIV transmission.

Older people have to deal with other health issues. These can complicate the selection of anti-HIV medications. They can also be confused with some of the side effects of HIV drugs.

HIV drugs seem to work as well in older people as in younger people, although their CD4 cell counts may be lower. Also, older people may be better about taking their medications than younger people.

Revised May 24, 2012

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Fact Sheets can be downloaded from the Internet at http://www.aidsinfonet.org

POPULATION FACT SHEET: AUGUST 2012

OLDER ADULTS

The number of people age 50 and older who are living with HIV/AIDS continues to increase, primarily because many HIV-positive people receiving appropriate care are living into middle and old age. New HIV infections among older Americans also continue to occur.[1] Older adults living with HIV/AIDS risk poorer health outcomes than their younger peers as a result of age-related comorbidities, such as cardiovascular disease, potentially accelerated HIV progression, and increased likelihood of late diagnosis.[2]

SURVEILLANCE

- Adults over age 50 accounted for nearly 17 percent of the total HIV cases diagnosed in 2010.[3,*]
- Of the total number of people living with AIDS in 2010, nearly 14 percent were age 50 and over.[4]
- Among people age 50 or older, rates of HIV/AIDS are 12 times higher among African-Americans and 5 times higher among Hispanics/Latinos than among Whites.[5] Older minorities with HIV disease also have fewer economic resources than their older White counterparts.[6]

CRITICAL ISSUES

Older adults often consider themselves at low risk for HIV infection, and they generally lack up-to-date information about disease prevention and transmission.[7,8] As a result, people over age 50 may engage in unprotected or high-risk sex without realizing it. Women over 50 can be especially susceptible to HIV given that vaginal dryness following menopause can lead more easily to cuts and tears during sex. Older women, however, are less likely than younger women to view themselves as at risk for HIV or to undergo HIV testing.[9] Clinicians also may underestimate the risk of HIV among older patients, or may attribute common HIV symptoms to the normal aging process.[10]

It's estimated that by 2015, 50 percent of people living with HIV in the United States will be 50 years of age or older, yet older adults are less likely than their younger counterparts to be routinely evaluated for HIV.[11] Older adults also are more likely to avoid disclosing past risk behaviors, or may experience an overall lack of access to care.

This means that many older adults seek care during later stages of their HIV disease.[12] A prompt HIV diagnosis is especially important for older adults because of the complex interplay between aging, age-related conditions, HIV disease, and HIV treatments.

HIV-positive older adults are at higher risk than their HIV-negative peers for developing age-associated comorbidities, such as cardiovascular disease, cancer, liver disease, bone loss, and depression.[13,14] Moreover, HIV and its treatments can sometimes accelerate the progression of these conditions. In turn, aging and age-related conditions may speed up HIV progression. Coupled with drug toxicity, aging and HIV disease also can complicate treatment.[15]

Treatment advances have helped many older adults living with HIV live longer and healthier lives. Still, even in the era of highly active antiretroviral therapy, older adults and injection drug users have some of the lowest survival rates from HIV.[16] More than 16 percent of AIDS cases among older adults are related to the use of injection drugs.[17]

To expedite HIV diagnosis among older adults, the U.S. Centers for Disease Control and Prevention recommends that clinicians offer testing to all patients under age 64. All older patients benefit from counseling and age-appropriate and culturally sensitive messages.[18]

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* Unless otherwise noted, HIV estimates and diagnoses are gleaned from data provided by 46 U.S. States (Hawaii, Maryland, Massachusetts, Vermont are not included) and 5 U.S. dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

U.S. dependent areas, however, are not included in reference to HIV among specific racial and ethnic groups, since the U.S. Census Bureau does not collect demographic information from all dependent areas.

AIDS surveillance data are based on reports submitted by all 50 States, the District of Columbia, and 6 U.S. dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, Republic of Palau, and the U.S. Virgin Islands).

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HIGHLIGHTS OF THE HIV/AIDS BUREAU'S RESPONSE

In 2010, 48 percent of all Ryan White HIV/AIDS Program clients were 45 to 64 years of age and 3 percent were over the age of 65.*

The February 2009 edition of the Health Resources and Services Administration (HRSA) *HRSA CAREAction* newsletter, available at http://hab.hrsa.gov/deliverhivaidscare/careactionnewsletter.html, explores in depth the interactions among HIV disease, drug toxicity, aging, and age-associated comorbidities, such as metabolic syndrome, cancer, and renal disease so that providers are more aware of these health issues.

HRSA has supported innovative research to bolster and develop community-based health care networks that reduce barriers to early HIV identification and ensure entry to high-quality primary health care among older adult populations. HRSA currently is gleaning best practices from these and other programs concerning the engagement of hard-to-reach populations into care for inclusion in an upcoming training manual, curriculum, and Webinar.

The HRSA publication, *Resources for HIV and Aging,* offers a comprehensive list of resources to assist providers caring for HIV-positive patients over age 50. The document includes guidelines and risk assessment tools for treating cancer, depression, and other age-associated comorbidities, as well as information on providing medical care for older women.

In addition, HRSA provides comprehensive training to clinicians and other providers delivering HIV services to older adults to ensure they have state-of-the-art primary care. Additional support to increase the capacity of grantees and providers working with older adults of color is accessible through the Minority AIDS Initiative. HRSA also has engaged in community consultations and collaborations with national agencies addressing HIV among older Americans.

* U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). *2010 Ryan White HIV/AIDS Program Services Report.*

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This publication lists non-Federal resources to provide additional information. The views and content in those resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its components.

hiv and older adults

acria

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Daniel Tietz
Executive Director and Editor-in-Chief

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A Snapshot of Older Adults Living with HIV

In 2005, 1,000 people volunteered for an unprecedented ACRIA study designed to shed light on the unique needs of people over 50 living with HIV. In the study – called *Research in Older Adults with HIV*, or ROAH – 80% of volunteers were people of color and 33% were women, mirroring older people living with HIV in New York City. ROAH found that their concerns focused on the illnesses of aging, increased feelings of isolation from social support networks, and the negative impact of HIV stigma, shame, or ageism, which is discrimination based on age.

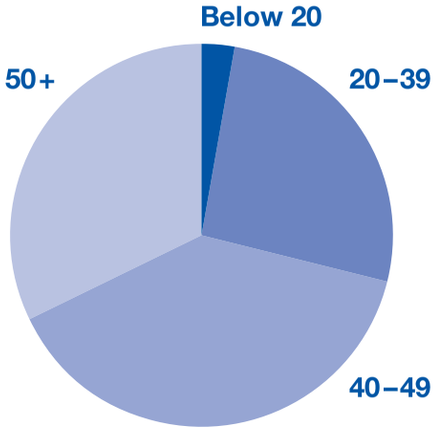
- Volunteers had been living with HIV for an average of 13 years, and while half had an AIDS diagnosis based on serious illness, only 13% had a CD4 count below 200. Nearly 85% were taking HIV meds.
- 67% self-identified as heterosexual, 9% as bisexual, and 24% as homosexual.
- 70% lived alone, which is double the number of all older New Yorkers.
- More than half of those who had used alcohol or drugs were in recovery. Over one-third continued to use recreational drugs or alcohol, and more than half smoked.
- Thirty-six percent had used injection drugs at some time.

ROAH and other research have found that older adults with HIV often lack the family and community support that can provide the care they will need as they age. This type of care is critical; about 44 million Americans currently act as caregivers to family and friends who have various illnesses. If this informal care were replaced by paid caregivers, it would cost more than $300 billion a year.

HIV and Older Adults

Until recently, few would have thought that people with HIV would become seniors. But thanks to striking advancements in HIV treatment, people with HIV are now living much longer. The number of older adults with HIV is today larger than ever – and the percent of people with AIDS over age 50 is now more than double that of people under 24.

Even though the success of HIV treatment is the main reason for this "graying" of the epidemic, one in every six new cases of HIV in New York City is found in people over 50 as well. It is likely that the majority of New Yorkers living with HIV will be over 50 years old within the next decade, and this trend is happening across the U.S. As the chart on the right shows, people over 40 make up 70% of all people with HIV in New York City.



We don't know all the unique challenges older adults with HIV will face, but we're discovering more every day. The effect of HIV on the aging process itself, for instance, is just beginning to be studied. We don't know if the major health challenges of aging – heart disease, diabetes, cancer, etc. – will occur sooner or more often as people age with HIV. It is critical that we learn more about these medical issues, since they are also common in those most affected by HIV in the U.S.: African-Americans, Latinos, and women.

We have much hard work to do to understand this epidemic.

Facing New Challenges

Most conversations about healthcare begin with the body, but wellness means taking care of the mind and soul as well. And people with HIV, particularly those who are aging, face a host of social challenges to emotional wellness. Perhaps at the top of that list of ills is the deadly disease of shame that persistent HIV stigma creates, and the difficulty that brings to the search for a life partner.

"We formed a local brunch group that meets monthly, but because of the stigma, we go out of our area for the brunch. In spite of the support group, there are times of loneliness. My general feeling is that I am not interested in dating again, just finding a companion with whom I can talk and travel, someone who understands what it is like to live with HIV and be a senior."

—Sharon, 59

Creating a Life without Shame

Some stigma is born from ignorance. Despite what we've learned about HIV over nearly three decades, many people still don't understand how the virus is spread and what puts people at risk. Myths from the early days of the epidemic persist: that AIDS is a disease only of gay men or drug addicts, or that the virus can be spread by touching or kissing. These myths continue to create fear and stigma about the virus and the people who have it. But people get HIV through certain high-risk activities, not because of who they are or what group they belong to.

HIV stigma can be deadly. It often combines with racism, sexism, homophobia, and ageism to create barriers to the services people need. It can have a strong impact on health and well-being, and can cause older adults to become isolated and fearful and to avoid needed medical and social services. It can prevent them from reaching out to their families, churches, or community organizations for help, and it can reduce the effectiveness of HIV prevention efforts.

Stigma related to HIV is more common than that of most other health conditions. Fear of HIV is so powerful that it can extend to the families and friends of people with HIV, and even to their HIV care providers. Some people fear that disclosing their HIV status or insisting on using condoms will limit opportunities for sexual contact or lead to rejection or violence from partners. For other people, the negative reactions they experience may decrease their desire to stay healthy, including taking all prescribed medications on time.

Older adults with HIV may also experience ageist attitudes from service providers, friends, and family. This creates a double barrier to prevention, treatment, and care. Knowledge about HIV and aging can go a long way to reduce the stigma caused by the misinformation that is still too common.

Stigma's Toll on Older New Yorkers with HIV

Participants in ROAH – ACRIA's study of 1,000 people with HIV over age 50 – said they experienced high levels of stigma, and that the negative reactions of others were harder to accept than their own feelings of guilt or shame.

- Over half of the volunteers in the study said they do not receive support from their places of worship, mostly because of negative attitudes toward people with HIV.
- Only 46% had told all their family members they have HIV, and only 35% had told all of their friends.
- The adults in ROAH reported depressive symptoms ten times more often than the general New York City population. About a third reported social isolation.

Telling It Straight:

I Was Stymied by Stigma

You know, stigma is a terrible thing. But people criticize you because they are angry at themselves; it's about what you know about yourself. You can be a long-term survivor, like me. I have four children and they're grown. They really don't talk about the virus to me, because I guess they look at me and they don't want to accept it. And I really don't get sick, so it's not a family conversation. But when they're ready, we'll talk about it.

Diane Smith, 59

Sexual Healing

One place that many people of all ages living with HIV feel stigma's sting is in the bedroom. The stress of disclosing HIV status, and the potential rejection that could – and too often does – follow that honesty, drives many people either to stick to positive sexual partners or to avoid sex altogether. A high number of the older adults living with HIV in ACRIA's study said they weren't sexually active. Still, a great many older adults are clearly choosing to remain sexually active – and that fact has crucial implications for those living with HIV.

The myth that sex is only for younger people remains strong. But the biological changes that happen when we age do not always include reduced sexual desire. Researchers have found that 60% of men and 38% of women over age 60 say they are sexually active. (The difference between men and women may be because women tend to live longer than men and are more likely to be widowed or without a partner.)

One study found that older adults who had sex at least once a month said that maintaining an active sex life was an important part of their relationships with their partners. Most said that they were at least as satisfied sexually as they had been in their 40s – about half of people aged 45-59 had sex at least once a week.

The older adults in this study said that being ill or on medication lessened sexual activity, and they reported that if their health were better, their sex lives would improve.

All of this means older adults face real risk for HIV transmission. Yet many, especially post-menopausal women, do not see themselves at risk for HIV or other STDs. As a result, they may be less likely to practice safer sex than younger people. Since erectile dysfunction medications like Viagra and Cialis can increase sexual activity, prevention strategies and safer sex messages that target older adults are needed.

Half of the volunteers in ACRIA's ROAH study said they had not had sex in the last three months. This may due to the fact that 70% of them lived alone and that only 15% lived with their sexual partners. The stigma and repeated rejection that those living with HIV encounter may also play a part.

Over the Hill? Not Under the Sheets

A recent landmark study of 3,000 people confirmed that interest in sex does not fall off later in life – and if it does, it is usually due to poor health or to having no partner.

- 73% of people aged 57-64 reported having sex in the previous year, as did 53% of those aged 64-75 and 26% of those aged 75-85.
- Over 53% of the men reported having sex exclusively with women, 38% exclusively with men, and almost 10% with both genders.
- Among those who were sexually active, the majority reported having sex two to three times a month.
- If a person's health was very good, that person was twice as likely to be sexually active as those in poor health.

Sixteen percent of people in ROAH who said they were sexually active reported that they had unprotected anal or vaginal sex with a partner who was not known to have HIV.

While 28% of those who were sexually active said they would not have unprotected sex under any circumstance, 32% said that a desire for sex and an attractive partner might lead them to do so, and 32% said they might if the partner asked for it. ROAH volunteers offered numerous reasons for having unprotected sex – 27% cited being high on drugs, 19% said they felt depressed or needy, and 14% believed there was only a low risk of getting an STD. Almost half of those who were sexually active

Telling It Straight:

I've Been Singled Out

I don't know if it's my age or my medication, but I don't have much of a sex drive. Anyway, I like cuddling and being affectionate more than what you see on TV, where you get all worked up. I would love to date again … but I'm at the stage in my life where I want more than I found in the men I tried to date. My girlfriend says I've got high standards. Well, yeah. So, right now I really haven't found anybody that I want to spend time with.

Patricia Shelton, 54

used alcohol or drugs with sex. And while the risk of infection with a second strain of HIV is still being debated, unprotected sex presents a clear risk of other STDs for people with HIV.

Use of drugs like Viagra was linked to an increase in unprotected sex among men with partners whom they knew to be HIV positive or whose HIV status was unknown. But these meds did not increase the incidence of unsafe sex when the men had sex with partners known to be HIV-negative.

Despite all of these realities, many healthcare providers don't consider older adults to be at risk for HIV and other STDs. They may be less likely to talk to older adults about drug or alcohol use, or may be uncomfortable providing safer sex info to people who are older than they are.

That puts the burden on us – as we age, we've got to push past fears and insist our healthcare providers take our sexual lives seriously, too. Ask questions, and insist they be answered. Conversations that may be inappropriate or uncomfortable in other settings may make the difference between wellness and illness when sitting down with your doctor. The stakes are high: When doctors and patients fail to communicate about sexual health, it throws them off the path to diagnosing broader health issues properly. Many age-related illnesses share symptoms with HIV disease, so not talking about risk factors and HIV-related symptoms can lead to a wrong or delayed diagnosis of HIV or other STDs – and a dangerous lag in beginning treatment. In fact, older adults with HIV are more likely to be diagnosed late in disease than their younger counterparts.

Did You Know?

Many older women who have been through menopause do not insist upon using condoms because they can't get pregnant. But the truth is that the physical changes of aging – such as the thinning of the vaginal wall – can make them more vulnerable to STDs, including HIV.

Medical Matters

Once emotional wellness is addressed, you're ready to address old-fashioned physical health as well – and that can be complicated when also dealing with the aging process.

People living with HIV often learn a lot about keeping the virus at bay, and some even become "HIV experts," helping those newly diagnosed get educated, too. But living well with HIV takes more than just understanding how to keep track of HIV medications and lab reports. Aging leads to a variety of health challenges, some of which are complicated by HIV. The following pages contain a brief overview of some of the most common conditions people encounter as they age – and tips for staying a step ahead of them.

"If you don't know, learn; and if you do, teach."

Those words created hope for me, and brought opportunity. So I just started asking a lot of questions. I'm at this age now, and there's a lot of knowledge I've absorbed over the years, and I want to share it.

—Ed Shaw, 66

Health changes that are a normal part of aging can be similar to changes that happen in people with HIV. Fatigue, lowered immunity, skin conditions, and nutritional imbalances happen with aging but can occur in people with HIV regardless of their age. Some HIV drug side effects, like the loss of fat in the face and limbs, also occur in some people as they age. So in older adults with HIV, it can be difficult to pinpoint the cause of certain conditions and to find the best treatment.

Certain aspects of aging are obvious: thinning hair, wrinkles, loss of height, etc. None of us are surprised by the fact that our bodies change as we age; look in a mirror and that truth is clear. But changes are also happening inside that we cannot see or feel. These changes involve our internal organs, happen at different rates, and are different for each individual. They are affected by genetics, gender, medications, substance use, life stressors, quality of medical and social support, and other illnesses.

HIV is more common in poorer communities, among people of color, and in women, all of whom are also at higher risk for many age-related diseases. For example, African-Americans are more likely to have high blood pressure or diabetes. In addition, the racial and ethnic groups most affected by HIV are also those who face the most difficulty in obtaining healthcare. So as people with HIV age, they face the challenges of health risks from aging, drug side effects, and other diseases and conditions – HIV alone will not define their health.

It's not possible to list all of the biological changes of aging here. It's also important to remember that people age in different ways and at different rates. Most changes are gradual, almost unnoticed, while others can occur suddenly. Their causes fall into three basic categories: disease, inactivity or disuse, or aging itself.

Immune System

Since immune function declines with age, HIV disease can progress more rapidly in older adults. The thymus gland – which produces immune cells such as the all-important CD4 cells – begins to shrink early in life, and as a result the number of immune cells in our bodies decreases as we grow older.

It was once thought this meant it would take longer for CD4 cell counts to rise in older adults once they started taking HIV meds. But studies show that three months after older adults start HIV drugs, their CD4 counts increase and viral loads drop much the same as they do in younger people. (This may be the result of older people being more adherent to drug regimens than younger individuals.)

Still, some older patients do not restore their CD4 counts to as high a level as younger patients, and this may be due to the aging process itself. And the decline in the immune system found in all aging adults means that older adults are at greater risk when a failure to diagnose HIV results in delayed treatment.

Older adults' immune systems are further burdened by oxidative stress, or the cumulative damage done to immune cells by molecules called free radicals. HIV further heightens this stress because it uses free radicals to replicate. So antioxidants like beta carotene and vitamins A, C, and E are important for older adults with HIV, and it's best if they come from fruits and vegetables.

Did You Know?

When an older person is infected with HIV, the CD4 cell loss can be greater than in younger people. Studies have found that older people with HIV who are not taking HIV meds are twice as likely to die as younger people with HIV.

Heart and Blood Vessels

Blood vessels lose elasticity and thicken with age. This change places older adults at risk for high blood pressure, heart disease, and stroke. But aging alone does not cause heart disease. There is much that can be done to prevent it – and prevention is a particularly important goal for those aging with HIV, as some anti-HIV drugs may heighten risk for heart disease.

High blood pressure, or hypertension, affects over 60% of people aged 60 or above. It increases the risk of heart attacks, strokes, and heart and kidney failure. When people are successful in lowering their blood pressure to normal, the risk of developing any of these complications is also lowered.

There is no clear link between HIV and high blood pressure. While several studies have shown that blood pressure may rise in people with HIV, this is usually due to aging, smoking, weight gain, or other non-HIV problems. People taking HIV meds do have a higher risk of developing high blood pressure, but this may be due to the changes in cholesterol and triglycerides that can be caused by certain HIV drugs.

Many doctors believe people whose blood pressure is above 135/85 need to be treated. But people with high blood pressure usually have no symptoms for years before they begin to develop complications, so it's important to monitor blood pressure regularly, either at visits to the doctor, at senior centers, or at other health events that target older adults. It's also useful to check blood pressure at home with a digital blood pressure monitor, to avoid falsely high readings that may happen in the doctor's office because of nervousness. The accuracy of a home monitor should be checked by taking it to the doctor's office and comparing its readings to those of the doctor's equipment.

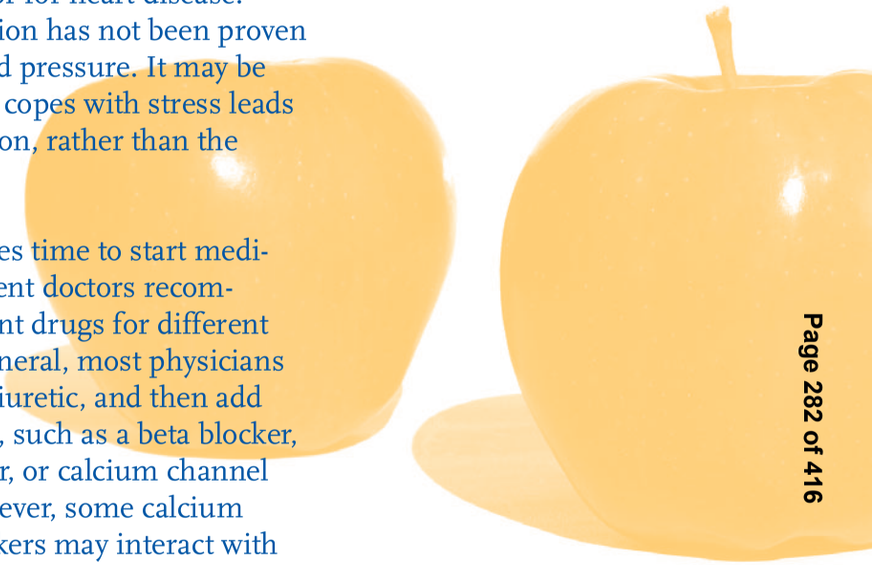
What Can You Do About It?

Blood pressure can be lowered in two ways: by living a more healthy life or by taking medication. Losing excess weight, stopping smoking, drinking less alcohol, using less salt, and increasing potassium and exercise can often be enough to treat mild hypertension. There are many medications available for those whose blood pressure does not respond to these efforts. Frequently, both a healthier way of life and medication are needed.

Even a weight loss of several pounds may be enough to end the need for drugs or to lower the dose needed. Exercise also helps, and moderate exercise is as effective as intense exercise. A 20-30 minute daily walk may be all that is needed. Eating more fruits and vegetables can also lower blood pressure, due to the potassium they contain. Using less salt may reduce the need for hypertension drugs, with or without weight reduction.

Drinking less alcohol (no more than 8 ounces of wine a day, for example) can reduce hypertension and may even help prevent it. Stopping smoking may not affect blood pressure, but it does remove another important risk factor for heart disease. Stress reduction has not been proven to lower blood pressure. It may be that how one copes with stress leads to hypertension, rather than the stress itself.

When it comes time to start medication, different doctors recommend different drugs for different people. In general, most physicians start with a diuretic, and then add another drug, such as a beta blocker, ACE inhibitor, or calcium channel blocker. However, some calcium channel blockers may interact with certain HIV medications.



National Cholesterol Education Program Guidelines

Total Cholesterol

Less than 200	Best
200 to 239	Borderline
240 and above	High

HDL

60 and above	Best (lower risk)
40 to 59	The higher, the better
Less than 40	Low (higher risk)

LDL

Less than 100	Best for people with heart disease or diabetes
100 to 129	Good
130 to 159	Borderline
160 to 189	High
190 and above	Very High

Triglycerides

Less than 150	Normal
150 to 199	Borderline
200-499	High
500 and above	Very High

High Cholesterol & Triglycerides

People who are at risk for heart disease because of high cholesterol will clearly benefit from lowering it. Since most people with HIV over 50 have one or more risk factors for heart disease, they are prime candidates for changing their habits and lowering their cholesterol. In addition, certain HIV meds can raise cholesterol and triglycerides.

There are two types of cholesterol: the "healthy" cholesterol HDL, or high-density lipoprotein, and the "lousy" cholesterol LDL, or low-density lipoprotein.

HDL helps remove cholesterol from the body, while LDL deposits it on the walls of blood vessels, which can lead to heart disease and strokes. Total cholesterol is basically the sum of HDL and LDL.

For many years, doctors considered an LDL level of 100 best, but many doctors now recommend getting it below 100 for people with heart disease or diabetes. The table at left shows the current recommendations for cholesterol levels.

Men over age 45 and women over 55 are at greater risk for heart disease. It's important to know if there is a family history of heart disease, as this increases a person's risk and might lead to earlier use of certain tests and treatments.

Telling It Straight:

I Got More than HIV on My Mind

I continue to take meds for HIV, but other problems manifest themselves as I age – like hypertension, high cholesterol, and depression (which was the hardest thing to deal with). Conversations with my doctor are now only partly related to HIV – they're more about checking my prostate and getting the colon cancer tests that are recommended for men over 50. Thankfully, on those fronts, so far, so good.

Paul Muller, 52

What Can You Do About It?

While people can't change their age or ancestors, there is a lot that can be done to lower the risk of heart disease. Foods that are high in salt can increase blood pressure. Limiting alcohol to only one or two glasses of red wine a day is best (if there are no other problems like gastrointestinal bleeding or certain other illnesses). Increasing the amount of omega-3 fatty acids (found in flaxseed oil, certain fish, and walnuts) can also help, as can reducing the amount of saturated fat.

Exercise may help prevent heart disease. Thirty minutes a day, five days a week is usually enough, but any amount is better than none. Begin by walking at least 20 minutes a day and slowly increasing the time. Good shoes and a safe place to walk are important.

Drugs known as statins are very effective in lowering LDL, but unfortunately many of them interact with HIV drugs. Your doctor will pick those with the least chance of interactions. Other drugs are used to lower triglycerides (another fat in the blood) and raise HDL. But a recent study of health records in California found that people with HIV taking drugs to lower cholesterol were less likely to reach the goals in the table on page 20 than people without HIV. This could be due to the fact that they had fewer drug choices because of interactions between these drugs and HIV drugs.

Did You Know?

Medication is often needed to reduce blood pressure or lower cholesterol and triglycerides. But some meds complicate HIV treatment, and some HIV meds may heighten heart disease risk. Plus, who needs more drugs? Lifestyle changes can help.

- **Exercise.** Walking 20-30 minutes a day may be all that's needed.
- **Lose weight.** Even the loss of several pounds can reduce drug dosages.
- **Eat your veggies.** In one study, people had normal blood pressure after only eight weeks of increasing fruits and vegetables and lowering fatty foods.

Body Weight

Just about everybody thinks they're either too fat or too skinny. But managing aging and HIV means you've got to keep an eye on both possibilities – it's important to avoid being overweight, but as you age it's also crucial to eat enough to maintain the nutrients your body needs.

People lose muscle mass and gain fat as they age, especially if they don't exercise. As a result, the body will burn fewer calories. Diet and exercise can help with these changes, and slow down or reverse the loss of muscle.

Recent studies have found some surprising results: it seems that the thinner a person is (all other things being equal), the longer she or he will live. Certainly, being overweight makes the heart work harder. Losing weight, however, is easier said than done. New research has shown that each person has a weight range that is very difficult to change. That is, someone who weighs 250 pounds may find it very difficult to get down to 150 and stay there. For the extremely obese, surgery may be needed. For the rest of us, the goal is to use diet and exercise to stay at the low end of each body's natural range.

Telling It Straight:

I know that HIV is something that I will have to live with from now on, but as I grow older, I'm also experiencing other health issues. Four months ago, my doctor told me I had high blood pressure. Even though it runs in my family, it was a bit overwhelming to try to deal with this new diagnosis. I wake up every morning and put my feet on the floor even if I feel a little dizzy. I can still see, walk, talk, and think. So with all this being said, I enthusiastically look forward to another milestone in my life and many more wonderful years in my life's journey.

Joan Warner, 64

Diabetes

The body's inability to control blood sugar properly, known as diabetes, is an increasing problem in the U.S., including among people with HIV. The risk for diabetes increases the more a person weighs. It also increases when taking certain HIV drugs, especially protease inhibitors. Type 2 diabetes, the kind that usually affects adults, is tied to body weight, age, and family history – if your parents had it, you are more likely to develop it as well. African-Americans are particularly plagued by diabetes. They are more likely to get it and more likely to die from it once they have it.

Diabetes is managed by losing weight, by changing the diet, and sometimes by taking pills or insulin injections. Often, losing weight is enough to normalize a person's blood sugar.

Diabetes can lead to heart disease and stroke, kidney damage, and damage to the retina of the eye. Diabetic neuropathy, or nerve damage, can also occur and is often difficult to separate from HIV neuropathy, which can be caused by certain HIV meds or by the virus itself. Damage to blood vessels because of diabetes can lead to amputation of the lower limbs because of gangrene, and this risk is greatly increased in those who smoke. But with treatment, diabetes can be controlled and these risks may be lessened.

While gaining weight is a concern for people in their 40s and 50s, maintaining weight can be a concern for some seniors, to sustain energy and the body's ability to repair itself. When a person lives beyond his or her 70s, the ability to digest and absorb nutrients can change significantly, making it difficult to maintain weight. Constipation also can affect older adults, since the intestines may slow down, as do stomach secretions and even swallowing.

The Senses

Vision, hearing, taste, smell, and touch all decline as we age. Again, this is different for everyone. In general, we lose our ability to hear higher pitched sounds, which can make it harder to hear conversations, especially in noisy rooms. The perception of certain types of pain can be decreased with age as well, and it may be harder to identify some flavors and odors. Certain meds, including HIV meds, can cause a change in taste.

After age 40, the need for reading glasses can occur either gradually or almost overnight. Eyes dry out as we age and are less responsive to light, especially in low light. Eye problems such as cataracts, glaucoma, and vision loss due to macular degeneration must be monitored and can often be effectively treated. Fortunately, HIV-related eye infections, such as CMV retinitis, are now uncommon.

Did You Know?

The risk for diabetes increases when taking certain HIV drugs, especially protease inhibitors. And African-Americans, who already are overrepresented in the HIV epidemic, are also particularly hard hit by diabetes. But there's a simple way to fend off adult-onset diabetes, or to lesson the damage it does once you have it: lose weight and exercise.

Dry mouth is probably the most common dental problem seen in people with HIV – it can be caused by HIV meds or other drugs. Low saliva increases the risk of cavities, which can lead to abscessed teeth, so regular checkups are essential for everyone, especially those with dry mouth.

In general, teeth are tough, so it is gum disease that causes the greatest tooth loss in older adults. Regular dental checkups and good oral hygiene can prevent this. Also, the taste buds can change and become less responsive with age. This affects the desire to eat, which can lead to unwanted weight loss.

Nervous System & Mental Health

The changes that occur in our brains mostly affect how the mind processes and uses information and remembers things. The risk for Alzheimer's disease increases with age, but it is not an automatic part of the aging process and is not the only condition that affects mental functioning.

Changes in brain function can make it more difficult to do more than one thing at a time (multitasking). It can be more difficult to remember names and numbers. Seniors may find themselves taking more time searching for the right word to use or to recall information. But regular physical activity and mental stimulation may help preserve brain function.

Nerve damage to the hands and feet (peripheral neuropathy), leading to pain or numbness, was common before HIV combination therapy became available. With better HIV treatments, it is seen less often, but diabetes or other illnesses of aging can cause similar symptoms. Pain medications and other treatments may be helpful.

Depressive symptoms are often reported by older adults, both HIV positive and negative. They may interfere with adherence to treatment, doctor visits, social activities, and personal relationships.

It can be difficult for doctors to diagnose depression because many of its symptoms are similar to common HIV symptoms like fatigue, poor appetite, weight loss, loss of sex drive, and sleep difficulties. Also, certain medications (particularly hepatitis C meds) can lead to depressive symptoms. Older adults with HIV and their care providers should pay attention to these symptoms, especially if they occur with other warning signs of depression like mood swings, having the "blues," feeling so sad nothing can cheer you up, or increased forgetfulness.

Many people with depression are treated by their primary providers, not psychiatrists, and increasing numbers of HIV providers prescribe antidepressants. But people with more serious problems, such as bipolar or anxiety disorders or severe depression, should be referred to a psychiatrist. Or, if antidepressants haven't helped within a couple of months, a psychiatric referral may be needed. People taking these meds should never stop them "cold turkey," but rather lower the dose gradually with a care provider's guidance.

Did You Know?

Older people with HIV may be more likely to have symptoms of depression than younger people with HIV, and are more likely to be depressed than people their own age who are HIV negative.

- It's estimated that 5% to 20% of people with HIV suffer from major depression – symptoms that don't go away over time and interfere with daily life.
- Many other people with HIV do not meet the criteria for a clinical diagnosis, but may have several symptoms of depression that can have a negative impact on their lives.

Bones

Bone growth stops by the time we reach our mid-20s, and everyone loses bone mass as they age. For some people, bones actually shrink. Joints become less flexible and may be affected by arthritis. Muscles become less elastic. Women are especially at risk for reduced bone density (osteopenia), which can lead to a major loss of bone density (osteoporosis), causing serious fractures and breaks.

Bone density has been reported to be lower in both men and women with HIV. This is most likely caused by HIV itself rather than by HIV meds. A recent study suggests that the longer one has HIV, the greater the loss of bone density. Exercise and calcium supplements have been shown to slow bone loss greatly or partially reverse it.

Osteoporosis is the most common bone disease. In this disease, the structural integrity of the bone is affected, the density of bone is lower, and bones break more easily. In the U.S., osteoporosis results in over 1.3 million bone fractures a year. About half are fractures of the vertebrae in the spine; another 25% occur in the hips and 25% in the wrists. Women over 50 are three times as likely as men to have vertebral or hip fractures and six times as likely to have wrist fractures. In addition, bone death due to loss of blood supply, called osteonecrosis, can be caused by medications or alcohol use. It is treated with medications, exercise, and sometimes, surgery.

Urinary system

Many age-related changes of the urinary system happen as a result of decreased kidney function. Medications, high blood pressure, and diabetes can all place stress on the kidneys.

Impaired bladder function occurs in almost a third of those over age 65. Older adults may have problems with controlling urination or bowel movements, called incontinence. In women this is often a result of reduced hormone levels and the thinning of the walls of the urethra. In men, it is often tied to changes in the prostate. Incontinence is treatable and does not need to be a part of aging.

The inability to get or keep an erection is called erectile dysfunction (ED) or impotence. It can occur at any age but is more common in older men. Some common causes are alcohol and tobacco use, fatigue, liver or kidney failure, stroke, prostate or bladder surgery, diabetes, high blood pressure, certain medications, and problems with a partner.

There are many treatments available if addressing these causes doesn't help. Drugs such as ED medications, injections, and surgery are all effective. The best treatment will depend on the cause of the problem, other conditions that may be present, and other medications being used.

Telling It Straight:

What I Really Need is Love

I was 62 years old at the time of my HIV diagnosis. I had already lived a lot longer than many and had few regrets, so I was not terribly threatened by the prospect of dying. My professional career was over anyway. My main regret was that I had not experienced my dream – the love of a man. What worse barrier to the realization of that dream could I imagine than HIV infection? My greatest chagrin about my status was that it severely limited my dating prospects!

John, 64

Liver

The liver can actually replace its damaged cells, which minimizes the effects of aging on this essential organ. The most common causes of liver damage are the chronic abuse of alcohol or acetaminophen (Tylenol), especially when taken together.

Although HIV may be present in liver cells, most damage is from co-infection with a hepatitis virus, especially hepatitis C. HIV meds can also lead to liver problems, and switching HIV meds may be necessary in some cases. Certain HIV meds also fight hepatitis B, and could lead to a hep B flare-up if the HIV meds are stopped by people who have both viruses.

People with HIV and hepatitis will do best to lower their use of alcohol and recreational drugs or to stop them altogether. There are treatments available for hepatitis, and it's essential that those who are not infected get vaccinated to prevent hepatitis A and B. Many people with hepatitis find it worthwhile to see a liver specialist in addition to their HIV care provider.

Kidneys

The kidneys (along with the liver) remove toxins from the body, and usually operate quite well even at older ages. Most kidney problems are due to other conditions like high blood pressure, diabetes, or urinary tract infections. HIV has been associated with a specific type of kidney disease known as HIV-associated nephropathy. Although uncommon, it may occur more frequently in African-Americans.

The right HIV meds can improve kidney function in some people, but certain drugs, like Viread, should be avoided in people with serious kidney problems. One HIV med (Crixivan) can lead to kidney stones, so it should be taken with at least eight glasses of water a day.

Skin

The majority of changes in the skin – lesions, age spots, and wrinkles – are due to sun-related skin damage, but the aging process adds to the stress on skin. Aging makes the skin less able to retain moisture and to control body temperature. And skin, along with hair, gets thinner and is more easily damaged.

Reduced production of oils can also lead to dry skin and wrinkles. Sweat helps regulate body temperature by helping the body stay cool. The aging body can be less able to regulate its temperature in response to outside temperature extremes because of a decreased ability to sweat. Certain medications can make the skin more sensitive to the sun, and some HIV meds can cause temporary or more serious rashes, or changes in the skin, nails and hair.

Skin cancer comes in two forms: melanoma and non-melanoma. Non-melanoma skin cancer, such as basal cell carcinoma, is common and very curable. Melanoma is rarer and much more serious. Most skin cancers are caused by overexposure to ultraviolet light from the sun. Using a sun block with an SPF of at least 15 can reduce the risk of skin cancer.

Early diagnosis is important in curing skin cancer, so people should tell their doctors if they notice any change in the size or appearance of a mole.

Did You Know?

Melanoma and another skin cancer, called squamous cell carcinoma, are seen more often in people with HIV and can progress more rapidly. We don't know if this is more serious in older adults with HIV, but given the fact that these cancers are more common in older people, it's likely that people with HIV will be at greater risk for these cancers as they age.

Telling It Straight:

My Peace of Mind Heals

I manage a lot, but HIV is the easiest – I'm taking two pills in the morning and afternoons. But for high blood pressure, I think I'm on my third regimen. I never eat salt, but I have to work at not getting upset over everything. Menopause is the worst. Because of that I don't rest properly. So I'm tired, but then what am I tired from? Is it everyday living? Is it HIV? Or is it high blood pressure? But I always tell people peace of mind is the best thing in the world for all of it. It took me years to get mine.

Patricia Shelton, 54

Before the 1980s, the skin cancer Kaposi's Sarcoma (KS) was seen mainly in older Italian and Jewish men and, rarely, in older women. When AIDS first appeared, young men developed a form of KS that progressed rapidly and was harder to treat. KS can also occur in the mouth, lungs, intestines, and other organs. Since the advent of effective HIV treatment, KS is seen far less often.

People who have had chicken pox (caused by the herpes zoster virus) may see it reappear as shingles when they age, leading to skin lesions on the chest and sometimes the face. Since people with HIV may have a compromised immune system, they are at higher risk for shingles-related complications like pain. A vaccine to prevent herpes zoster infection is now available for those who never had chicken pox, and is recommended for those over age 60, but not for people with HIV or weakened immune systems.

Cancer

Skin cancer is not the only flash point for older adults with HIV: the risk of cancer increases both with a lower CD4 cell count and with age. Even a modest decline in immune function may be enough to increase the risk of a range of cancers, so people with HIV need to be particularly careful to have regular cancer screenings as they age.

Lung Cancer

More Americans die each year of lung cancer than of colon, breast, and prostate cancer combined. This is partly due to the fact that it is so hard to cure. Lung cancer has a five-year survival rate of only 15%, and this has not improved greatly over the past few years. Over 80% of all lung cancers are caused by smoking. Stopping smoking greatly reduces the risk of lung cancer, but it can take years for the lungs to repair the damage done.

A large study found that lung cancer rates were higher among people with HIV. In NYC, twice as many people with HIV smoke as do HIV-negative people. Even in areas where this is not true, the rate of lung cancer and the aggressiveness of the illness are increased in people with HIV. While nicotine addiction is hard to overcome, there are new treatments that can help, such as pills, gums, and patches to reduce nicotine cravings, and certain antidepressants.

Breast Cancer

Breast cancer is the second most common cancer in women (skin cancer is the most common), but also occurs, rarely, in men. A recent study of more than 85,000 women with HIV in the U.S. found less breast cancer than in HIV-negative women, but the rate seems to be rising.

Most breast tumors are benign, meaning they are not cancerous. Usually a biopsy of the tumor is needed to see if it is benign or malignant (cancerous). If the breast cancer has not yet spread to other parts of the body (like the lymph nodes) it is almost always treatable. But once it has spread, it is harder to control. The good news is that the rate of death from breast cancer has declined over the last few years, probably because of increased screening.

All women should have yearly mammograms after the age of 40, but MRIs give more accurate results in women who are at high risk. People are at higher risk for beast cancer if they have already had it in one breast or have a family history of the disease. Genetic tests are available for those with a strong family history.

Women under 40 who are at high risk need to be followed closely by a doctor skilled in this disease.

Colorectal Cancer

Cancer of the colon and rectum is more common in people over 50 – the rate rises from 15 cases per 100,000 people in their 40s to 400 cases per 100,000 people over age 80. Because colon and rectal cancers have much in common, they are often referred to together as colorectal cancer.

There is no clear evidence that these cancers are more common in people with HIV, but as the HIV-positive population ages, this may change.

Warning signs of colorectal cancer include blood in the stool, a change in the shape of the stool, or pain in the lower abdomen. Everyone who is over 50 should have regular screenings. Colonoscopies are one option, and are usually done in the hospital on an outpatient basis. A flexible tube, called a colonoscope, with a light at the end is passed through the anus into the colon and the entire length of the colon is examined. The doctor is looking for small growths, called polyps, which can become cancerous. Removing them before this happens can prevent the disease.

Anal pap smears are recommended yearly for certain people with HIV, including men who have sex with men, anyone with a history of anal warts, and women with abnormal cervical tests. HPV (human papillomavirus) can progress faster in people with HIV, so catching it before it becomes cancerous is important.

Endometrial, Cervical and Ovarian cancer

Endometrial cancer occurs in a woman's uterus and happens most often after menopause. The most common symptoms are irregular periods or vaginal bleeding – women with these symptoms should see their gynecologist.

Women with HIV should have pap smears more frequently – some need them at least every six months – because of an increased risk for cervical cancer, especially if they have low CD4 counts. These tests look for changes in cells in the cervix (the part of the uterus that extends downward into the vagina). A large study showed a lower risk of uterine cancer in women with HIV, but a higher risk of cervical cancers, and no increased risk for ovarian cancers. However, cancers of the ovaries are hard to detect at early stages.

Prostate Cancer

Over 80% of people with prostate cancer are men over 65. Men with a history of prostate cancer in their families and African-American men are at higher risk. We don't know if men with HIV have a higher rate of this disease.

This is the most common cancer in men but most men who have it will not die from it, especially if it does not spread beyond the prostate. A rectal exam can find many cases. The PSA, or prostate-specific antigen, test is more sensitive but often detects cancers that will not spread. Surprisingly, some men with low PSA levels have prostate cancer, while some men with high levels do not have cancer. Once someone is found to have an elevated PSA level, a needle biopsy of the prostate is usually done, and if cancer is found surgery may be needed.

It is important that patients understand these nuances before a PSA test, because a high PSA level often leads to biopsies and surgeries that may not be actually needed. The complications of surgery can include impotence and urinary incontinence – and though not everyone has these complications, it's also true that not everyone with prostate cancer needs surgery. Some physicians recommend that only people at high-risk for prostate cancer take a PSA test.

Benign prostatic hyperplasia, or BPH, is not cancerous. It is caused by enlargement of the prostate and commonly occurs with aging. BPH can constrict the urethra (the tube that urine passes through) and result in a slower and weaker stream of urine. Men with BPH have frequent urination, often waking up at night to urinate. The most effective treatment is surgery, which is used if drug treatments don't work.

Telling It Straight:

I Stand Up for Myself

If people are negative, I can turn it back to positive. I've got lots of nieces and nephews, and I've sponsored a lot of them to come over here. There's quite a lot of stigma in the Caribbean about gay lifestyle and HIV. I did have a problem one time with a nephew who attacked me when my sister told him I am gay; I had to take him to court. But I gave him the movie *Philadelphia* and, over the years, we have worked things out.

David Singh, 69

Managing Your Meds

HIV meds are definitely easier to take these days: fewer pills, fewer food restrictions, and once-daily dosing of many HIV meds. But they still differ in important ways from other meds older adults may be used to taking. Unlike blood pressure or cholesterol meds, for instance, missing even a few doses of HIV drugs can lead to resistance and treatment failure. So if older adults are to benefit from HIV treatment, special care must be given to adherence education and assistance.

Not All Mixes Match

Over 85% of people in ACRIA's ROAH study reported that they take HIV meds. Most took other prescription or over-the-counter meds as well, and that means they need to keep a close eye on how all of their medications interact. Sometimes the amount of one medication in your body can be increased by other meds you are taking at the same time, which can cause heightened side effects. On the other hand, sometimes the interaction between two drugs you're taking can accidentally decrease the amount of an HIV med in your system, leading to treatment failure. Also, some combinations may be hard on the kidneys or liver, or lead to other problems.

So it's important for everyone to check all the pills they take with their medical care provider at least once, and also whenever they start a new med. This includes prescription meds, herbs, supplements, vitamins, and over-the-counter meds like Advil or Rolaids. The care provider can then check for drug interactions, as well as checking the medical record to make sure everything is safe and correct. This booklet does not supply a complete list of meds that interact with HIV meds. People on HIV meds should check with their HIV medical providers or pharmacists before they start any new med. Medical providers love it when people are knowledgeable and ask about interactions.

Some protease inhibitors, such as Norvir and Kaletra, slow down the metabolism of other meds, which means the other meds are removed from the body more slowly. People taking protease inhibitors should start erectile dysfunction drugs like Viagra at low doses to avoid the risk of potentially serious side effects. Lower doses may also be needed for medications used to treat high cholesterol, high blood pressure, anxiety, and insomnia. Some cholesterol-lowering meds and corticosteroids should be avoided when taking protease inhibitors such as Norvir or Kaletra. And when a protease inhibitor is stopped, other meds may need dose adjustments.

Reyataz should not be taken with proton pump inhibitors like Prilosec or at the same time as antacids like Pepcid, because those meds can reduce the stomach acid that is needed to absorb Reyataz. People taking Sustiva or Atripla may need to change their methadone dose. Coumadin (used to keep blood clots from expanding) may need to be adjusted when Atripla or Sustiva is started or stopped.

Alternative therapies

People often have strong beliefs about herbal or nutritional supplements. Whether or not your doctor agrees with your beliefs, it's important to discuss any natural remedies you take, since there is a risk of interactions with HIV meds. For example, St. John's wort, an herb used for depression, should not be used with some HIV meds, nor should garlic when taken in a high-dose capsule form. Kava kava may cause liver problems, and echinacea, an herb used to reduce cold symptoms, should probably not be used for extended periods of time by people with HIV.

Herbal and nutritional supplements are not classified as drugs by the FDA and do not require the same thorough testing for purity and effectiveness, so impurities and mislabeling are possible. Close monitoring of HIV viral load may be useful when a new herbal or nutritional supplement is tried.

Liver and Kidneys

Some HIV meds are removed from the body by the kidneys, so certain HIV meds are given in lower doses if severe kidney disease is a problem. Atripla and Viread cannot be used in patients with severe kidney disease. Many HIV meds are cleared from the body by the liver as well. Some of the protease inhibitors should be given in lower doses if severe liver disease is a problem.

Sustiva and Atripla may cause a false positive on a urine screen for marijuana, even though they don't contain any marijuana-like substances. Recreational drugs such as Ecstasy may be deadly in combination with some HIV meds. Because many recreational drugs are removed from the body by the liver, a person could overdose when HIV meds slow down the liver's function. Poor adherence, or missed doses, is a more common problem when people mix HIV meds and recreational drugs, including alcohol.

It's Your Life to Control

Much of this booklet has focused on the challenges that all older adults face as they age. It is not clear whether this process and age-related illnesses will be different for those living with HIV. Will the virus and HIV meds make age-related disorders worse? We simply do not know. But people with HIV need to alert their healthcare providers to any new symptoms they have, and to get regular tests for age-related illnesses.

Conversely, living with HIV may help in managing aging. Seniors often need to develop positive coping skills as they age. Could the coping skills that people develop when they live with HIV be useful as they confront the challenges of aging? They may be less threatened by illness and disability. They may be able to accept age-related conditions better compared with those who have not lived with a life-threatening chronic illness.

On the other side of the coin, like people living with HIV, many seniors have developed positive coping skills along with the emotional maturity they gain with age. But life experience is no sure defense against illnesses like Alzheimer's disease, addiction, anxiety disorders, and depression. And aging well is not only about medical care – a healthy social environment and emotional life are equally critical.

Many HIV-positive older adults have been able to find happiness and strength while coping with a challenging illness. They have had the support of a unique system of medical care. Adapting the medical system that has provided this care and support is the challenge facing us as the number of older adults with HIV increases. In the end, it is a challenge that people living with HIV and those who care for them must confront and overcome.

ACRIA is an independent, not-for-profit community-based AIDS research and education organization committed to improving the length and quality of life for people with HIV through medical research and health literacy.

ACRIA conducts an HIV Health Literacy Program to offer people with HIV and their care providers the tools and information they need to make informed treatment decisions. Health Literacy Program services include: workshops conducted at community-based groups throughout the New York City area in English and Spanish; technical assistance trainings for staff of AIDS service organizations; individual treatment counseling; and publications, including a quarterly treatment periodical and booklets in English and Spanish on treatment-related topics. TrialSearch is our online, searchable database of HIV clinical trials enrolling throughout the United States. ACRIA's National Training and Technical Assistance Program offers training and ongoing support to help non-medical service providers and community members in various parts of the country acquire the skills and information needed to provide HIV treatment education in their communities. The Older Adults Training and Technical Assistance Program offers similar services locally and nationally with a focus on the needs of middle-aged and older adults.

To learn more about ACRIA's research studies or the HIV Health Literacy Program, please call or email us at treatmented@acria.org. Information about our programs and copies of all of our publications are also available on our website.

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Older Adults and HIV: A Special Report and Action Plan

Daniel Tietz, Executive Director

November 2010

Aging and HIV: An Overview

By 2015 a majority of people with HIV in the United States will be over age 50.[1,2]

This population is growing in both size and complexity. ACRIA's landmark study, *Research on Older Adults with HIV* (ROAH)[3] brings into sharp relief the emerging medical and psychosocial challenges confronting older adults as they age with HIV. Challenges arising from the early onset of age-related morbidities, high levels of depression, and low-functioning social networks are compounded by a service delivery system frequently hampered by the stigma and discrimination associated with homophobia, ageism, and HIV-phobia.[4]

To ensure that older adults with HIV are able to lead healthy and full lives and remain actively engaged in their communities, researchers, providers, service organizations, and policymakers must examine their assumptions about what will soon be the majority of Americans with HIV.

For example, how should health and service providers respond to a 58-year-old with HIV who presents physical or mental health conditions usually associated with people in their 70s? How should the Social Security Administration (SSA) treat the disability status of a 61-year-old with HIV whose health conditions permit only intermittent work? And how should providers coordinate the care of someone for whom HIV-related health challenges are less pressing than other conditions, such as cancer, cardiovascular disease, diabetes, osteoporosis, and depression?

For too long, the needs of older adults with HIV have been neglected or overlooked. The failure of the federal government to fund and mount a bold, large-scale national study of these older adults, many of whom are long-term survivors, leaves us without the data needed to inform effective policies and programming. Primary care providers routinely fail to test older adults for HIV or to screen for behavioral risk factors, leading to high rates of concurrent HIV and AIDS diagnoses.[5] AIDS service and aging service organizations have often not recognized this change in the HIV epidemic, have little knowledge of each other, and have rarely if ever worked together. Moreover, they often do not have the competencies or capacities to build the kind of integrated service delivery model that can provide this population with the critical care, supportive services, and health information they need. And the National HIV/AIDS Strategy (the Strategy) makes little mention of prevention and treatment issues related to older adults.

At the same time, the Strategy is moving our collective efforts in the right direction. Its call for a more highly coordinated, integrated, and responsive HIV and AIDS service delivery

[1] Effros, 2008.
[2] Justice, 2010.
[3] Karpiak, Shippy & Cantor, 2006.
[4] Brennan, Karpiak, et al., 2009.
[5] Sweeney, M.M., 2009.

model signals a turning point. Its call for targeting resources toward the most highly affected communities is also welcome. Allocation of resources according to disease burden and level of risk is certain to advance the goals of reducing new infections, increasing access to care, improving outcomes, and reducing HIV-related disparities. But these goals can be achieved only after indicators of health and quality of life of the over-50 population are explicitly and consistently incorporated into the Strategy's definition of the problem, its goals and objectives, and its implementation plan.

Older Adults and HIV: Recent Findings

This new approach should be informed by the growing body of literature that is defining the unique challenges faced by someone aging with HIV. Key findings include:

- Older adults with HIV experience an array of complex medical conditions. These include age-related morbidities, such as cardiovascular disease and osteoporosis, and drug-drug interactions. The advent of highly active anti-retroviral therapy (HAART) transformed HIV into a manageable chronic illness, with the result that HIV disease is now just one of many conditions that require medical attention. ROAH found that older adults with HIV and an average age of 55 have three times as many morbidities as HIV-negative adults over age 70.[6] Often, however, fragmented care compounds their health challenges.

- Older adults with HIV often have smaller and lower functioning social networks than other older adults.[7] ROAH found that 70% of study participants live alone—twice the rate of other similarly aged New Yorkers without HIV. Other research has produced similar findings. As a result, they have limited access to the traditional forms of informal support provided by a spouse, partner, children, or extended family.[8] This large unmet need has profound implications for a formal care system that is arguably incapable of meeting even current demand.

- HIV-positive adults are five times as likely to experience depression when compared with HIV-negative adults of similar age.[9] Depression arising from chronic stress, trauma, stigma, loneliness, and social isolation can suppress immune response and exacerbate the cognitive decline that is typical in the normal aging process.[10] Moreover, depression has a negative impact on engagement in care and treatment adherence.

- Alcohol and substance use, including nicotine addiction, are significant challenges for older adults with HIV. ROAH found that more than one-third of participants

[6] Havlik, 2010.
[7] Cantor & Brennan, 2010.
[8] Karpiak & Brennan, 2010.
[9] Applebaum & Brennan, 2010.
[10] Christian Grov, et al, 2010.

reported current use of recreational drugs (37%) or alcohol (38%) and 57% smoke.[11] The persistently high levels and severity of mental health and substance use disorders suggests that current interventions are not leading to improved outcomes.

- Ageism, homophobia, racism, AIDS-phobia, sex-phobia, sexism, and poverty erect powerful barriers when an HIV-positive older adult seeks services, from primary care to long-term care or mental health and substance use services.[12]

- Two-thirds of older adults over 50 do not use condoms,[13] disproving assumptions that older people are not at risk for HIV. Still, ageism and sex-phobia often prevail, as providers, and even AIDS educators, are reluctant to discuss sexual risks, offer an HIV test, or provide prevention information.[14] Older adults are therefore the least likely of all patient groups to get tested and to know their HIV status.[15] Moreover, 42% of those over age 50 who test positive for HIV also receive an AIDS diagnosis, compared with 23% of those under 50.[16] Status quo prevention efforts, which are not tailored to older adults, are failing this population and contributing to the increase in new infections.

Priority Policy Recommendations

Decisive, immediate, and simultaneous policy adaptations are required across multiple fronts:

Medical and Behavioral Research

The National Institutes of Health (NIH) should make HIV and aging a top research priority, utilizing new and existing resources to understand this population better. In so doing, the Office of AIDS Research should actively plan, budget, and guide trans-NIH efforts to focus efficiently and effectively on older adults with HIV, most notably (but not exclusively) with the National Institute of Allergy and Infectious Diseases, National Institute on Aging, National Institute on Drug Abuse, National Cancer Institute, National Institute of Neurological Diseases and Stroke, National Institute of Mental Health, and the Center for Scientific Review.

NIH should promote and fund research to:

- Investigate the extent to which the onset and course of age-related morbidities differs between HIV-positive and -negative older adults.

[11] Karpiak & Brennan, 2010; Applebaum, 2010.
[12] Emlet 2010; Karpiak & Brennan, 2010; Golub, et al.; 2010; Bhavan, 2008.
[13] Schick, 2010.
[14] Golub, et al., 2010.
[15] Golub et al., 2010
[16] Karpiak & Brennan, 2009.

- Determine the association between barriers to access and health outcomes.
- Understand better the unique biological and psychosocial characteristics of older adults with HIV and determine how they affect health outcomes.
- Understand better how HAART interacts with aging bodies and treatments for other conditions.
- Determine the association among and between mental health disorders, substance use, low-functioning social networks, and unprotected sex among older adults.
- Determine whether the factors precipitating depression differ between HIV-positive and HIV-negative older adults, and whether the course and severity of depression is similar to that of the general population.
- Assess which lifespan factors (e.g., mental health issues, substance use, etc.) contribute to HIV risk and how best to address these factors.

Integrated Service-Delivery Demonstration Projects and Structural Interventions

The Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration, among others, should:

- Fund capacity building, technical assistance, and training for AIDS services organizations, faith-based organizations, community-based organizations, lesbian/gay/bisexual/transgender (LGBT) organizations, and aging services providers to integrate evidence-based over-50 HIV prevention, treatment, and care programs into larger organizational, cultural, and programmatic frameworks.
- Fund/conduct Special Projects of National Significance grants or other demonstration projects to develop effective evidence-based capacity building, technical assistance, and training, not only among health care workers but for all HIV and senior services providers, to reduce HIV and LGBT stigma and discrimination and to improve knowledge and understanding of the prevention and care needs of older persons living with or at risk for HIV.

The Department of Health and Human Services and the Department of Education, among others, should:

- Urge the development of gerontology, social work, and other curricula at colleges and universities, as well as medical schools, that train aging specialists and service providers in the particular characteristics and needs of the over-50 HIV-positive population and those who are at-risk.

The CDC should:

- Adjust its epidemiological surveillance systems and requirements to collect and deliver complete age and risk category data for both HIV incidence and prevalence/total cases.
- Fund research to develop new (or adapt existing) evidence-based HIV/STI behavioral interventions targeting older adults at risk for HIV and older adults with HIV, particularly for the most at-risk populations, such as women of color and, especially, older men who have sex with men.

The Administration on Aging should:

- Expand the definition of "vulnerable populations" to include those with HIV or a larger group of "specific health minorities" that could include seniors with HIV and other diseases.
- Encourage service systems to become more flexible and responsive to the needs of older adults with HIV, e.g., consider functional status and need in addition to chronological age in determining eligibility for services.

The SSA should:

- Amend its disability eligibility criteria to take into account improvements in treatment (the last revision was in 1993) and to allow for greater flexibility for those who are able to work only intermittently.

Conclusion

Older HIV-positive adults will soon be the majority of Americans with HIV, and more people over age 50 are being diagnosed every year. Yet the U.S. research agenda, the health care system, and aging and HIV service providers have only begun to respond to this reality, and our systems remain quite unprepared to deal with these emerging issue. In this report, ACRIA presents specific policy recommendations to address the needs of older adults with HIV and those at highest risk of contracting the virus. These recommendations are by no means exhaustive, but constitute *vital first steps*. We urge immediate adoption of these recommendations and stand ready to do our part to understand this population better and to ensure quality care and services for older adults with HIV and those at risk.

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AMERICA'S LEADING GAY NEWS SOURCE

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The graying of AIDS: living longer with HIV

July 19, 2012 | 4 Comments

By Michael K. Lavers on July 19, 2012

D.C. resident John Klenert signed up for a National Institutes of Health-funded AIDS study at Johns Hopkins University in 1984. The Centers for Disease Control reported the first cases of what became known as AIDS three years earlier, but some of Klenert's friends had already passed away from the virus by the time the research project had begun.

"We figured if there was going to be a cure that we would be the first ones to volunteer to get these tests," he said.

Johns Hopkins researchers in 1986 screened the first blood samples that Klenert and other study participants had given once scientists discovered the virus that causes AIDS. "For me, the first blood I had given was positive," he said. "I would have been shocked had I turned out to be negative."

Older people with HIV will be the focus of a July 25 forum at the International AIDS Conference. Panelists will include Ricardo Jimenez of the Ecuadorian Red Cross, Carolyn Massey of Older Women Embracing Life, Inc., Wojciech Tomczynski of the Polish Network of People Living with HIV/AIDS Association and Ruth Waryaro of Help Age International in Uganda. Doctor Kevin Fenton of the Centers for Disease Control and Prevention and Stephen Karpiak and Mark Brennan-Ing of AIDS Community Research Initiative of America's Center on HIV and Aging and New York University College of Nursing are among those who are scheduled to speak during the plenary.

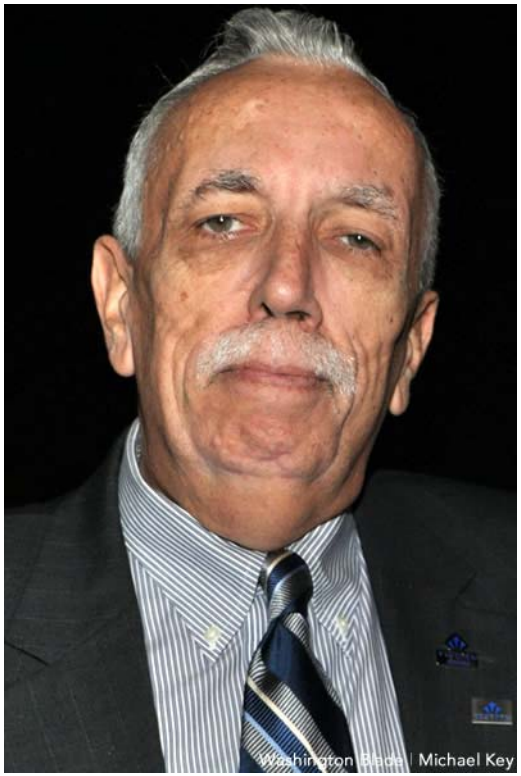
The CDC estimates that 10.8 percent of the roughly 50,000 new HIV infections that occur each year in the United States are among those older than 50. It further reports that 16.7 percent of new diagnoses in 2009 were among this demographic, with half of them also having AIDS. Federal health officials predict that half of people with HIV in the United States by 2015 will be older than 50.

ACRIA, the New York-based Gay Men's Health Crisis and Services and Advocacy for GLBT Elders co-organized the forum as part of what SAGE Senior Director of Public Policy Robert Espinoza described to the Blade as a need to increase visibility around HIV-related aging issues.

"We feel it's an important conversation because there are so many people who are aging with HIV and AIDS," he told the Blade.

Increased access to treatment in the United States and other developed countries has allowed more people with HIV to live longer. The arrival of more widely available anti-retroviral drugs in the mid-1990s has also contributed to this trend.

"If you were 35 in 1990 and you made it to the mid to late 90s and got on protease inhibitors, there's a good chance you're still alive today and you'd be above 50," said ACRIA executive director Daniel Tietz. "And that's the reality."



John Klenert (Washington Blade photo by Michael Key)

Older people with HIV face unique challenges

Johns Hopkins and CDC researchers noted earlier this year that older people with HIV are more likely to suffer higher rates of cardiovascular disease, osteoporosis, non-AIDS related cancers and other chronic illnesses. Klenert, who is now 63, has had a brain tumor removed and an operation to repair an aneurysm over the last 30 years. He said that his neurologist and cardiologist both said that his HIV status did not contribute to either of these conditions.

"There are many folks who age into this — they've had HIV for a while, their HIV is reasonably well-managed," said Tietz. "It's their other things. It's their hypertension, the diabetes, the heart disease that are posing challenges in terms of management."

This population also faces the same hurdles that service providers maintain older LGBT people without the virus routinely face. These include a lack of health care, financial insecurity and social isolation, but a person's HIV status can acerbate these problems.

"The LGBT community in general is not great on aging issues; they tend to be more youth centered," said Espinoza. "We find that a lot of older adults with HIV are often looking just for both the caregiving support they need to manage their health and remain optimistic and maintain their emotional health, but they are looking for community."

He and other service providers stressed that stigmas associated with HIV and sexuality can dissuade older people from discussing their sexual health with doctors and other health care providers.

"If you're not talking openly to people who manage your health then it's going to then prevent the kind of services you need to age successfully," said Espinoza, further stressing that many health care providers don't even provide HIV tests to their older patients who could have just become sexually active after leaving a relationship or getting divorced.
"We're dealing with constituents who have been living with HIV and AIDS for years. We're dealing with constituents who have been infected for years, but just got diagnosed, which often means the illness has progressed more in their bodies. And then we're also dealing with constituents who just became infected and are trying to assimilate to both the emotional and health issues related to their infection."

The New York City Council has funded ACRIA's efforts to bolster HIV prevention efforts among older New Yorkers with HIV. The National Institutes of Health's Office of AIDS Research has also established a working group to study the virus' impact on older people.

"I don't think government officials have put this on their radar screen as much as they should," said Espinoza. "As the demographic really begins growing in the next two years, we're going to see more questions from aging providers and health care professionals about what it means to appropriately serve older adults with HIV and engage them in their facilities or in their long-term care facilities. And with that, I'm hoping that government officials will also increase their attention and increase the funding for that kind of programmatic prevention."

Seeking to increase visibility

Those who advocate on behalf of older people with HIV further stress that lack of visibility remains a problem.

The Graying of AIDS project profiles older people with the virus as a follow-up to photojournalist Katja Heinemann's eponymous photo essay that "Time" published in 2006 to mark the epidemic's 25th anniversary. D.C. resident Ronald Johnson, vice president of policy and advocacy for AIDS United, is among the 11 people that Heinemann and Naomi Schegloff profile in photographs and short videos.

Schegloff, who works in the public health field, told the Blade that she "very much appreciated" what she described as "frank discussions" about sexuality that took place with many of those whom she and Heinemann profiled. Discrimination, a desire for companionship and a general lack of information about HIV are also common themes.

"A lot of older adults have not been on the market in the last 30 years, or have barely been on the market in the last 30 years," said Schegloff. "If they've been with a partner — married or otherwise — for a long time, they may or may not have dated at a time when HIV was something we knew about. If for them condoms are something that you use to avoid getting pregnant and they're heterosexual and they're a woman and they've gone through menopause, they're not worried about that anymore. And it used to be that for people of a certain generation, the worst thing you could get through sex as one person told us in an interview is something you can take penicillin for now. They weren't necessarily thinking about this thing [HIV] as being relevant to them."

Heinemann and Schegloff plan to photograph and interview those from the United States and around the world who are interested in participating in their project during the Global Village at the International AIDS Conference. They will upload images, interview excerpts and other content to an online exhibition during the five-day gathering.

"For us as a visual project and a documentary project, we're hoping to really put a face to this that will be a little bit of a wakeup call where you don't just read the statistic," said Heinemann. "But you're also able to see oh yeah wait a minute, this is not just Bill in Chicago and Ronald in D.C. This is also a person from Tanzania; this is also a person from Russia or someone from India."

Klenert, a former Victory Fund and Gay and Lesbian Alliance Against Defamation board member, also reflected upon those with HIV who continue to grow older.

"I'd like to think that people in my age group are hopeful as well as surprised," he said in response to a question about the changes he has seen since he tested positive. "I'm guessing that most of us didn't think that we would live this long. There's that old greeting card [that says] had I lived this long I would have taken better care of us. Back when we were in our 30s — or late 30s — none of us expected to live this long because back then the mortality rate was almost 100 percent."

Filed under health, national news. You can follow any responses to this entry through the RSS 2.0.

Tagged with ACRIA, Centers for Disease Control, Daniel Tietz, HIV/AIDS, John Klenert, Katja Heinemann, Naomi Schegloff, Robert Espinoza, SAGE

A Call to Action for HIV Awareness, Education and Prevention for Older Adults

Timothy P. Harrison, Ph.D.

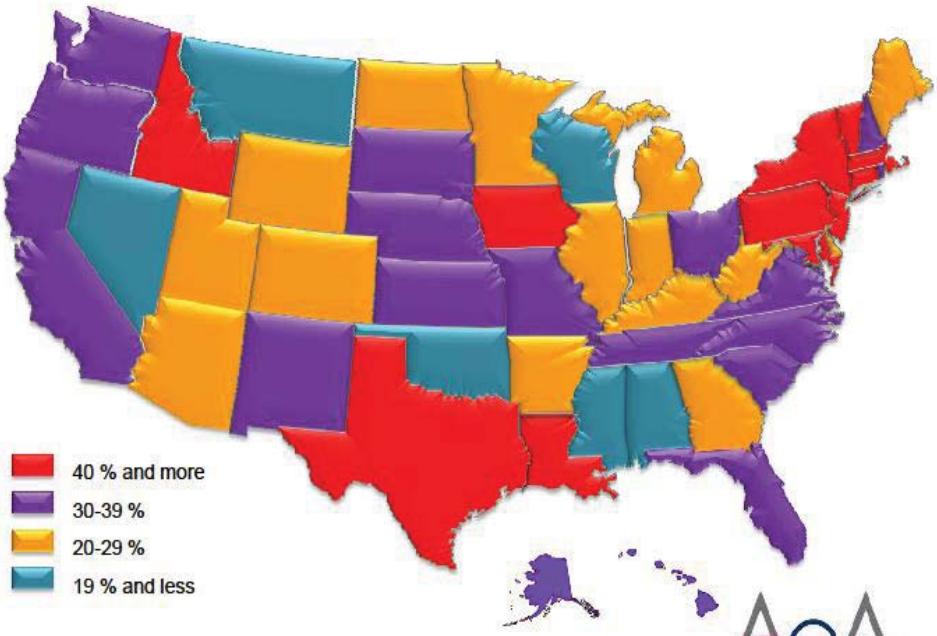
September 18, 2012

Does HIV/AIDS Affect People Like Me?

- New cases of HIV infection
  - 11% are people over 50 years old
  - 23% are women
  - 27% are heterosexual
  - 61% are MSM
  - 44% are African American
  - 20% are Latino
- HIV/AIDS affects everyone

Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. (2011) Estimated HIV Incidence in the United States, 2006-2009. PLoS ONE 6(8): e17502. doi:10.1371/journal.pone.0017502.

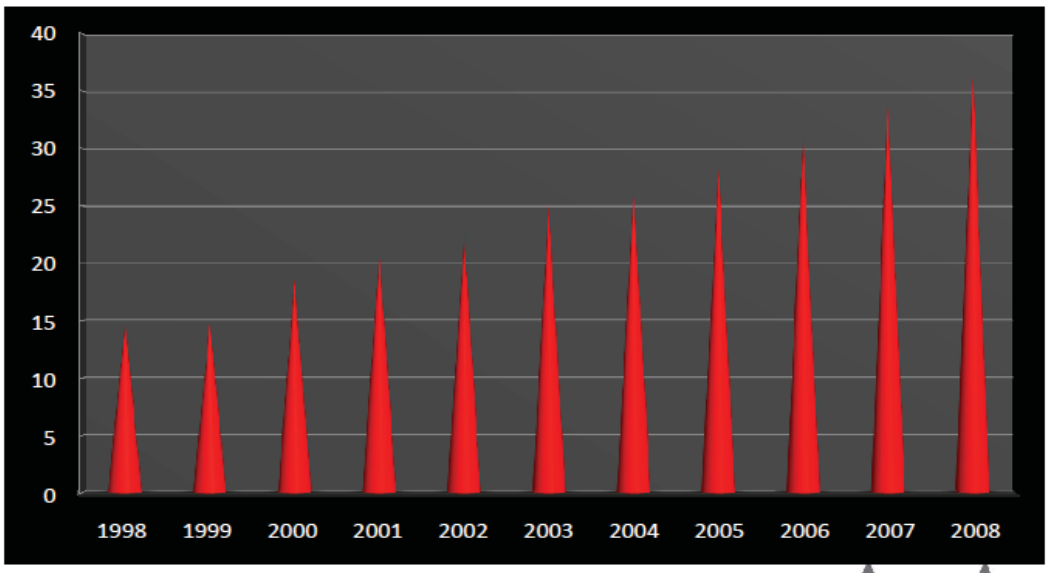
% of People with HIV Age 50 and Older 2009-2010



Administration on Aging

% OF PEOPLE LIVING WITH AIDS DIAGNOSIS OVER AGE 50 IN US

CDC SURVEILLANCE DATA



U.S. Department of Health and Human Services, Administration on Aging, Washington DC 20201 PHONE 202.619.0724 | FAX 202.357.3555 | EMAIL aoainfo@aoa.gov | WEB http://www.aoa.gov

Administration on Aging

Growing Population of Older Adults Living with HIV Disease

- **Dramatic increase in those 50+ living with HIV disease in the United States**
  - -Newly infected older adults
  - -Long term survivors
    - HAART Effectiveness
- **•Estimates are by 2015 50% of those with HIV disease in the U.S. will be 50+**

Justice, Amy, ACTHIV Meeting, May 2010, *Aging Hearing: HIV over fifty, exploring the new threat*.
Senate Committee on Aging, Washington, DC 2005.

Prevention Challenges

- Sexual Risk Factors
- Lack of Knowledge about HIV/AIDS
- Misperception of risk among older adults
- Low Condom Usage
- Drug Use
- Underestimation of Risk by Health Professionals
- Misdiagnosis

Prevention Challenges II

- Stigma
- Biology
- Socio-demographic disparities and HIV prevalence among MSM, African Americans and Latinos, and larger urban areas

HIV Testing Among Older Americans

Study of women ages 50-95 in Atlanta, GA illustrates some of the challenges around HIV prevention and testing for older Americans. Report moderate to high-risk, but not interested in getting tested.

- No need
- Not at risk
- Already been tested

Akers, A., Bernstein, L., Henderson, S., Doyle, J., and Corbie-Smith, G. (2007). Factors associated with lack of interest in HIV testing in older at-risk women. *Journal of Women's Health, 16(6)*, 842-858.

Older Americans Testing Too Late

- Quicker progression from HIV to AIDS
  - ✓ Increased damage to immune system when diagnosed
  - ✓ Lower median CD4 counts at first presentation to care
  - ✓ Greater likelihood of AIDS-defining diagnosis at, or within 3 months before, first presentation to care
- Shorter period of survival
  - ✓ 3-year survival rates declines with age

Brooks, John T., Buchacz, K., Gebo, K., and Mermin, J. (2012), HIV Infection and Older Americans: The Public Health Perspective, American Journal of Public Health, Vol. 102, No. 8.

Challenges with Care

- **Inferior Responses to Antiretroviral Therapy**
  - ✓ Older patients with suppressed viral loads consistently experience less robust CD4 count responses
- **Select Chronic Illnesses**
  - ✓ Persistent immune dysfunction, HIV-related inflammation, and fatigue
  - ✓ Likely increase in number of chronic illnesses, including cardiovascular disease; kidney and liver disorders; bone weakening and fractures; certain non-AIDS defining cancers; and others
  - ✓ Psychiatric and neurocognitive conditions, including depression, suicide ideation, anxiety, dementia, neuropathy
  - ✓ The role of the normal aging process may also be complicated by co-infections like hepatitis or HPV; obesity; alcohol, tobacco or drug use; and stress
  - ✓ A significant rate shift of deaths due to AIDS-related opportunistic illnesses to non-AIDS-related causes
- **Implications of long-term ART usage**
  - ✓ Possible long-term toxicities and other treatment complications
  - ✓ Adherence fatigue
  - ✓ Safe-sex fatigue

Brooks, John T., Buchacz, K., Gebo, K., and Mermin, J. (2012), HIV Infection and Older Americans: The Public Health Perspective, American Journal of Public Health, Vol. 102, No. 8.

What Can Be Done?

- Increase awareness about HIV risk among older Americans
  - ✓ Health care and service providers must educate themselves on this issue
  - ✓ Improve behavioral risk assessment, both sex and drug usage
  - ✓ General HIV/AIDS awareness and education campaigns targeting older Americans
- Emphasize the importance of early diagnosis and treatment among older Americans and their caregivers

HIV Screening

- CDC recommends routine HIV screening for adults and adolescents, up to age 64, including pregnant women, in health care settings in the United States and recommends reducing barriers to HIV testing.
- Persons aged 64 and over should be counseled to receive HIV testing if they have risk factors for HIV infection.
- Routine testing is intended not only to identify persons who are unaware that they are HIV infected but also to reduce the stigma of being tested.
- Making testing routine for older persons can help open a discussion about risk behavior between a physician and an older person.

Additional Action Steps

- Improve Coordination of Primary and Complex Subspecialty Care
  - ✓ Linkage of the newly diagnosed to specialty care, as needed
  - ✓ Coordinated Chronic Disease Management with cardiologists, oncologists and nephrologists
- Continue Age-Appropriate Preventive Screenings
- Incorporate HIV Prevention into Routine HIV Care to Prevent Ongoing HIV Transmission
  - ✓ Brief risk assessment: discussions of sexual health
  - ✓ Risk-reduction counseling
  - ✓ STD testing
- Improve Surveillance and Research

Brooks, John T., Buchacz, K., Gebo, K., and Mermin, J. (2012), HIV Infection and Older Americans: The Public Health Perspective, American Journal of Public Health, Vol. 102, No. 8.

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U.S. Department of Health & Human Services

Clinical Interventions in Aging

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REVIEW

Religion, spirituality, and older adults with HIV: critical personal and social resources for an aging epidemic

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Abstract: By 2015, approximately half of adults with HIV in the United States will be 50 and older. The demographic changes in this population due to successful treatment represent a unique challenge, not only in assisting these individuals to cope with their illness, but also in helping them to age successfully with this disease. Religious involvement and spirituality have been observed to promote successful aging in the general population and help those with HIV cope with their disease, yet little is known about how these resources may affect aging with HIV. Also, inherent barriers such as HIV stigma and ageism may prevent people from benefitting from religious and spiritual sources of solace as they age with HIV. In this paper, we present a model of barriers to successful aging with HIV, along with a discussion of how spirituality and religiousness may help people overcome these barriers. From this synthesis, implications for practice and research to improve the quality of life of this aging population are provided.

Keywords: HIV, aging, spirituality, religion, stigma, coping, successful aging

Introduction

Thanks largely to the effectiveness of highly active antiretroviral therapy (HAART), people with HIV are aging.[1,2] In 2005 in the United States, those 50 and older comprised 15% of all new HIV/AIDS cases, 24% of existing HIV cases, 29% of existing AIDS cases, and 35% of all HIV/AIDS-related deaths.[3] By 2015, adults 50 and older will make up half of the HIV population in the United States; this number is expected to continue to grow because of the aging of younger cohorts with HIV as well as new infections among persons over 50.[4]

With this upward shift in the age of people living with HIV, it is important to consider ways to promote successful aging in this growing population. Building upon the work of Rowe and Kahn,[5] Crowther and colleagues proposed four components of successful aging: 1) active engagement in life; 2) maximizing cognitive and physical functioning; 3) minimizing disability and disease progression; and 4) positive spirituality within a developmental context.[5,6] It is proposed that all of these components work together to promote successful aging; if one area is neglected, then the other components are negatively affected, ultimately reducing one's ability to age successfully. This model's inclusion of spirituality parallels Pargament's thematic switch from a biopsychosocial model to a biopsychosociospiritual model in understanding holistic therapeutic change.[7,8]

The purpose of this article is to summarize knowledge of spirituality as it is used to confront many of the barriers associated with successful aging with HIV. For this

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review, a model of successful aging with HIV is presented as a guide. A particular focus on spiritual benefits of coping will be provided during this review and in the implications for clinical practice and research. In discussing spirituality and religion, these two concepts are related but sometimes mutually exclusive. In this article, spirituality refers to "a person's attempt to make sense of his world beyond the tangible and temporal. It strives to connect the individual with the transcendent and transpersonal elements of human existence. It might, but need not, include religion".[9] While religion may contribute to spirituality, it refers to an outward expression of beliefs as exhibited by behaviors, practices, and rituals which focus on a core system of doctrines, morals, and norms.[9,10]

Barriers to successful aging with HIV

Using the four components of successful aging with HIV mentioned above,[5,6] barriers to each of these components are identified in the model in Figure 1. Although not exhaustive, these represent major barriers that have been articulated in the HIV and aging literature.[2,4,11,12] Underlying this model are three assumptions. First, the four components necessary for successful aging in the general population also apply to those aging with a chronic disease such as HIV. Second, this model assumes that barriers to each of these components act as stressors, activating the physical, cognitive, social, and spiritual resources of successful aging available to the individual, in accordance with Folkman and Lazarus's Stress Process Model.[13] And third, all of these barriers are dynamic and interrelated, just as are the four components of successful aging. For example, age-related stigma and HIV-related stigma, although independent concepts themselves are also intertwined, in that older adults with HIV may be experiencing a combination of the two.

Starting in the left hand corner of the model in Figure 1 and going clockwise, medication side effects from HAART (eg, diabetes, high cholesterol, heart disease); unhealthy lifestyle choices (eg, smoking, substance abuse); and increased multi-morbidity with HIV compromise the

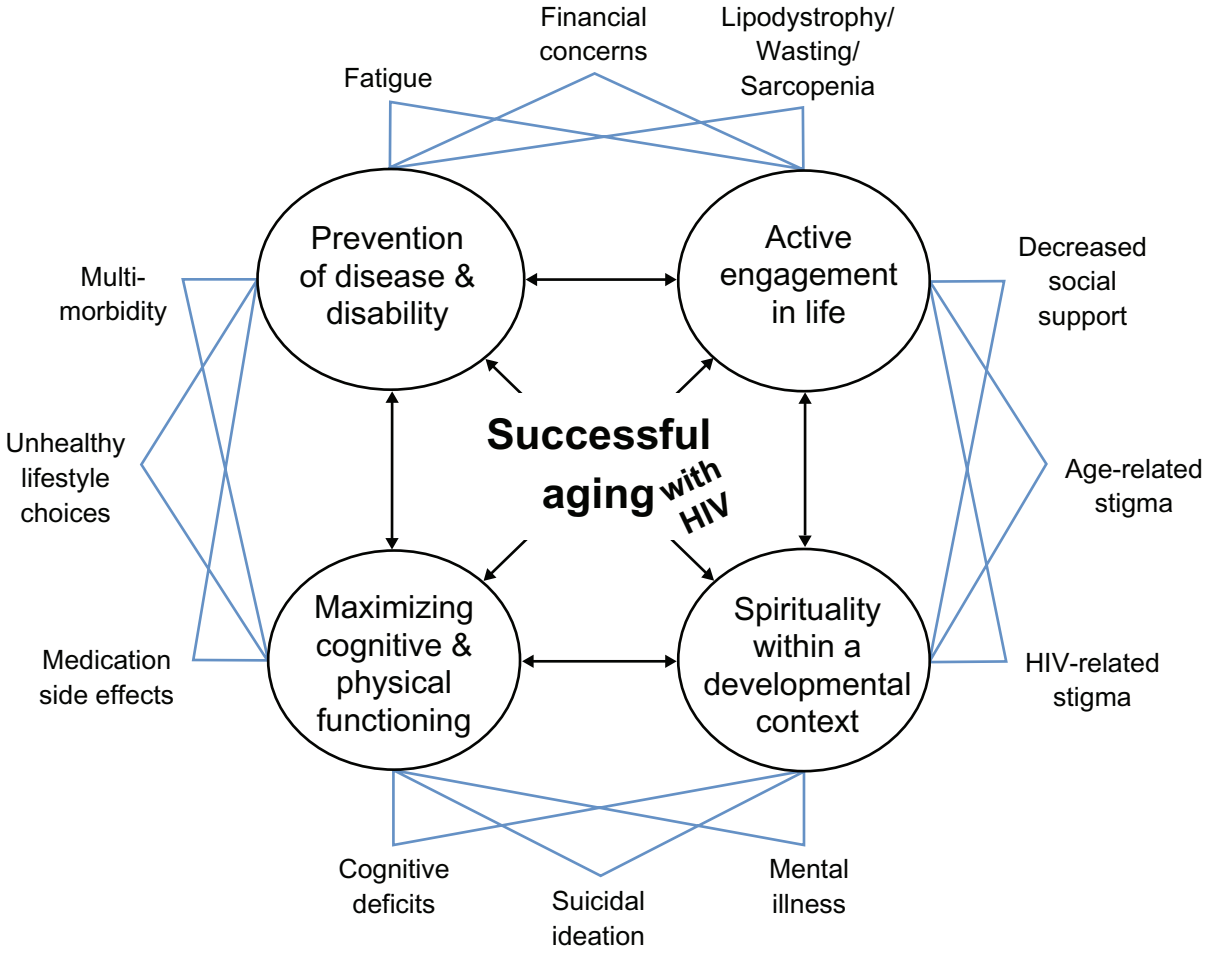

Figure 1 Barriers to and components of successful aging with HIV.

components of maintaining and maximizing cognitive and physical functioning and the prevention of disease and disability.[2,14] Fatigue due to medication side effects; not possessing financial means to pay for medications and other self-care needs; and lipodystrophy and decreased muscle mass (eg, wasting, sarcopenia) compromise the components of prevention of disease and disability and active engagement in life. For example, lipodystrophy in more pronounced cases can result in severe loss of subcutaneous fat in the face producing profound disfiguration, which may reduce one's inclination to socialize and actively engage in life.

Decreased social support (and increased social isolation), age-related stigma, and HIV-related stigma compromise the components of active engagement in life and spirituality within a developmental context. Studies show that 71% of older adults with HIV live alone and few (15%) reported living with a partner or spouse.[15] Many older adults with HIV consider emotional and instrumental support from their social networks is either unavailable or inadequate.[16,17] Decreased social support is closely tied to HIV stigma. HIV stigma can intensify other types of stigmas faced by many older adults, such as ageism, sexism, and racism. This may involve rejection, stereotyping, fear of contagion, violations of confidentiality, and protective silence (ie, concealing one's HIV status to avoid negative reactions from others).[18] Thus, many older adults with HIV withdraw socially due to HIV stigma,[19,20] further decreasing active engagement in life. Stigma also serve to challenge successful aging with HIV with regard to spirituality. Cotton and colleagues reported that 25% of people with HIV/AIDS are alienated from their place of worship because of HIV stigma, and 10% changed congregations because of their HIV status,[21] which can also contribute to poorer active engagement in life. Findings are similar among older adults with HIV, with 15% reporting attending services less frequently following their HIV diagnosis. Furthermore, less than half of these older adults disclose their HIV status to their congregations.[22]

Finally, mental illness (often depression and anxiety), suicidal ideation, and cognitive deficits compromise the successful aging components of "spirituality within a developmental context" and "maximizing cognitive and physical functioning". These barriers have a greater prevalence in adults with HIV.[23–25] In a large sample (N = 1,478) of adults with HIV, approximately 40% were found to be depressed and approximately 20% were found to have an anxiety disorder.[14] Grov and colleagues found similar rates of major depression among older adults with HIV (39%), which was strongly related to HIV stigma and loneliness.[26] In one study of 113 older adults (>45 years) with HIV/AIDS, 27% experienced suicidal ideation within the past week.[27] With regard to cognitive functioning among older adults with HIV, the evidence to date is mixed; however, there are strong indications of neuropsychological impairments in this population in certain cognitive areas such as memory, executive function, attention, and speed of processing.[2,28]

Certainly, such cognitive deficits, suicidal ideation, and mental health issues can exert direct negative effects on physical health as well as interfering with adherence to HIV medications (such as not remembering or being apathetic about taking medications).[29,30] These cognitive deficits, suicidal ideation, and mental health concerns may be aggravated by financial concerns, multi-morbidity, and other such stressors. These stressful situations may also increase cortisol levels, exacerbate other health problems such as substance use, and compromise self-care behaviors such as sleep hygiene; all of which can lead to poor cognitive and physical functioning.[24]

All of these barriers represent unique yet inter-related stressors that can contribute to poor functioning in each of the four major components of successful aging. With such stressors, it is understandable why someone aging with HIV may feel particularly overwhelmed, hopeless, and abandoned – not only by society, but perhaps from their beliefs, faith, religious communities, and even by God.[31] Yet, despite such barriers to successful aging, many people with HIV still benefit from their religious and spiritual beliefs and actually thrive under such circumstances.

Spirituality of aging

Involvement in religious and spiritual practice has been found to correspond to better health-related outcomes regardless of age.[32–35] Such involvement may provide one with social support, norms for healthy behaviors, and a sense of well-being which promotes better overall mood.[36] But with advanced age, older adults have unique stressors that may compromise successful aging and are exacerbated when they are aging with HIV. Such stressors include multi-morbidity, diminished social supports, limited financial capacity, limited functional ability, and end-of-life concerns. Spirituality and religiousness can serve as buffers to life stress, by allowing individuals to interpret their life experiences in the context of their beliefs, which provide purpose and meaning in life, as well as promoting transcendence over circumstances, and bolstering feelings of inner resources and connections to others.[10,36–39]

As an example of such benefits, Lowry and Conco examined the role of spirituality in the lives of older adults in Appalachia.[40] Using a qualitative study design, they asked participants a variety of open-ended questions about health, spirituality, and religiosity, as well as social supports. In general, these researchers found that spirituality protected these older adults from negative attitudes and declines in physical health. The primary themes that emerged included the belief that God is actively involved in their lives, God calls them to action, and God supports them at times of loss. In this study, it was clear that the participants' personal relationship with God buffered them from the negative aspects of aging by providing them solace and a sense of purpose

Spirituality and coping with chronic disease

Just as in the gerontological literature, the chronic disease literature shows the biopsychosocial benefits of spirituality and religiosity in buffering one from the stressors of such diseases. Such benefits have been observed in numerous diseases including bipolar disorder,[41] cancer,[42] diabetes,[34] and heart disease,[35] as well as other stigmatizing diseases such as visual impairment.[33] Such benefits have also been observed with HIV.[21,43–48]

Despite a history of HIV being particularly stigmatized by some religious communities,[22,49] Lorenz and colleagues found adults with this disease had a high level (80%) of religious participation;[50] of those, most reported that their religion (80%) and spirituality (65%) were "somewhat" or "very" important. Brennan and colleagues found that older adults with HIV had similar rates of religious participation to other groups of older adults. Participation remained high even among those who did not disclose their HIV status to their congregation, and 47% reported receiving support from their congregations.[22] In a sample of 279 adults with HIV, Ironson and colleagues found religiosity and spirituality corresponded to lower cortisol levels, increased positive health behaviors, larger social supports, hope, and improved long-term survival among older adults with HIV.[51] Similarly, in a sample of 450 HIV/AIDS outpatients, Szaflarski and colleagues found that nearly a third indicated feeling that their life was better now than before they were diagnosed with HIV.[52] Specifically, they found that a 1 SD increase in the Duke Religion Index was related to a 68.5% increase in the odds ratio that life was better. Clearly, from these studies, spirituality and religious involvement is associated with better health outcomes in adults with HIV.

Yet, religion can hinder positive biopsychosocial outcomes. In a qualitative study, Miller interviewed African American gay men with AIDS about their religious involvement.[53] Some reported rejection by their church for being gay or HIV positive. In fact, some who maintained a relationship with their church reported lower self-esteem. Clearly, although religiosity and spirituality can have positive biopsychosocial outcomes, it can also be a source of stress and may negatively impact self-care behavior. In a sample of 306 adults with HIV in the southern United States, those who considered that their disease was a punishment from God were more likely to miss taking their medication and had trouble keeping their medical appointments.[54]

Spirituality of aging with HIV

HIV presents several unique barriers to successful aging. As Figure 1 shows, older adults with HIV may be more vulnerable to a number of issues including stigma both for being older and having HIV. Yet, just as in the HIV and gerontological literatures, adults aging with HIV have also been shown to benefit from religiosity and spirituality.[22,45,55] Having coped with stressful experiences over the course of their lives, older adults with HIV may have the capacity to negotiate difficult situations such as barriers to successful aging due to HIV by drawing upon their repertoire of coping strategies.[56]

Being diagnosed with HIV is a life event that may serve as a catalyst for growth and maturity. Many adults aging with HIV report that they grew spiritually from being diagnosed with HIV. In a sample of 50 adults with HIV, Vance found that 72% of older adults with HIV indicated that their spirituality changed as a result of being diagnosed;[31] likewise, 44% considered HIV to be a blessing in that it helped them to dig into their spirituality and forced them to confront issues of health, self-care, and God's purpose for their lives. Others have found that spirituality and religiosity do increase with a diagnosis of a disease. Sodestrom and Martinson found a similar effect to Vance's finding, with 88% of cancer patients finding meaning in their illness through their beliefs and faith.[57] Other studies examining spirituality in adults with HIV have found that spirituality levels are higher in older adults with HIV than younger adults with HIV;[50,58] however, some studies do not detect such differences.[45] Other research finds that levels of spirituality among older adults with HIV were the same or higher compared to other adults coping with chronic illness.[44] These findings regarding the importance of spiritual and religious resources among older

adults with HIV suggest that one could facilitate successful aging with HIV through spiritually-based interventions and practice modalities.

Implications for practice

Health professionals working with older adults with HIV need to assess the role of spirituality and religiosity and make an effort to include their findings in the management of the disease. Given the evidence that spirituality is a major component of successful aging with HIV (Figure 1), ignoring this important aspect of successful aging could contribute to poorer health outcomes. Older adults with HIV could benefit from a more comprehensive approach to disease management that incorporates their level of spirituality and religiosity, as well as appropriate referrals for those who need counseling in these and related areas of their lives. Such counseling may be of value to many with HIV as they confront and cope with issues of intimacy, fear, guilt, anger, and confusion over the disease.[59] During counseling, religious and spiritual issues will undoubtedly emerge. Some issues may stem from anger at religious institutions for their particular views on HIV or homosexuality. Others may focus on broader spiritual issues including end-of-life concerns such as "Will I go to heaven?"; while others may be concerned about more basic questions such as "Does God still love me?"

Traditionally, secular counseling has steered away from incorporating matters of faith and spirituality into the psychodynamic setting; too often this is considered the sole domain of clergy and spiritual counselors.[60] In the secular domain, Freud and others often considered the concept of God as a father image to be a form of wish fulfillment; in such a capacity, patients may not be able to work through deep personal issues due to adherence to strict religious doctrines or mores that limit personal growth. However, Freud and others also noted that religion and spirituality can serve as a catalyst for working through issues and promote coping, growth, and transcendence.[61,62] Yet religion and spirituality can be treacherous psychological waters to navigate with some therapists suggesting that instead of drowning in such unpredictable and uncharted rapids, it is better to walk on the banks of reason and logic.

Likewise, spiritual and religious counseling has traditionally steered away from secular techniques, leaving the treatment of severe mental illnesses such as schizophrenia, bipolar disorder, and other more serious conditions to the medical community and maintaining their focus on faith-based approaches. But over the past few decades, spiritual and religious counseling has adopted more secular counseling techniques; this can be observed in training programs for clergy that incorporate more psychology classes and greater emphasis on the medical model.[60] Similarly, secular counseling has acknowledged the importance of the spiritual and religious lives of patients and has recognized that spiritual and religious thoughts and imagery are a rich source of personal information.[60,63]

Given that 85%–90% of those in the United States report believing in God or a higher power and that some 71.5% actually pray once a week,[64] ignoring matters of faith and spirituality is tantamount to ignoring the proverbial "elephant in the living room". Clearly, religious and spiritual experiences are just as important to people as the objective circumstances of their lives. In fact, Gallup poll (cited by Foster)[65] found that 66% of those in the United States reported that they would prefer to go to a counselor with spiritual beliefs and values if they were seeking a mental health professional. Others have also come to the realization that it is valuable to incorporate the spiritual in counseling.

For example, the well-known 12-step program, originally developed to address alcoholism, incorporates several concepts of God or a higher power to help resolve personal conflicts and provide a guide for living. In the first step of the 12 steps, it states "We admitted we were powerless over alcohol – that our lives had become unmanageable".[66] In this statement, alcohol can be substituted with any other recurrent problem whether it is unforgiveness, depression, a life-changing mistake, or even HIV. In fact, Potik suggested translating the 12-step program, normally used in alcohol and other addiction counseling, to other life situations such as adapting to a chronic disease.[62] As Potik explains, these 12 steps can be used flexibly to help recover from a number of issues. The principles of the 12-step program can be used to help with a number of spiritual issues and emotions that are consistent and debilitating, whether the problem is fear of HIV, guilt over how one acquired HIV, regret over the life one could have had without HIV, or anger over how one has been treated due to one's HIV status.

As seen in the literature on the spirituality of aging and HIV, issues of fear, guilt, regret, and anger are recurrent themes; such emotions can be powerful, crippling, and stymie one's ability to move forward and live one's life fully. Clinging to such toxic emotions can be likened to addiction in that it can destroy relationships, prevent one from maintaining or forming relationships, and even lead to other addictions such as alcohol to escape such feelings of despair.

Such emotions also represent feelings of powerlessness as addressed in step one of the 12-step program – and could be articulated as "we are powerless over HIV". In acknowledging this powerlessness, Potik explains that this is not "giving up" but rather it is a form of "acceptance". By admitting such powerlessness, one opens up to a greater power beyond one's own capability – whatever one's nomenclature. This subsequently leads to step 2 – "Came to believe that a Power greater than ourselves could restore us to sanity". By such a fundamental reliance on this power, one opens up to the possibility that one can be made whole again. Although it is beyond the scope of this article to explore the other 10 steps, it is clear that the steps gradually build on each other to help one to acknowledge weaknesses, take inventory of strengths, and to maximize one's ability to live the best one can, one day at a time. Such steps would appear to be valid mechanisms for coping with the powerlessness and unpredictability of being diagnosed and aging with a life-threatening chronic illness such as HIV.

Implications for research

For researchers studying the management of chronic illnesses like HIV, religious and spiritual resources represent a fascinating, meaningful, and beneficial way of optimizing health-related outcomes. The few research areas presented in this article focus on the development of hardiness and resilience, spirituality across groups, and the change of attitudes about HIV among communities of faith.

Since the concept of hardiness parallels aspects of spirituality, Vance, Struzick, and Masten proposed a daily cognitive-behavioral approach that employs exercises for developing characteristics of hardiness.[55] In this cognitive-behavioral program, a client aging with HIV may be experiencing anxiety and depression. So the therapist would help the client identify sources and icons of optimism and strength. Such sources could be inspirational songs, television shows, movies, books, poems, mantras, prayers, and art. The key to identifying such sources is that they must be personally and intensely meaningful to the client; often, these are very spiritual in nature. By identifying such salient sources, they can be woven into a cognitive-behavioral program to be used by the client on a daily basis. Examples of such structured features of the program may include the following instructions: 1) "Before getting out of bed each day, meditate for at least a few minutes about how you are going to take care of yourself so you can take care of your friends and family", 2) "Repeat the following mantra every time you ride the elevator at work – 'It is fine to fall, and even better to rise again,'" 3) "Enjoy positive media such as Star Trek, Robin Williams, and gospel music", and 4) "When you go to bed, write in your journal the two most positive things that have happened to you today". Obviously, such an approach would include spiritual and/or religious activities, be more detailed and descriptive, and contain behaviorally-objective goals to ensure that the target behaviors occur in order to change thoughts and behaviors to facilitate a hardy attitude. By developing a more hardy and proactive attitude, one should be better adjusted psychologically and spiritually to deal with some of the barriers to successful aging with HIV.

A similar approach has also been studied in a group intervention to help adults with HIV. Tarakeshwar, Pearce, and Sikkema created an eight-session group intervention to address issues specific to HIV;[67] a focus on spirituality was included. Using a pre-post experimental design in this pilot study, researchers found that after completing this intervention, participants reported having more positive spiritual coping skills and feeling less depressed.

Spirituality may also support cognitive functioning in older adults with HIV. Many adults with HIV have been observed to suffer from subclinical cognitive deficits; there are concerns that with advancing age that such deficits will become more profound.[2] Since HIV is also associated with depression and anxiety, such negative affect has also been shown to negatively impact cognitive functioning.[2] Thus, interventions that reduce such negative affect may actually improve cognitive functioning.[24] Promoting spirituality as a coping resource may help reduce such negative affect and subsequently help promote successful cognitive aging in this population. Also, certain spiritual practices, such as meditation or attending religious meetings, have been shown to be stimulating cognitive exercises in their own right. In this sense, spiritual practices support the cognitive component of successful aging as well.[68] Despite these connections in the literature, a more systematic evaluation of how spirituality can affect successful cognitive aging with HIV needs to be evaluated.

Despite such interventions that employ aspects of spirituality and religious coping, evidence suggests that different groups of people may derive differential benefits from spirituality and religious involvement. In a series of studies, Vance and colleagues[69] surveyed 421 adults with HIV from across Alabama. A structural equation model was constructed that examined the effects of years since diagnosis with HIV, age, and education on the mediating role of religious activity on three biopsychosocial outcomes (ie, health status, social support, and mood). In the overall sample, older participants engaged in more religious activities, and

engagement in such activities was predictive of greater perceived social support. However, when the same structural equation model was examined for different subgroups in the sample (ie, men, women, African Americans, Caucasians, homosexuals, heterosexuals); women, African Americans, and homosexuals seemed to benefit more from such religious activities.[70–73] However, these results are in contrast with other findings. In a study of older adults without HIV, McFarland[73] found that men tended to receive more mental health benefits from religious involvement than women. Why such differential benefits occur is not clear. More research into this area is needed.

Finally, as already mentioned, religion and spirituality has not always been a source of solace or strength for many with HIV. Historically, at the beginning of the epidemic especially, several religious enclaves denounced those with HIV, offering recrimination to "immoral" behaviors such as intravenous drug use, homosexuality, and sex outside of marriage. These bombastic views were internalized for some with the disease. In their sample of 90 adults with AIDS, Kaldjian, Jekel, and Friedland found that 17% of adults with AIDS reported that their disease was a punishment from God.[74] Such guilt and self-denigration can obviously hinder mental health.[75] Brennan and colleagues report that stigma is a major factor in the failure of older adults with HIV to access support from their religious congregations, noting that many fear rejection due to moral judgments because of their seropositive status.[22] Over time, with more education and knowledge about HIV, such harsh views may have softened in some religious communities as well as in society overall. Whether this change in societal attitudes has increased access to religious and spiritual sources of solace and support among older adults with HIV remains unknown.

Conclusion

Successful aging with HIV is possible; however, studies indicate several potential obstacles such as decreased social support, with many lacking intimate relationships; increased multi-morbidity; and potential financial difficulties from years of being unable to work and prepare for retirement.[2] These factors can be a source of regret, depression, and anger. Fortunately, religious and spiritual resources represent a source of coping for many, with the caveat of being able to access such resources without the barriers of stigma and moral recrimination. It is important for mental health professionals, both religious and secular, to recognize that many of their clients with HIV are aging within a spiritual context; a context that may be turbulent or serene based upon their personal history and spiritual interpretation of their lives. Social support from a religious or spiritual body of like-minded people could certainly help some older adults with HIV. Still, mental health professionals will need to be creative in helping the older client with HIV to embrace their powerlessness over the disease itself in order to tap into inner strengths, become hardy, and age successfully.

Disclosure

The authors report no conflicts of interest in this work.

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