QUICK LESSON ABOUT

Acquired Immunodeficiency Syndrome (AIDS) in Older Adults

Description/Etiology

Acquired immunodeficiency syndrome (AIDS) is diagnosed when the immune system of an individual with human immunodeficiency virus (HIV) is so severely compromised that either the numbers of CD4 lymphocytes in his or her immune system drop below a certain level or he or she develops one of a specific group of opportunistic infections (OI). There are many types of OIs associated with HIV, including pneumocystis pneumonia, mycobacterium tuberculosis (TB), syphilis, human papillomavirus (HPV), hepatitis C, and hepatitis B. HIV is transmitted from one person to another through exposure to blood, semen, vaginal secretions, and breast milk. The virus must pass through the skin or mucous membranes into the body to cause an infection.

AIDS, which once was considered universally fatal, is now considered a chronic illness manageable through advancements in medical treatment. As a result, increasing numbers of older adults will be living with HIV/AIDS (Wing, 2016). The U.S. Centers for Disease Control and Prevention (CDC) identifies older adults infected with AIDS as those individuals 50 years of age and older. Antiretroviral medications (ARVs) have enabled many HIV-positive individuals to live longer and to survive into older adulthood. There are consequences to long-term ARV use and these can manifest as comorbidities in older adult clients. There is a diminished ability in older adults to metabolize the medications, which can lead to toxicity; preexisting hepatic, cardiac, and metabolic conditions can be exacerbated by the use of ARV and by HIV or AIDS itself (Cahill & Valadez, 2013). HIV is associated with higher rates of chronic illness, persistent inflammation and frailty (i.e., a concept that refers to multiple physiologic deficits or cumulative physical, social and/or psychological deficits that increase the person's vulnerability to adverse outcomes); neurocognitive impairment is also prevalent in persons with HIV (Calcagno et al., 2015). For older adults with a new diagnosis of HIV/AIDS (versus older adults in whom AIDS was diagnosed at a younger age), the diagnosis is more likely to come later in the course of the disease and they may be late starting treatment as a result. Older adults also may be more susceptible to HIV because they do not consider themselves at risk and often lack knowledge of the disease and the risk factors associated with it. There is a common misconception that older adults are not engaging in sexual activity; however, medication intended to treat sexual dysfunction has contributed to continued sexual activity well into old age. In addition, among heterosexual older adults, sexual activity tends to be unprotected because pregnancy is no longer a concern (Pratt et al., 2010). In general, older adults tend to have weaker immune systems, which in turn can lead to greater susceptibility to HIV infection and more rapid disease progression. Researchers have found that older adults with HIV/AIDS have shorter survival times and higher rates of mortality (Chambers et al, 2014). Diagnosis of HIV in older adults can be difficult without HIV testing because many symptoms associated with the disease (e.g., weight loss, fatigue, dementia) also are common with aging.

Older adults with HIV experience an array of psychosocial issues. Ageism, sexual minority status and victimization,isolation, issues related to HIV status (e.g., stigma, grief regarding illness, fear of disclosing diagnosis to others, living with uncertainty about disease course), as well as disease-related neurological changes, comorbidities, and functional limitations can contribute to poor quality of life and mental health outcomes in older adults with AIDS.

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Treatment and support are essential for older adults with HIV/AIDS. Aggressive treatment such as highly active antiretroviral therapy (HAART; a combination of reverse transcriptase inhibitors, protease inhibitors, and fusion inhibitors) is commonly used. In addition to HAART, a variety of strategies can be used to support psychosocial needs and successful aging. Older adults with AIDS can benefit from individual and family therapy and participation in support groups. Addressing behavioral risk factors, particularly lack of exercise, poor nutrition, smoking and substance abuse, is important to optimize physical health. Prevention through education and lifestyle changes is the key to reducing the incidence of HIV infection and associated morbidity and mortality in older adults.

Facts and Figures

In 2015,approximately 36.7 million persons globally were living with HIV, and 1.1 million persons died from AIDS-related illnesses with tuberculosis accounting for approximately 1 in 3 deaths (UNAIDS, 2016). There are an estimated 1.2 million persons in the United States infected with HIV/AIDS (CDC, 2017b).Data from numerous countries, including the United States, Brazil, and Europe, indicate that AIDS in older adults is an increasing concern (Fonseca et al., 2012). The CDC reports that in 2014, 17% of the 44,073 cases of HIV diagnosed in the United States were attributed to adults who were 50 or older; among those aged 50 and older, 40% of persons newly diagnosed with HIV were also diagnosed with AIDS (CDC, 2017a). Male-to-male sexual contact and intravenous drug use accounted for 70% of new HIV/AIDS diagnoses in 2015 (CDC, 2016b).

Researchers in Brazil found that 2.5% of new AIDS cases were identified in persons age 60 and older; these older adults were less likely than persons diagnosed at a younger age to be intravenous drug users and more likely to have contracted AIDS through heterosexual activity (Fonseca et al., 2012). In Eastern Zimbabwe, HIV prevalence is higher in men aged 45 -54 (23.4%) than in men aged 15-44 (11.0%); higher rates of risky sexual behaviors (e.g., not using condoms, having multiple sexual partners) was also found among older adults (Negin et al., 2016).

Functional limitations and comorbid conditions are more important predictors of health-related quality of life for persons with HIV than whether the individual's illness has progressed to AIDS (Emlet, Fredriksen-Goldsen & Kim, 2013). Additionally, there is a high rate of comorbidities in older adults with HIV. In a small study of older adult women in the United Kingdom, 90% had at least one comorbid condition (e.g. high blood pressure, diabetes, depression), and 50% of participants had more than one comorbid condition (Samuel et al., 2014). Researchers in a United States study found that older adults with HIV had higher rates of impairment in instrumental activities of daily living (e.g., housekeeping, transportation) than non-infected peers (Johs et al., 2017).

In a British study involving older adults with HIV, researchers found that most expressed positive quality of life; having a partner and not being on public assistance predicted a better perceived quality of life, whereas anxiety, depression, and concerns about memory problems predicted worse quality of life (Catalan et al., 2017).In a small randomized control study, researchers found that an intervention involving 6physical activity counseling sessions designed to increase personal decision making based on self-determination theory (SDT)was associated with improved physical activity and functioning (e.g., increased endurance and strength), decreased depression, and improved quality of life in older adults with HIV (Shah et al., 2016). In a study of older women living with HIV, researchers found that strategies such as acceptance, self-care, and finding meaning in one's life were associated with improved wellbeing, whereas difficulty accepting one's medical condition, lack of social support, substance abuse, and/or non-adherence with treatment were associated with less favorable outcomes (Psaros et al., 2015).

Risk Factors

Older adult risk factors for AIDS include multiple sexual partners, unprotected sexual activity between males, IV drug use, unprotected anal and vaginal intercourse, sexually transmitted diseases, blood transfusion prior to 1985, the presence of opportunistic infections (which may be misdiagnosed as other conditions), tattoos and body piercings with contaminated needles, and lack of education or HIV testing. Many healthcare professionals make the assumption that older patients and clients are not at risk and as a result do not educate this population on the risks of HIV and AIDS. Women who are postmenopausal are at greater risk of contracting HIV/AIDS because estrogen loss causes thinning of the vaginal mucosa, which may lead to tears of the vaginal walls during sexual activity (Brooks et al., 2012). Other conditions that contribute to the transmission of the HIV virus are poverty and lack of health care.

Signs and Symptoms/Clinical Presentation

› Psychological: Older adults with AIDS may experience feelings of loneliness, guilt, anxiety, anger, confusion, denial, depression, shame, and fear. They may also experience grief from the death of family members from AIDS-relatedillnesses and have suicidal ideations

› Behavioral: Older adults with AIDS may have substance abuse problems. Older adults may have spent much of their lives hiding their sexual orientation due to stigma, shame, and fears of discrimination
› Physical: The adult's general appearance may be affected as a result of having AIDS. He or she may appear malnourished, have severe diarrhea and other flu-like symptoms, and have respiratory problems and other signs related to OIs. Older adults with AIDS may experience symptoms such as sweats, fever, respiratory distress, nausea, weight loss, and wasting
› Social: Older adults with AIDS may withdraw from social relationships; show signs of isolation; experience difficulty connecting with others; and have trouble expressing emotions. They may have lost partners, family members, and friends, resulting in diminished social support. Older adults may be in a setting such as a care facility in which they feel they must hide their sexual orientation. There are also generational differences in the coming-out process that may cause the life experiences and trauma histories of older adults with HIV or AIDS to be different from those of younger individuals. The older adult's parents may be deceased or too old or ill to provide assistance while the older adult's children may be coping with feelings of shame regarding their parent's illness. Adult children may isolate themselves from a parent with AIDS or be unable to provide care because of their own aging issues

Social Work Assessment

› **Client History**
  • Conduct a biopsychosocial-spiritual assessment to include information on any physical, mental, environmental, social, financial, spiritual, and medical factors relating to the client's care
  • Assess onset, duration, and symptoms, as well as history of recurring infections
  • Obtain information on client's sexual history; assess sexual health needs and the impact of HIV/AIDS on intimacy and sexuality
  • Assess for substance abuse and mental health issues
  • Assess client's stress-management skills and coping mechanisms
  • Obtain client's permission to ask any known, available family members for additional relevant information
› **Relevant Diagnostic Assessments and Screening Tools**
  • The Veterans Aging Cohort Study (VACS) Index can be used to assess ageing processes and severity of illness in persons with HIV/AIDS
  • Mental health screens that minimize screening somatic symptoms are recommended for use with older adults, for instance, the Geriatric Depression Scale
› **Laboratory and Diagnostic Tests of Interest to the Social Worker**
  • Antibody, antigen or RNA/DNA testing for HIV infection may be performed if HIV status is unknown
  • Toxicology tests can be appropriate if drug or alcohol misuse is suspected

Social Work Treatment Summary

Early diagnosis and intervention provides older adults with HIV the best chance for effective treatment. Unfortunately, many AIDS-related symptoms imitate medical problems that are common in older adults, which may lead to delayed diagnosis or misdiagnosis and thus, delayed treatment. In addition, older adults are less likely to get tested for HIV. The social worker needs to stress the importance of HIV testing for all adults regardless of age. The assessment of physical functioning and geriatric syndromes are important in older adults in whom HIV has been diagnosed (Greene et al., 2016). Also, assessments of cognitive changes in this population are more critical. HIV and AIDS can have adverse effects on cognitive functioning and the brain, increasing the risk for dementia, depression, and Alzheimer's disease.

Newly diagnosed individuals may need support with adjusting to and disclosing their HIV status. Disclosure can have both positive and negative impacts, potentially eliciting increased social support but in some cases also precipitating rejection and loss of intimacy. The social worker should help the individual understand and cope with the stigma associated with the disease. To do this, the social worker must understand the age-cohort differences that may exist when working with a 50-year-oldclient versus a 75-year-old client, for example. Older adults who are HIV-positivemay have a diminished quality of life as a result of typical aging compounded by their HIV status. For older adult gay men, their self-identity may have been altered by society's viewpoint during their formative years. Most likely at that time there was very little outward societal or familial support, which can have lifelong consequences. The social worker must also be aware of the triple stigma in place for some clients if they are coping with ageism, public misconceptions related to HIV/AIDS, and antigay prejudices. Because of his or her HIV status and/or sexual orientation, there may be significant deficits in the individual's support system. Peers may have replaced family supports or the individual may be utilizing formal caregivers rather than family and friends as informal caregivers.

Medical treatment can be broadly divided into the following categories: prophylaxis for OIs, malignancies, and other complications of HIV infection; treatment of OIs, malignancies, and other complications of HIV infection; and treatment of HIV infection itself with HAART (Katz, 2017). Healthcare providers considering HAART regimes for AIDS-infected older adults should consider the availability of medications, the impact of the medication schedule on quality of life, the interaction of AIDS drugs with other medications being taken for age-related issues, and the ability of the individual to administer complex treatment regimens. It is crucial that the individual understand the importance of adhering to medication schedules and dosages and the possible consequences if the schedule is disrupted.

In addition to HAART and treatment of OIs, older adults with AIDS also benefit from interventions that address their overall health and psychosocial functioning. Many individuals with HIV/AIDS have comorbid substance use disorders, depression and/or anxiety. Mental health and/or substance abuse treatment may be indicated, including individual and/or family therapy, and support groups. Internet-based or telephone support can enhance accessibility of services for individuals with limited mobility, transportation issues or concerns about privacy. Nutritional assessment and interventions, exercise programs, spiritual care, and complementary and integrative health can support improved health and wellbeing. Sexual health needs should be addressed, including educating the client on preventing the spread of HIV to others, including discussing safe sex practices and needle usage. Although there have been significant advances in the treatment of AIDS, there is no cure or vaccine to prevent the disease.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Problem	Goal	Intervention
Older adult is at risk of contracting HIV/AIDS	To prevent adult from contracting HIV/AIDS	Educate on risk factors associated with HIV contraction; provide education on safe sex, importance of clean needles and syringes if adult is an intravenous drug user
Older adult has HIV/AIDS	To provide the adult with a safe and healthy environment	Ensure that drug regimen is administered and followed; teach strategies to control the spread of HIV (safe sex practices, use of clean needles and syringes if individual is an intravenous drug user); educate about reducing risk of secondary infection/ OIs; educate individual on support services; provide nutritional information; offer mental health services, support group information, individual and family counseling

Problem	Goal	Intervention
Older adult has feelings of loneliness, guilt, anxiety, denial, depression, and fear regarding diagnosis of AIDS/ HIV	Decrease negative feeling about AIDS/HIV and improve coping skills	Refer to mental health services, support groups, and educational programs; educate regarding the importance of regular exams and medication maintenance, provide tools to improve coping and self-efficacy, refer client to in-home support services if needed

Applicable Laws and Regulations

› The United States Rehabilitation Act of 1973, Section 504 protects individuals against discrimination due to illness
› The United States Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects individuals by ensuring the privacy of their health information and their right to review and make corrections to their medical records
› In the United States, 49states have HIV testing laws that require HIV testing as part of an individual's routine healthcare visit and in 32 states, Medicaid covers routine HIV screening (CDC, 2016a)
› Forty-two U.S. states require viral load laboratories to report all CD4 results to HIV public health agencies that track disease progression and treatment outcomes(CDC, 2016a)
› In the United Kingdom, the Equality Act of 2010 defines all persons in whom HIV is diagnosed as disabled, which provides protection against discrimination (Aidsmap, n.d.)
› Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly
› Internationally, social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the national code of ethics that applies in the country in which they practice (IFSW, 2012). For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to older adults living with HIV/ AIDS and practice accordingly(NASW, 2015)

Available Services and Resources

› Centers for Disease Control and Prevention's National STD Hotline, (800) 227-8922
› HIV-Age, http://hiv-age.org/
› HIVAids Tribe, https://support.therapytribe.com/hivaids-support-group/
› National (U.S.) AIDS Hotline, (800) 342-AIDS
› National HIV and STD Testing Resources, https://gettested.cdc.gov/
› National Institute on Aging, https://www.nia.nih.gov/health/hiv-aids-and-older-people
› Positively UK, http://positivelyuk.org/
› U.S. Department of Health and Human Services, AIDS Info,https://aidsinfo.nih.gov/

Food for Thought

› Because the incidence of infection in adults over age 50 is increasing, more effort needs to be made to provide routine screening and promote education and lifestyle changes for older adults at risk
› Black and Hispanic older adults in the United States and Aborginal older adults in Canada are at disproportionate risk of HIV/AIDS (Brennan et al., 2011)
› Of adults with a new HIV diagnosis at age 50 or older, African Americans comprise 43%, Whites make up 37%, and Hispanics make up 16% (CDC, 2017a)
› Illicit drugs may be an issue for older adults with HIV. In one study, 24.9% of the study population of HIV-positive adults over the age of 50 were current drug users compared to 9.4% of older adults without HIV (Skalski et al., 2013)

› The majority of research on HIV in older adults is focused on the aging population living with HIV and not on older adults in whom HIV is newly diagnosed (Ellman et al., 2014)
› Researchers found that older adults were more likely to receive a new diagnosis of HIV in an inpatient setting, have lower CD4 cell counts, and have an AIDS-defining illness at the time of diagnosis when compared to the younger study population. HIV and AIDS were concurrently diagnosed in 68.9% of the older age group compared to 38.9% of the 18- to 49-year-old age group (Ellman et al., 2014)
› More than half of Americans living with HIV are men who self-identify as gay or bisexual. There is a need for cultural competency in regard to the needs of gay individuals in elder care (Cahill & Valadez, 2013).

Red Flags

› Older adults with HIV suffer higher rates of chronic diseases due to weakened immune systems and the effects of ARVs; they are more likely to be on multiple medications and are at risk for drug interactions (Wing, 2016)
› Current screening guidelines for HIV testing in medical settings are for individuals ages 13 to 64 and do not include those age 65 and older (Ellman et al.,2014)
› It is estimated that one-fifth of persons in the United States who are infected with HIV are not yet diagnosed (Katz, 2017)
› Sexual health needs of older adults with AIDS should not be overlooked. Research literature indicates that between 15 – 47% of older adults with HIV are in sexually active relationships and practice risk reduction strategies (Brennan et al., 2011)
› Advance care planning is beneficial for all adults, but particularly recommended for older adults and persons with chronic life-limitingillnesses
› A high proportion (between 22 – 50%) of persons with HIV/AIDS meet criteria for depression (Brennan et al., 2011)

Discharge Planning

› Stress the importance of adhering to the specified drug regimen
› Educate the individual on preventing the spread of the disease; discuss safe sex, address the need to use clean needles, and offer support services including follow-up counseling
› Educate the individual on avoiding secondary infections and provide necessary resources
› Refer for medical, financial, and counseling services as indicated

DSM 5 Codes

› [Major or mild neurocognitive disorder due to HIV infection, 294.1x]

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