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Sexual Health Risk Behaviors Among Older Men Who Have Sex With Men: Implications for Interventions

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Sexual health risk behaviors, HIV and sexually transmitted infection (STI) transmission, substance use, stigma, and loneliness among older men who have sex with men are discussed. Implications for interventions are provided, including (a) assessment of health-related risk behaviors, (b) brief interventions, (c) HIV and STI screening, and (d) relevant developmental and contextual factors.

Keywords: sex, aging, interventions, older MSM

In one of the most comprehensive surveys of sexual attitudes and behaviors conducted with Americans between the ages of 57 and 85 years, Lindau et al. (2007) reported that Americans remain sexually active well into their older age. Older adults navigate their sexual lives in the context of their life-span development, adjusting to hormonal and vascular changes, physical and mental health concerns, and coping with the loss of significant loved ones (National Institute on Aging, 2009). Additionally, aging Americans have to cope with the stigma of ageism and a culture that places a strong emphasis on youth and sexuality (DeLamater & Sill, 2005). Because life expectancy has been steadily increasing for older Americans (National Institute on Aging, 2011), counselors will likely encounter sexuality-related issues with this population. More important, given the social and political changes that have occurred in the United States with sexual minority populations, counselors are likely to encounter individuals with various sexual expressions, including older men who have sex with men (MSM).

The early pioneering work concerning older MSM indicated that those living over the age of 50 years were sexually active, maintained an ability to perform sexually, reported no change in levels of sexual enjoyment with other men, and

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were satisfied with their sexual lives (Berger, 1982; Kelly, 1977; Kimmel, 1978; Pope & Schulz, 1991). Today, older MSM have an active sex life and enjoy sex as any other group of men—younger or older; gay, bisexual, or heterosexual (Fish, 2012; Pope, Wierzalis, Barrett, & Rankins, 2007). However, sexuality scholars have been researching high-risk sexual behaviors of older adults (e.g., Cooperman, Arnsten, & Klein, 2007; Orel, Spence, & Steele, 2005), and recent research studies have extended these findings to include a subsample of older MSM (e.g., Lim et al., 2012; Lovejoy et al., 2008). It is essential that counselors understand the behavioral and psychological correlates associated with sexual at-risk behaviors to facilitate affirmative and effective interventions with older MSM. With fewer reported HIV-related deaths as a result of medical advancements (Rosenfeld, Bartlam, & Smith, 2012), counselors will need to understand the contextual intricacies that encompass the lives of older MSM. In this article, we review the empirical literature on at-risk sexual behaviors among older MSM, explore correlates associated with at-risk sexual behaviors, and discuss recommendations for intervention.

SEXUAL RISK BEHAVIORS AMONG OLDER MSM

Some older MSM seek sexual connections through nurturing committed relationships, whereas others find connection through casual sexual encounters, sexual friendships, or even paying for sex (Pope et al., 2007). The venues for finding partners for intimate sexual relationships also vary. Older MSM use bars, sex clubs, and bathhouses as venues for sexual networking opportunities (Jacobs et al., 2010), but they are also using the Internet to develop sexual networks (Fernandez et al., 2005; Halkitis & Parsons, 2003; Hospers, Harterink, & Veenstra, 2002; Tsui & Lau, 2010; Wilson, Cook, McGaskey, Rowe, & Dennis, 2008). In addition to the various venues that older MSM may be using to find sexual partners, older MSM report having multiple sexual partners. In a probabilistic random sample of 507 older MSM living in New York City, Chicago, San Francisco, and Los Angeles, Dolcini, Catania, Stall, and Pollack (2003) found that approximately 25% of men between the ages of 60 and 69 reported nine or more sexual partners, whereas 15% reported 15 or more sexual partners during the past 12 months of participating in the study. These sexual-related behaviors are oftentimes associated with the transmission of sexually transmitted infections (STIs) and HIV, reduced condom use, substance use, stigma, loneliness, and loss.

STIs, HIV, and Disclosure

Among older adults, Calvet (2003) highlighted that there are substantial risks for acquiring STIs such as gonorrhea, herpes, syphilis, HIV, and HPV (human papillomavirus). By 2015, adults age 50 and older will make up approximately 50% of all HIV/AIDS cases in the United States (Effros et al., 2008), and older

MSM may be especially at risk for HIV infection. In 2008, the Centers for Disease Control and Prevention (CDC) reported that rates of HIV infection were steadily increasing among older MSM (CDC, 2008). Data collected from 46 states between 2007 and 2009 revealed that the number of new HIV infections among older Americans (50 years or older) increased nearly 22%, from 209,433 to 256,259 (CDC, 2013). Most of the infections were among men, and approximately 60% of these new infections were contracted via male-to-male sexual contact (CDC, 2013).

Disclosure of STI/HIV status is another factor to consider with older MSM, and the tenets of social exchange theory could potentially explain why older MSM may or may not disclose their status. From a social exchange theory framework, Serovich (2001) described that HIV-positive men may avoid disclosure and gravitate toward rewarding consequences that maximize behavioral or relational profits (e.g., avoid fear of rejection for acceptance). There is already a documented trend showing that HIV-positive MSM may not necessarily disclose their HIV status during every sexual encounter (Marks & Crepaz, 2001; Rosser et al., 2008). Klitzman et al. (2007) found that one fifth of a sample of 1,828 HIV-positive MSM reported unprotected anal sex with a casual partner without disclosing their HIV status, and being on antiretroviral medication for HIV was not significantly correlated with disclosure of HIV. With the success of numerous antiretroviral regimens to help combat the effects of viral infections, older MSM may be less inclined to disclose their HIV/STI status.

Condom Use

Although not exclusively the only mode of transmission, STI and HIV infections are commonly associated with not using condoms during sexual encounters with a known or unknown infected partner. In a study examining sexual behaviors among adults 50 years or older living with HIV/AIDS, Lovejoy et al. (2008) reported among their MSM subsample that 37% did not regularly use condoms during sex in the past 3 months. Jacobs et al. (2010) conducted a self-report, quantitative study on 802 MSM ages 40 to 94 years from South Florida and explored significant factors that were associated with unprotected receptive and insertive anal sex. Gathering the sample from community venues (e.g., bars, social events), Jacobs et al. reported that 87% of the sexually active men in the sample, including those between the ages of 60 and 94, did not use a condom during receptive or insertive anal sex with at least one sexual partner in the last 6 months. Jacobs et al. also reported that having an HIV-positive status was significantly associated with a higher risk of unprotected anal sex, both as the receptive and insertive partner, particularly with men ages 40 to 59.

In a content review of 58 peer-reviewed empirical research studies that examined HIV and aging, Sankar, Nevedal, Neufeld, Berry, and Luborsky (2011) concluded that older adults did not consider themselves to be at risk for HIV infection and were more reluctant to take preventive measures

than younger adults. Additionally, knowledge regarding the seriousness and the perceived threat of acquiring HIV does not necessarily lead to increased condom use among older adults (Illa et al., 2008; Maes & Louis, 2003). Through a series of qualitative interviews with 27 gay men over the age of 40 years living with HIV, Murray and Adam (2001) found that the men in the sample attributed unsafe sex to condom fatigue and difficulty maintaining an erection with a condom. They also concluded that older HIV-positive MSM may be more willing to succumb to a partner's request to have unprotected sex for fear of being rejected, and a lack of assertiveness skills related to negotiating safe sex practices was also noted as a predictor.

Substance Use

Ober, Shoptaw, Wang, Gorbach, and Weiss (2009) examined 779 racially diverse (51% non-Hispanic Black, 24% Hispanic, 20% non-Hispanic White, and 5% other) MSM living in Los Angeles and found that approximately 19% of MSM over the age of 49 years used methamphetamine or crack during their last sexual encounter. Additionally, Ober et al. reported that having unprotected anal sex (insertive or receptive status was not mentioned in the study), performing sex in public, exchanging sex for drugs or money, and having a higher number of sex partners were all factors associated with higher drug use among lower income older MSM.

Heath, Lanoye, and Maesto (2012) reviewed nine studies related to alcohol, substance use, and risky sexual behavior with MSM over the age of 50. They concluded that the use of alcohol and drugs in the past year, including marijuana, crystal meth, and cocaine, increased the likelihood of engaging in at-risk sexual behavior, such as unprotected anal or oral sex with partners of unknown HIV status. Moreover, findings from studies suggested alcohol and drug use contributed to higher rates of HIV infection (Heath et al., 2012). This finding is especially concerning given data that suggest that older MSM do not perceive HIV to be a serious health threat (MacKellar et al., 2007).

Lim et al. (2012) analyzed longitudinal data that were collected in Pittsburgh, Pennsylvania, consisting of 237 MSM between the ages of 50 and 59.5. They tracked the number of reported sexual partners, frequency of substance use, depressive symptoms, attitudes on sex, and venues for seeking sexual partners. Using Nagin's group-based longitudinal modeling procedures, Lim et al. identified a high-risk group of 27 MSM. Members of this group reported 30 or more sexual partners within the span of 6 months; were more likely to be predominantly White/European American; reported higher use of marijuana, poppers, crack, and cocaine; and reported not using a condom during insertive and receptive anal sex. In addition to recreational drug use, male erectile enhancement drugs (e.g., Viagra) are also predictive of unprotected anal sexual encounters among older MSM (Jacobs et al., 2010).

Stigma

Commonalities exist between older heterosexual men and older MSM with regard to health, finances, and companionship (Berger & Kelly, 2002). However, older MSM have to cope with sexual identity sigma, such as heterosexism (Brown & Cocker, 2011), and anxiety over potential discrimination (Stein, Beckerman, & Sherman, 2010). There is also evidence that suggests a gender difference with regard to the experience of sexual identity stigma. Grossman, D'Augelli, and O'Connell (2002) surveyed 416 lesbian, gay, and bisexual (LGB) persons between the ages of 60 to 91 living across the United States and found that rates of internalized heterosexism were higher among aging sexual minority men than sexual minority women. Among MSM, internalized heterosexism correlates with decreased feelings of self-esteem, fewer social supports, depression and psychological distress, body dissatisfaction, and increased propensity to use substances (Szymanski, Kashubeck-West, & Meyer, 2008).

According to Kimmel (2002), cohort effects could potentially influence the way older MSM respond to stigma, because older MSM developmentally matured during various historical and sociopolitical periods. David and Knight (2008) found that when compared with MSM in their 20s, MSM in their 60s were less likely to disclose their sexual identity and possessed significantly higher scores on a scale of negative attitudes toward homosexuality. Race may also affect perceptions of sexual identity stigma; older Black gay men were likely to report more stigma than younger Black gay men and White men (David & Knight, 2008). Along with the stigma attached to sexual identity, older MSM also have to contend with ageism (Chen, Androsiglio, & Ng, 2010; David & Knight, 2008). Schope (2005) surveyed older gay men and lesbians and found that gay men indicated more negative views of growing older, were more ageist, and placed more importance on physical attractiveness compared with lesbian women. Additionally, older MSM have been traditionally stereotyped as being either asexual (Fish, 2012) or predatory toward younger MSM (Berger & Kelly, 2002). These stigmatizing stereotypes have the potential to increase fears of rejection and decrease perceptions of self-esteem and self-worth (Fish, 2012).

Loneliness and Loss

Older MSM report feelings of loneliness, isolation, and lack of companionship and are more likely to live alone compared with their heterosexual counterparts (Brown & Cocker, 2011; Fish, 2012; Stein et al., 2010; Wierzalis, Barret, Pope, & Rankins, 2006). Grossman et al. (2002) found that gay and bisexual men were more likely to feel responsible for their loneliness; for MSM, loneliness may be the result of having lost friends and intimate partners to HIV and AIDS. Grossman et al. reported that nearly 90% of all the LGB persons over the age of 60 knew someone in their lifetime who died of advanced HIV/AIDS-related causes. Rosenfeld et al. (2012) reviewed epidemiological data of AIDS-related deaths between 1987 and 1998 and concluded that the HIV/

AIDS epidemic was such a profoundly contextual and historical event that it significantly shaped the lives of baby boomers who have entered or are now beginning to enter older adulthood. Many older MSM witnessed significant loved ones die in their lifetime, possibly rendering older MSM with feelings of loss and loneliness.

The experience of loneliness could exacerbate the proclivity to engage in at-risk sexual behaviors (Hubach, DiStefano, & Wood, 2012). In a sample of HIV-positive adults over the age of 50 living in New York City (which included both MSM and heterosexual men and women), loneliness was found to be predictive of unprotected sex (Kott, 2011). When looking specifically at MSM, Martin and Knox (1997) found that MSM who reported unprotected anal intercourse with nonprimary sexual partners scored higher on ratings of loneliness compared with MSM who had a primary sexual partner. Shernoff (2005) reported that sexual behavior functions as a coping mechanism for lonely and isolated MSM and that unprotected anal intercourse is a method some MSM use to decrease feelings of loneliness (Halkitis, Siconolfi, Fumerton, & Barlup, 2008).

RECOMMENDATIONS FOR INTERVENTION

Much of the existing literature on risk behaviors related to sexual health among older MSM provides epidemiologists, public health scholars, social scientists, and medical and behavioral health professionals with essential insight into the lives of this population. Although not all older MSM demonstrate some of the aforementioned risk behaviors or potential contextual correlates (i.e., internalized heterosexism, loneliness), it is important that the sexual lives of older MSM are attended to in a respectful and dignified manner. Much of the cited literature on the health-related behaviors of older MSM (e.g., Heath et al., 2012; Jacobs et al., 2010; Lim et al., 2012) was not necessarily written for professional counselors (e.g., mental health, rehabilitation, marriage, and family) or for health professionals providing behavioral-based interventions to assist with the reduction of risk behaviors or its contextual correlates. To date, there are few, if any, clinically based recommendations for interventions with the older MSM population.

Older MSM could seek counseling for an array of reasons, and it is important that any professional providing therapeutic services take a holistic view of sexual health and well-being. Grounded in the cited empirical studies and theoretical scholarship on older MSM, the following recommendations for assessment, counseling, and intervention are provided: (a) thorough assessment of health-related risk behaviors, specifically sexual risk behavior and substance use; (b) execution of brief interventions; (c) HIV and STI screening; and (d) addressing contextual factors during assessment and counseling, specifically sexual orientation and age-related stigma, loneliness, and sexual networking.

Assessment of Health-Related Risk Behaviors

Sexual risk behaviors. Counselors are encouraged to assess older MSM clients for potential high-risk sexual health behaviors in a nonshaming and nonjudgmental manner. It is best to assess behaviors once there is an established therapeutic alliance. As a result of cohort effects (Kimmel, 2002), historical and cultural rules of communication may dictate how much older MSMs may disclose about their sexual behavior in early counseling sessions. Counselors should assess for the number of different partners; the degree to which condoms are used across all sexual encounters (i.e., every sexual encounter, anal sex, oral sex); the potential that a client exhibits fatigue over monitoring safe-sex behavior (safe-sex fatigue); the degree to which the client likes uninhibited sexual encounters (in public and private); and particular knowledge, cognitions, and affect related to contracting HIV and other STIs (Lim et al., 2012; Lovejoy et al., 2008; MacKellar et al., 2007). Furthermore, counselors should inquire whether their clients are practicing unsafe sex as the insertive partner, the receptive partner, or both (referred to in the MSM community as "top," "bottom," and "versatile," respectively). Lastly, depending on the degree of risk that is assessed, counselors should inquire about whether or not their older MSM client is exchanging sex for money or drugs (Ober et al., 2009).

Counselors may want to consult Fisher, Davis, Yarber, and Davis's (2010) text titled *Handbook of Sexuality-Related Measures* for potential structured questionnaires and inventories around sexuality. Although many of the measures published in the text have been used in research, some of the measures offer clinical utility for counseling. Additionally, not all of the published measures lend themselves to older MSM, but the text does offer a variety of measures that could be tailored to this population, by offering inventories on sexual risk behavior, aging and sexuality, condom use, and sexual communication practice.

Substance use. It is important to expand the conversation of safe sex beyond just the use of latex condoms during oral or anal sex and to include the reduction of alcohol and drugs as part of risk reduction campaigns. Older MSM report alcohol use and drug use during sex (Heath et al., 2012; Ober et al., 2009), which influence the proclivity to engage in risky sexual behavior. It is important for counselors to assess not only the amount and type of substance use but also the degree in which alcohol and drugs are used in conjunction with sexual activity. It is also important to explore potential triggers that lead to substance use, such as combating feelings of loneliness (Martin & Knox, 1997), fears related to potential rejection (Fish, 2012; Stein et al., 2010), or the desire for connection and sexual intimacy (Murray & Adam, 2001).

Of course, this conversation on drug use also includes male erectile enhancement drugs, such as Viagra, which have become significantly associated with at-risk sexual behavior (Jacobs et al., 2010; Lim et al., 2012). Counselors should assess and explore how male enhancement drugs are used in conjunction with a client's sexual behavior. The extent to which male erectile enhancement drugs

are used in conjunction with other substances should also be explored, and counselors should encourage older MSM to consult their medical physicians regarding any harmful interactions. Jacobs et al. (2010) suspected that Viagra use was connected to anxiety about potential sexual inadequacies and functioning; therefore, counselors should address potential anxieties about sexual performance with older gay men to promote more satisfaction with safe sex.

Brief Interventions

Brief interventions consist of education, assessment, and counseling. The use of brief interventions to help facilitate the reduction of both high-risk sexual behavior and HIV transmission has been advocated by scholars and health professionals (CDC, 2001; Crepaz et al., 2006; Illa et al., 2008; Weinhardt, Carey, Johnson, & Bickham, 1999). Counselors could combine various brief interventions discussed in this section to help older MSM reduce risk behaviors that make them susceptible to transmitting or acquiring STI or HIV.

The CDC (2001) encouraged the use of the client-centered HIV prevention counseling approach, which consists of a personalized risk assessment, education on HIV transmission, exploration of past attempts to reduce risky behavior, and helping clients commit to behavioral changes. In a meta-analysis of studies published between 1985 and 1997 on the effectiveness of brief interventions, Weinhardt et al. (1999) found that HIV-positive participants increased condom use after testing and counseling, whereas HIV-negative participants did not necessarily modify their behavior more than untested participants after participating in testing and counseling. In another meta-analysis from studies conducted between 1988 and 2004, Crepaz et al. (2006) stated that behavioral-based interventions significantly reduced unprotected sex and decreased the transmission and acquisition of STIs. Crepaz et al. concluded that interventions that were delivered by health care providers or counselors in intensive and individual modalities that were focused on skill building and other life issues, such as mental health and medication adherence, significantly facilitated the reduction of sexual risk behaviors.

Brief interventions have also been geared specifically at MSM. In a randomized control trial with MSM between the ages of 18 and 49 years, Dilley et al. (2002) reported that a single-session counseling intervention focused on changing thoughts, attitudes, and beliefs (referred to as personalized cognitive counseling) was effective in reducing high-risk sexual behaviors among MSM. In another randomized control trial that tested the effectiveness of personalized cognitive counseling, in which approximately 22.5% of those in the treatment group were over the age of 40, Dilley et al. (2007) found that the intervention facilitated by paraprofessional counselors was effective in reducing the frequency of unprotected anal intercourse among MSM. However, despite the reduction of high-risk sexual behavior, Dilley et al. also noted that there was no significant difference between personalized cognitive counseling and the control condition, which was "counseling as usual."

More recently, Safren, O'Cleirigh, Skeer, Elsesser, and Mayer (2013) tested a time-limited intervention (Project Enhance) that focused on assessment, education, and motivational interviewing techniques to facilitate behavior change in a randomized control trial with MSM. Participants in the study were 40 years of age on average, and Project Enhance specifically focused on educating participants on HIV transmission, use of substances before and during sexual encounters, managing life stress, and cultural concerns regarding sexuality. Although the proposed intervention was effective in reducing high-risk sexual behavior, it did not significantly differ from the comparison group (Safren et al., 2013).

Although none of the aforementioned brief interventions were specifically targeted toward older MSM, Project ROADMAP (Reeducating Older Adults in Maintaining AIDS Prevention; Illa et al., 2010) was one of the first proposed secondary prevention interventions for older adults living with HIV. The brief intervention was conducted in a group format in four sessions and focused on education, effects of HIV on sexual behavior, enhancing assertive communication skills, preventing relapse of at-risk sexual behaviors, and rewarding one's self for maintaining safe-sex behavior. In a randomized control trial that had approximately 16.7% self-identified MSM, data showed that there was an increase in knowledge regarding how HIV is transmitted and a decrease in unprotected sexual acts as a result of participating in Project ROADMAP (Illa et al., 2010).

Although not all of the aforementioned studies revealed significant differences from their control groups, the results were promising in that they showed a decrease in risk behaviors that are evidence based. Results from these studies suggest that there is a necessity for the continued development of brief interventions to reduce risk behaviors among older MSM.

HIV and STI Screening

Mental health professionals are in a special position to provide appropriate counseling in the area of HIV/STI screening, especially given their training and ability to build a therapeutic alliance. It is important to encourage, discuss, and explore the benefits of regular HIV/STI screening with older MSM, especially when the data indicate that this population is reporting having multiple unprotected anal and oral sex partners within a 12-month period (Dolcini et al., 2003). Data also indicated that older MSM are having sex with other HIV-positive men, may not know their partner's statuses, and are not necessarily using latex condoms during sex (Heath et al., 2012; Klitzman et al., 2007). These factors increase the risk for HIV and STI transmission; therefore, it is important to test and screen regularly depending on the level of sexual activity an older MSM may report.

Another recommendation is to teach older MSM not only to ask, "What is your HIV status?" but also, "When was the last time you were tested? For what were you tested? What were the results of those tests?" Although some clients may say that those series of questions may "kill the sexual mood," it may open up a dialogue around sexual health and empower older MSM to have more

control over their sexuality. Lastly, counselors who are employed in health care settings should discuss the implications of STI screening among medical health care providers. Counselors could explore any potential resistance or hesitancy among medical professionals to test and screen older MSM for HIV/STIs.

Addressing Contextual Factors During Assessment and Counseling

Stigma. Counselors should assess and address internalized heterosexism and ageism given their prevalence among older MSM (David & Knight, 2008; Grossman et al., 2002) and their significant psychosocial correlates (Szymanski et al., 2008). Among older MSM, internalized heterosexism is a significant predictor of substance use and unprotected receptive anal sex (Jacobs et al., 2010) and has also been linked with loneliness (Brown & Cocker, 2011; Fish, 2012; Stein et al., 2010; Wierzalis et al., 2006). Internalized heterosexism is one of the most significant psychosocial stressors that could explain why older MSM may be willing to engage in drug use and unprotected anal sex.

Hunter (2012) recommended a combination of liberation, feminist/profeminist, and affirmative counseling practices to address stigma in individual, group, or couples counseling. Specifically, these approaches address and help a client challenge oppressive societal, cultural, and political processes that sanction behavior and identity that may be rooted in gender, heterosexism, and ageism. It may be beneficial for counselors to help their clients develop a conscious awareness of their own level of internalized heterosexism and ageism, as well as how they may facilitate unhealthy substance use and high-risk sexual behavior and enhance negative affective states. Counselors may also want to address the connection that internalized heterosexism and ageism have with feelings of attractiveness and the perceptions that one has with regard to how society, and in particular, the gay male community, view aging MSM (Schope, 2005). Addressing internalized heterosexism and ageism in counseling may promote better self-esteem, more affirmative and positive views of aging among MSM, and less risky sexual and substance use behavior.

Loneliness. A significant proportion of older MSM have lost friends and significant loved ones to HIV and AIDS and other diseases (Fish, 2012; Grossman et al., 2002; Rosenfeld et al., 2012; Wierzalis et al., 2006) and, as a result, may experience extreme loneliness; isolation; distress around aging, sexuality, and intimacy; and fear around HIV and AIDS (Pope et al., 2007). Also, older MSM who are lonely may seek out potentially risky venues for sex, such as public venues, sex clubs, and bathhouses. Counselors could help their older MSM clients understand the significance and meaning behind their loneliness, while helping to resolve any fears and anxieties concerning the contextual significance of loneliness. Counselors should make sure to validate the personal networks (e.g., friends, family of choice) of older MSM (Fish, 2012) and help advocate for more inclusivity and less stigma in older adult residential facilities (Stein et al., 2010). Counselors are encouraged to help motivate and empower their

older MSM clients to establish emotionally fulfilling and meaningful intimate connections with other MSM and help their clients explore venues for sexual connection that are safe and satisfying and that elevate feelings of self-worth. Specifically, Pope et al. (2007) recommended that older MSM connect with subcultures within the MSM community, such as the "bear," "leather," or "BDSM" (bondage and discipline, sadism and masochism) communities that may be less discriminatory of older MSM. Counselors are especially encouraged to attend gay pride events, consult with local LGB organizations, and conduct their own research on the Internet to learn of local community resources that are available for older MSM.

Changes in sexual networking. An area of investigation needing scholarly expansion pertains to how older MSM encounter potential partners for sex and intimacy. Bars/clubs, bathhouses, and sex clubs are potential venues for sexual networking (Jacobs et al., 2010; Lim et al., 2012; Pope et al., 2007), but older MSM are also using the Internet (e.g., Craigslist, Gay.com) and mobile-based (smart phone) applications (e.g., Grindr, Scruff) to meet sexual partners. Although use of such platforms use could be a positive venue for meeting other MSM in the hopes of reducing loneliness and isolation, the anonymity associated with the Internet and mobile applications poses a potential threat for increased sexual risk behaviors.

More recently, researchers have started to examine the potential risk associated with using technology for sexual encounters, and some studies have suggested that those who used the Internet to seek partners practice more sexual risk-taking behaviors and are therefore at an increased risk for STIs or HIV (Fernandez et al., 2005; Halkitis & Parsons, 2003; Hospers et al., 2002; Tsui & Lau, 2010; Wilson et al., 2008). Therefore, counselors should expand their knowledge on the use of web-based programs and mobile technology applications that are used by older MSM and explore with their clients how these technologies are used in the clients' life. It may be possible that by exploring the use of technology in counseling, high-risk behaviors could be reduced and prevented.

CONCLUSION

Counselors should understand that in order to provide affirmative interventions that address the sexual lives of older MSM, they must understand the diversity of issues that are associated with behavioral and psychological health. As Pope et al. (2007) indicated, there are unique issues that affect the sexual lives of older MSM, and these should be accounted for when facilitating interventions geared toward sexuality and sexual health. Issues such as substance use, sexual identity stigma, ageism, changes in technology and sexual networking, and loneliness should be considered as some of the contextual factors that intersect with sexual health. Sex is an important component to overall health, and older MSM deserve satisfying sexual lives.

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