Body Image and the Complications of HIV Treatment

Elizabeth Chapman, PhD

Over the past few years the picture of HIV has changed considerably as people have gained access to effective HIV combination treatment. The advent of these new medications has led to the perception that HIV is a chronic, containable, and easily managed condition. This picture, however, is not completely accurate: there are formidable hurdles to adhering to HIV antiviral therapy and ongoing problems for those who succeed.

Although some people with HIV experience a rapid recovery to health, many also experience considerable anxiety about an expanding future, uncertainty about continuing health, and guilt about surviving. For some individuals, the schedule of medications is daunting and the side effects are intolerable. For others, either hoped-for recovery does not materialize or an assortment of less threatening problems continues to undermine the quality of their lives. One of the most significant of these complaints is medication side effects that have a visible effect on an individual’s body image. This article discusses the relatively under-explored area of HIV-related body image, focusing on the impact of medication side effects, specifically, lipodystrophy syndrome.

Defining Body Image

Body image is what we believe to be true about our bodies, the way that we perceive our bodies, and the way we feel about them. It consists of two components: attitude and perception. The attitudinal or evaluative component relates to feelings or beliefs individuals have about their bodies or certain areas of their bodies, in contrast to a purely perceptual focus that is related more to information about the actual shape or size of the body. Body image is dynamic. It changes over the course of time, and in the case of HIV, as health progresses to illness, and as illness progresses through recovery. It also varies in the context of social and representational forces. For instance, in Western cultures the representation of overweight female bodies is rarely a positive one. Larger women influenced by this representation may feel more negative about their bodies than they otherwise would.

Peter Slade describes body image as a loose mental representation influenced by factors such as weight change; biology; cultural and social norms; individual attitudes toward weight and shape; cognitive and affective variables; individual psychopathology; and an individual’s lifelong experience of physical contact. These various influences can be collapsed into three components. First, there is the objective way the body appears and performs. Second, there are the external views of society that incorporate social ideals and social forces, that is, the socially constructed nature of our lives. Third, there are the individual feelings and the psychological resources a person has, which can either modify or amplify the impact of both physical and representational influences.

For example, HIV impacts the body not only through the physical aspects of immune system depletion, visible signs of illness, and the unpredictable course of disease, but also through symbolic aspects. There are crucial elements specific to HIV such as the notions of contamination and pollution that may also lead to stigma and internalized stigma. However, the social context of HIV (and therefore the impact of these representations) has altered over recent years. More recent archetypes of people with HIV that dominate the news include the “AIDS survivor,” a representation that portrays the person in a largely hopeful light. This representation nonetheless continues to compete with the “AIDS carrier,”
Editorial: Out of Body
Robert Marks, Editor

The paradox of HIV treatment is that sometimes the cure feels worse than the disease, especially when treatment begins before symptoms arise. Sometimes the cure also looks worse than the disease. “Fat redistribution,” a side effect of antiviral treatment, can appear at a time when a person’s HIV disease might otherwise be invisible—both to others and to him or herself.

The effects of HIV on body image are not new. They existed before triple combination treatment and protease inhibitors. People with HIV became experts in hiding or at least adjusting to the lesions of Kaposi’s sarcoma, the impaired gait of toxoplasmosis or PML, the gauntness of HIV-related wasting, and the message that their bodies might be dangerous to others.

But the challenges to body image that occurred in the old days coincided with disease progression; now they also coincide with disease control. As Elizabeth Chapman and Paul Kunsberg point out in their articles in this issue of FOCUS, these challenges steal from people with HIV, who might otherwise begin to regain some sense of normalcy in their lives, the visible manifestation of wellness. As Kunsberg puts it, “HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.” The cure discloses the disease.

A Perfect World

In a perfect world, being identifiable as ill would be nothing worse than being identifiable as a doctor or an athlete, a size 7 shoe or an 8. But in our imperfect society, HIV disease—indeed, illness in general—is tied up in stigma and shame, and people with HIV are put at risk, emotionally and physically, by the uncontrolled disclosure of their condition.

Chapman and Kunsberg outline the full range of challenges brought on by HIV-related changes to the body. The potential effects are severe, but what comes through in both articles, and particularly in Kunsberg’s first-person account, is that psychological support can increase a person’s capacity to handle this assault on self-esteem.

Kunsberg came to terms, even transcended, his condition. His words, and Chapman’s analysis, make it clear that while “body image” is a condition rooted in a physical reality, it is ultimately tied to the much more fluid environment of the mind.

References
One of the key factors affecting the severity of the emotional response to body image changes is whether there are visible signs of a condition that allow someone to be labeled and stigmatized.


depending on the medications taken, whether an individual was over- or under-weight before the regimen, the stage of HIV infection at initiation of treatment, and racial background. Men and women tend to be affected differently. Women are more likely to experience upper body fat accumulation, including the enlargement of the breasts.

Research has largely focused on identifying lipodystrophy, defining its prevalence, and understanding the associated metabolic changes and physical manifestations. There is little research on the effects of the syndrome on emotional health or quality of life. One major problem is that the longer a person takes HIV antiviral treatment, the more likely it is that he or she will experience changes in appearance, and this has raised debate about when treatment should be instigated. For example, Keith Henry notes that delaying therapy may reduce the chances of side effects as well as reduce the risk of antiviral resistance. Current estimates, however, suggest that facial wasting often occurs rapidly—within three months of treatment initiation—and may be seen in approximately 30 to 40 percent of people taking HIV combination treatments.

Furthermore, instigating HIV antiviral treatment early in the course of disease can lead to the occurrence of treatment-related body changes before signs and symptoms of HIV itself, perhaps making these side effects even less acceptable. Individuals who have experienced the impact of opportunistic infections and perceive their lives to have been saved by antiviral medications may be more comfortable with body changes. Anecdotal reports, however, suggest that even in the face of improved health, quality of life and self-esteem may be compromised by visible side effects. As side effects become more intolerable, some individuals are no longer able to perceive medication as giving life, instead feeling that it has turned against them. As resentment builds, it can compromise medication adherence.

Some studies suggest that changing medication regimens or diet and exercise habits may improve body shape and reverse lipodystrophic abnormalities. These reversions of metabolic disturbances, however, do not always occur. In addition, the fat deposits associated with lipodystrophy are not soft like the ones associated with aging. They are more solid, harder to disperse, and more likely to surround the internal structures of the body than to lie just under the skin. These differences may relate to the way HIV antiviral drugs change the body’s processing of fats and sugars.

Since changing HIV treatment or stopping it entirely may not be effective or medically realistic, researchers are investigating a number of treatments that reverse or conceal the signs of lipodystrophy. Most medications, except for recombinant growth hormone, have not been found to be successful. In response, many patients are turning to cosmetic surgeons.

Among the treatments these providers offer are polylactic acid (New Fill), polymethyl methacrylate (PMMA), polyvinyl/polyacryamide gel (Evolution), and fat transfer injections. Polylactic acid, injected into the hollow of the cheek, stimulates the growth of collagen and the development of a thicker layer of skin that fills out wasted areas. PMMA and Evolution are gel substances that plump the facial wrinkles when injected into the cheek hollows, and fat transfer involves removing body fat from one part of the body and injecting it into the hollows of the face. To be effective, these treatments may need to be repeated and researchers have not clarified the longer-term consequences for any of them. Furthermore, access to such treatments through clinical trials is limited and private treatment can be expensive.

The Severity of Body Image Concerns

As noted above, one of the key factors in the severity of the emotional response to body image changes is whether there are visible signs of a condition that allow someone to be labeled and stigmatized. Visible side effects of anti-HIV medications fall into this category. They exert their impact partly by revealing to others that a person is taking HIV medications and partly by imitating the facial gauntness of wasting that occurs in latter stages of HIV disease. Even if there are no actual signs of rejection from others, individuals may experience internalized stigmatization.

The representational forces influencing...
body image have always been significant and are considered to be partly responsible for recent increases in anorexia and bulimia. Similarly, facial wasting, which alters the naso-labial folds around the mouth, can make a person appear much older, a challenge in a culture obsessed with youth and fitness. For others, who experience wasting in different areas of the body, feeling “too skinny,” sensing the discomfort of those around them, and being ridiculed may lead to despair. Some individuals tolerate bodily changes, for instance, weight loss or gain, better than others, but it may be particularly difficult to look sick when one feels well, or to look “askew” when facial weight loss strikes asymmetrically.

The psychological responses to body changes vary among different groups, and when people fail to live up to the ideal body image of the particular group with which they identify, they may feel stigmatized. Although body image has preoccupied women for some time, in the last three decades, men have become increasingly concerned with body image. Men and women tend to have different concerns about their bodies. Women often worry more about reducing the size of their thighs, hips, and buttocks, while men may focus more on increasing the size of their legs, shoulders, and arms.

Negative reactions may not only undermine HIV medical treatment, they may also lead to increased anxiety and depression, significant problems in social functioning, and reduced self-esteem. Some individuals may develop more serious psychiatric problems such as body dysmorphic disorder. People with body dysmorphic disorder obsess about their appearance, for example, excessively worrying that their skin is marked, their hair is too thin, or their legs are too short. It can be difficult to reassure people with body dysmorphic disorder that the flaw is not as extreme as they perceive it to be, and the condition may lead to suicide attempts. One's psychological profile before the onset of body image changes will be influential when dealing with the problem; whether one is depressed or anxious, whether one has high self-esteem or not, whether one is in a stable relationship or searching for a partner. All these factors influence coping patterns and adjustment to body image change.

Conclusion

Although one response to HIV-related body image changes is to propose that they are an unfortunate but justifiable side effect of battling HIV, preliminary research suggests that they may have serious effects on behavior and mental health. To enable people to cope with a changed body image, mental health and medical providers must acknowledge the potential effects, and offer access to cognitive-behavioral therapies and cosmetic surgery. Cognitive-behavioral therapy can prompt better coping with body image changes through the analysis of cognitive thought patterns and by teaching more adaptive ways of thinking about body image.

The cognitive aspect of therapy concerns ways of thinking: ideas, attitudes, assumptions, mental imagery, and ways of directing attention. The behavioral aspect is about helping someone meet the challenges and opportunities of their life with a calm mind and enabling them to take actions that have desirable results. Ultimately, however, decisions about whether to undertake psychotherapy or surgery will rest with an individual and his or her clinician as a joint decision and will be dependent on the availability of treatment centers and personal resources.

Clearinghouse: HIV and Body Image

References


It happened gradually at first. I began to notice subtle changes in my face and body. I ignored them initially, thinking they were my imagination, but over time they became more pronounced. Body fat had fallen off beyond my efforts at the gym. My stomach became hard and distended and my pants fit differently. Most troubling to me was the gradual disappearance of most of the fat from my face. At the same time, my cholesterol and triglyceride counts had risen to alarming levels.

I looked in the mirror one day and I no longer saw the person that I had been. When one of my dates picked up a photograph and asked, "Who’s the cute guy in the suit," I was daunted. The guy was me—only a few years earlier.

The media added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary.

The media added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary.

Medical reports of unforeseen treatment side effects began to corroborate what was happening to me. The media described a spectrum of new conditions and added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary. For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose—or not to disclose—had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.

Accompanying my awareness of these physical changes were anxiety, depression, and emotionally charged issues that I thought I had resolved. I felt exposed and strangely confused about why I cared so much about feeling exposed. I was blindsided by how much of my sense of self was tied up in appearance. I thought I was more “evolved” than this response implied, that my sense of self was stronger. I also thought I had come to terms with having HIV. As I lost my choice to disclose, I was confronted by my status in a way that made me feel I had to come out of the HIV closet again. In the past, my strategy for disclosure both personally and professionally had been to establish connections with people I trusted, and trust that those I chose to tell would not really care. Something that had been part of my private life suddenly felt available to the public, and I had no choice about it.

As I began to sort out my own internal responses to what was happening to my face and body, I also began to cope with the obvious scrutiny of others. My condition became more evident to those around me, and I realized that I had to address the implications of this new reality.

Ugly Words

Medical reports of unforeseen treatment side effects began to corroborate what was happening to me. The media described a spectrum of new conditions and added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary. For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose—or not to disclose—had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.

Accompanying my awareness of these physical changes were anxiety, depression, and emotionally charged issues that I thought I had resolved. I felt exposed and strangely confused about why I cared so much about feeling exposed. I was blindsided by how much of my sense of self was tied up in appearance. I thought I was more “evolved” than this response implied, that my sense of self was stronger. I also thought I had come to terms with having HIV. As I lost my choice to disclose, I was confronted by my status in a way that made me feel I had to come out of the HIV closet again. In the past, my strategy for disclosure both personally and professionally had been to establish connections with people I trusted, and trust that those I chose to tell would not really care. Something that had been part of my private life suddenly felt available to the public, and I had no choice about it.

As I began to sort out my own internal responses to what was happening to my face and body, I also began to cope with the obvious scrutiny of others. My condition became more evident to those around me, and I realized that I had to address the implications of this new reality.

Ugly Words

Medical reports of unforeseen treatment side effects began to corroborate what was happening to me. The media described a spectrum of new conditions and added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary. For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose—or not to disclose—had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.

Accompanying my awareness of these physical changes were anxiety, depression, and emotionally charged issues that I thought I had resolved. I felt exposed and strangely confused about why I cared so much about feeling exposed. I was blindsided by how much of my sense of self was tied up in appearance. I thought I was more “evolved” than this response implied, that my sense of self was stronger. I also thought I had come to terms with having HIV. As I lost my choice to disclose, I was confronted by my status in a way that made me feel I had to come out of the HIV closet again. In the past, my strategy for disclosure both personally and professionally had been to establish connections with people I trusted, and trust that those I chose to tell would not really care. Something that had been part of my private life suddenly felt available to the public, and I had no choice about it.

As I began to sort out my own internal responses to what was happening to my face and body, I also began to cope with the obvious scrutiny of others. My condition became more evident to those around me, and I realized that I had to address the implications of this new reality.

Ugly Words

Medical reports of unforeseen treatment side effects began to corroborate what was happening to me. The media described a spectrum of new conditions and added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary. For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose—or not to disclose—had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.

Accompanying my awareness of these physical changes were anxiety, depression, and emotionally charged issues that I thought I had resolved. I felt exposed and strangely confused about why I cared so much about feeling exposed. I was blindsided by how much of my sense of self was tied up in appearance. I thought I was more “evolved” than this response implied, that my sense of self was stronger. I also thought I had come to terms with having HIV. As I lost my choice to disclose, I was confronted by my status in a way that made me feel I had to come out of the HIV closet again. In the past, my strategy for disclosure both personally and professionally had been to establish connections with people I trusted, and trust that those I chose to tell would not really care. Something that had been part of my private life suddenly felt available to the public, and I had no choice about it.

As I began to sort out my own internal responses to what was happening to my face and body, I also began to cope with the obvious scrutiny of others. My condition became more evident to those around me, and I realized that I had to address the implications of this new reality.

Ugly Words

Medical reports of unforeseen treatment side effects began to corroborate what was happening to me. The media described a spectrum of new conditions and added ugly words like “lipodystrophy,” “protease paunch,” and “buffalo hump” to my AIDS vocabulary. For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose—or not to disclose—had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.

Accompanying my awareness of these physical changes were anxiety, depression, and emotionally charged issues that I thought I had resolved. I felt exposed and strangely confused about why I cared so much about feeling exposed. I was blindsided by how much of my sense of self was tied up in appearance. I thought I was more “evolved” than this response implied, that my sense of self was stronger. I also thought I had come to terms with having HIV. As I lost my choice to disclose, I was confronted by my status in a way that made me feel I had to come out of the HIV closet again. In the past, my strategy for disclosure both personally and professionally had been to establish connections with people I trusted, and trust that those I chose to tell would not really care. Something that had been part of my private life suddenly felt available to the public, and I had no choice about it.

As I began to sort out my own internal responses to what was happening to my face and body, I also began to cope with the obvious scrutiny of others. My condition became more evident to those around me, and I realized that I had to address the implications of this new reality.
me, and I felt subject to the same stigma that comes with the recognition of any disease. This stigma was compounded by the fact that HIV is transmitted sexually. I had difficulty separating my own emotionally charged perception of what was happening from responses that ran the gamut from rejection to concern. I realized several things were going on.

My Mirror Image

Beyond the feeling of exposure every time I looked in the mirror, I faced a new image that to me, was unattractive. I realized how much I was a victim of society’s “looks” consciousness, and as a single gay man I felt uncomfortably aware of the changes in my appearance. The media warned that cosmetic changes might be one of the prices to be paid for extended life. I agreed, and that made me feel even worse. I felt guilty for complaining to my doctor about what was happening to my face and body, aware of the fact that without the drugs causing these changes, I would most likely not be having the conversation at all.

My looks were definitely changing, and I was internalizing as absolute judgments my own perceptions about my appearance. Beyond that, the response of others towards me—towards my appearance—was different now and that was troubling. Whether it was friends and family who knew me before or men cruising me on the street and turning away, I felt rejection. What was happening seemed similar to the aging process. Unlike the gradual appearance of lines around the eyes and a few gray hairs, however, the velocity of my experience made it feel out of control. The physical changes happened so fast that I could not keep up with my emotional responses to them.

I grappled with the fact that I was in turmoil over what seemed to be a superficial issue—my appearance—in light of my relative health. I lost sight of my gratitude for feeling pretty well while many people around me were suffering from more serious concerns. It became apparent that if I left this confusion of feelings unresolved, I would risk the quality of my life. I recognized that this was another challenge in the experience of living with HIV, and that if I did not address my rejection of myself, I would become further isolated and depressed.

I mounted an attack on two fronts: physical and emotional. My doctor and I reviewed my HIV medications and made changes. I added steroids, new vitamins, and Chinese herbs to my regimen. I adjusted my workouts at the gym, started acupuncture, and began practicing Yoga. I consulted a nutritionist and changed my diet. As I began to feel better physically my cholesterol and triglyceride levels improved.

At the same time, I briefly joined a support group, restarted therapy, and began doing volunteer work. I talked honestly with family and friends about what was happening. Processing my feelings helped me deflate the magnitude of the challenges I was facing. I had turned too far inward and had given more power to these physical changes than they deserved. It felt as if my projection of fear, embarrassment, and shame undermined how I was being perceived by others, and it definitely had a negative impact on my self-perception.

It was cathartic to share with others what was happening to me. Beyond the release of pent-up feelings, I realized by their responses to my comments that what I had projected on the rest of the world was not always what the rest of the world saw. I also realized it was okay for me to feel bad about the shift in my appearance. As my panic subsided, I was able to see that much of my life was the same; despite the changes in the mirror, I was still me. Most importantly, I came to understand that what I bring to the world from the inside matters most to both myself and to others. As I regained this more broadly defined sense of self, I began to feel better.

Conclusion

The challenge continues and finding balance is an ongoing goal. The reality is that my looks are different now and sometimes that is difficult, but I feel a renewed sense of what it means to be a long-term survivor and an obligation to engage in my life. There are things that have happened that I cannot change. I am grateful to be here—learning to live with them.

Authors

Paul Kunsberg is a resident of San Francisco and has been living with HIV since 1988.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Weight Loss and Body Image in Gay Men

A small qualitative study of HIV-positive gay men found that HIV-related weight loss increases self-consciousness in social interactions, particularly when meeting new people or visiting with family. Participants who had disclosed their HIV status voiced concerns that their emaciated appearance might cause anxiety about their disease progression, and participants who had not revealed their status feared that their appearance disclosed their status for them.

Researchers sent eight gay men, ages 26 to 43, a 13-item questionnaire asking them to rate their concerns about and behaviors related to body image issues. Participants demonstrated "size perception accuracy" by choosing the silhouette that best reflected their appearance. Researchers then conducted semi-structured interviews with participants. All of the participants were HIV-infected White gay men who had lost 10 percent to 19 percent of their usual body weight.

Seven of the eight men interviewed said they had avoided social interactions within the last two months because of their weight. All but one of the participants chose the same silhouette that the researcher had chosen for them to reflect their appearance, suggesting that these men did not have a distorted perception of their size. Only two of the participants discussed pressures within the gay community to conform to a physical ideal. Half of the participants made statements that suggested a sense of loss of control over their bodies due to HIV, and three of the eight connected their weight loss to disease progression and eventually dying.

The Effect of Ethnicity on Body Image

A New Orleans study of women with HIV reveals that ethnicity is significantly linked to preferred body image. African American women were more likely than other women to be satisfied with their body size.

Researchers surveyed 103 HIV-infected women: 70.9 percent were African American, 22.3 percent were White, and 2.9 percent were Hispanic. The average age of the African American women was 32 years old, and the average age of the non-African-American women was 35 years old. Participants responded to a two-page questionnaire concerning preferred body size and dietary history and then chose from among a set of silhouettes the one that best reflected their perceived body size, preferred body size, and the body size the subject believed her partner would prefer.

Only one percent of African American women, compared to 19 percent of other women, chose an underweight image as their ideal body size. Eighteen percent of the African American women, compared to 4 percent of other women, had tried to gain weight in the last year, and only 6 percent of the African American women, compared to 23 percent of other women, had tried to lose weight in the last year. These results are consistent with research done with women not infected with HIV, which found that African American women were more likely to prefer a heavier body size and less likely to perceive themselves as overweight.

Thirty-seven percent of underweight women perceived themselves as normal weight, including 42 percent of underweight African American women and 27 percent of underweight other women. Of the overweight women, 74 percent thought of themselves as normal weight, including 81 percent of the African Americans women and 50 percent of other women. None of the normal-weight women perceived themselves as overweight, but 13 percent believed that they were underweight. There were no significant links between the progression of the illness (as reflected by the CD4+ cell count or history of opportunistic infections) and body image perceptions.

Managing Fat Distribution Disorders
Currier J, Carpenter C, Daar E, et al. Identifying and managing morphologic complications of HIV and HAART. *AIDS Reader*. 2002; 12(3): 114–125. (University of California Los Angeles; Brown University; Columbia University; and Tufts University.)

A comprehensive review of recently published studies concerning causes and treatments of HIV-associated body
changes found that recombinant human growth hormone (R-hGH) is particularly successful in reducing common HIV-related fat redistribution disorders.

The two common fat redistribution disorders, thought to be caused primarily by treatment with protease inhibitors and nucleoside reverse transcriptase inhibitors, are lipo hypertrophy (fat accumulation) and adipose lipoatrophy (loss of subcutaneous fat). Fat accumulation is associated with an increase in visceral tissue in the abdominal region and upper back (buffalo hump). Loss of fat is typically from the extremities, face, and buttocks. There is a high prevalence of fat redistribution syndromes among HIV-infected individuals.

One study reported that 49 percent of people with HIV had one or more signs of fat redistribution. Of the 1,077 patients surveyed from eight clinics in seven U.S. cities, 13 percent had signs of fat loss, 13 percent had fat accumulation, and 23 percent had a combination of the two. Predicting factors of these changes included older age, use of stavudine (d4T; Zerit), use of indinavir (Crixivan) for two years or more, and a more advanced stage of HIV infection.

There are a variety of treatment options with varying results and side effects: the two most effective are R-hGH and metformin. There is little evidence that switching antiviral medications significantly reduces fat redistribution side effects.

R-hGH is successful not only in reducing abdominal girth and buffalo hump in people taking protease inhibitors—that is, decreasing visceral adipose tissue—but also in doing so without significantly decreasing subcutaneous adipose tissue. R-hGH treatment did not significantly affect the weight, CD4+ cell count, or viral load. Metformin, used to increase glucose tolerance in people with type II diabetes, is successful in decreasing insulin levels and increasing the ratio of subcutaneous adipose tissue to visceral adipose tissue in HIV-positive non-diabetic subjects with fat redistribution and abnormal glucose tolerance levels.

Stigma and Body Image

A Midwestern study found that people with HIV disease had lower rates of self-esteem than people with cancer, that the primary cause of reduced self-esteem were feelings of stigma, and that social isolation and poor health status were found to have significant negative effects upon body image of both people with HIV and people with cancer.

Researchers surveyed 130 people with HIV and 76 people with cancer. The sample consisted of HIV-positive individuals at various stages of disease (including 127 men and three women, whose mean age was 37) and people with cancer currently receiving treatment (including 45 women and 31 men, whose mean age was 52). Researchers designed a questionnaire asking participants about their stigma-related experiences within the previous four weeks. They classified responses into four categories: social rejection, financial insecurity, internalized shame, and social isolation. They also evaluated responses in terms of conceptions of self, including self-esteem, personal control, and body image. They analyzed these experiences, along with data on symptom severity, to determine a person’s level of stigmatization, the role of stigmatization on conceptions of self, and the relationship of stigma to disease severity.

HIV infection was associated with significantly greater feelings of stigma than cancer, and disease type was found to be the most consistent predictor of the level of stigmatization. Individuals with HIV felt more social rejection, financial insecurity, internalized shame, and social isolation than people with cancer. Despite these differences, type of illness was not a significant predictor of negative body image. Women, however, consistently reported poorer body image than men, and older age was associated with improved body image.
DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit http://www.ucsf-ahp.org/HTML2/archivesearch.html.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!

ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.