



Response to commentary

The case for ‘anabolics’ coaches: selflessness versus self-interest?

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ARTICLE INFO

Keywords:

Anabolics coaching
Harm reduction
Anabolic androgenic steroids
Personal training
Risk management
Image and performance enhancing drugs

In this issue, [Gibbs and colleagues \(2022\)](#) explore the concept of ‘anabolics coaching’; the practice of providing advice on the effective use of Image and Performance Enhancing Drugs (IPEDs). IPED users are more likely to trust information from experienced users and concerns have been raised about their reliance on ‘broscience’ ([Havnes & Skogheim, 2020](#)). The authors put forward a persuasive argument for ‘anabolics’ coaches as a part of a harm minimisation approach to bolster safe consuming practices. They note the ethical challenge of seeing ‘anabolics’ coaches as credible because they have used IPEDs and may promote use as they are socialised into a culture where the benefits of use outweigh the risks. [Gibbs et al. \(2022\)](#) counter this by discussing the ethical stance taken by the coaches in their risk management. Ignoring the self-selection of participants, perhaps the less ‘risk focussed’ coaches chose not to take part, this risk-management approach can be seen as self-serving, as a coach’s reputation can be enhanced or destroyed by clients’ feedback. Experienced IPED users saw supporting others to manage risks as a positive aspect of their own use, a duty and adding to their status ([Harvey, 2020](#)). The authors reflect that some participants sought to disassociate from ‘others’ who they saw as less ethical. We acknowledge the notion of ‘othering’ yet there is still a risk here, as there may be less scrupulous coaches, who focus on income, are less concerned about reputation, or are perhaps socialised into a way of thinking, especially if they have established their credibility by being an experienced IPED user.

Interestingly, dependency on Anabolics Androgenic Steroid (AAS) is not explored by [Gibbs et al. \(2022\)](#). Yet, when assessing risk around

substance use, people with substance dependence are considered at greatest risk of harm. Studies suggest a 30% prevalence of dependency amongst AAS-users ([Grönbladh et al., 2016](#); [Kanayama, Brower, et al., 2009](#)) linked to serious physical and mental health concerns ([Hauger et al., 2020](#); [Kanayama, Hudson, et al., 2009](#); [Quaglio et al., 2009](#)). This raises questions: Are those who are dependent more open to unethical ‘anabolics coaches’?; Would an ‘anabolics coach’ recognise dependency?; Would they advise dependent users to give up? The authors suggest that the distrust of medical professionals could be the reason for seeking advice from their coaches. Approximately one-third of AAS-users seeks support from doctors ([Amaral et al. 2022](#)). AAS-users speak of doctors as: (1) taking a prevention stance; (2) condemning IPED use; (3) being judgemental; (4) not recognising AAS benefits; and (5) being less knowledgeable than most AAS-users ([Dunn et al., 2016](#); [Griffiths et al., 2016](#); [Harvey et al., 2020](#); [Havnes et al., 2019](#)). Therefore, further investigation is needed to change the narratives in both the IPED subculture and amongst medical professionals. Health promotion as an intervention seeks to compel individuals to change their behaviours by communicating the health concerns around IPED-use, however this is complex due to the benefits of use. A simple message about the immorality of use or a focus on side-effects is unlikely to impact the behaviours of many IPED users, in part due the reinforcement they receive within the IPED using subculture ([Smith et al., 2009](#)). Consequently, there is a need for a range of harm minimisation approaches around IPED-use, including ‘anabolics coaches’ who could be a trusted ally to

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both users and professionals, and act as a bridge to accessing medical services.

Gibbs et al. (2022) note that not only is a coach likely to be pro-use but they may be part of the lucrative IPED supply chain. This needs further investigation before ‘anabolics coaches’ can be part of the solution. However, there is something here that could support the harm minimisation approach. UK legislation puts people at risk as it promotes an unregulated black market with counterfeited or contaminated products (Coomber et al., 2014; Frude et al., 2020). In the UK there is a trend for home-grown drugs and Berry (2018) cites a case where a bodybuilder, gained access to Chinese suppliers to get ‘unadulterated’ supplies and learnt to synthesise the final product. Berry (2018) notes that trust was at the heart of this, leading him to conclude that access to such supply chains could make drugs safer for consumers reducing adulteration risks. Is it possible that ‘anabolics coaches’ may offer short cut access to such networks and therefore help to reduce the risk of use?

Harvey et al. (2020) found that some users paid for support related to AAS use as they had enough money to buy needles or blood tests, felt a personal responsibility, and were indignant at the thought of needing a handout. This potentially speaks of the importance of self-esteem, identity and the idea that one should not rely on others. Therefore, is there a moral case for the public purse not to fund support services for recreational IPED users and that those who can afford to pay should do so? If yes, it provides space for the ‘anabolics coach’. To address some of the ethical issues perhaps there is a need for them to be accredited as the authors imply. Pope et al. (2010), suggest that AAS dependence may be diagnosed reliably, via an interview process, raising the questions: is this something that could be included as part of a ‘anabolics coaching’ accreditation route, with an ethical impetus on accredited ‘anabolics coaches’ to collaborate with medical and other support professionals and the AAS user if an assessment of dependency is found? Can someone who endorses or even supplies IPEDs be accredited? And if yes, do they then become part of the system?

When first encountering this concept, particularly from authors who acknowledge they are ‘insiders’, it can feel counter-intuitive with the potential to be seen as ‘supporting’ the use of potentially harmful substances. Similar to concepts such as consumption rooms, which are now often part of harm minimisation when working with people who use illegal substances (Lloyd & Godfrey, 2010). In the UK AAS are classified as Class C substances and supplying AAS, including via online from outside the UK, sharing or giving them away free, is unlawful and can lead to a jail sentence. However, despite being banned in many sports, use per se is not illegal and, therefore, health promoters should offer advice, information and support to users as a pragmatic, although not perfect, solution. Since an ‘informal’ structure already exists, health promotion agencies should consider using ‘anabolics coaches’ in their endeavours. If ‘anabolics coaches’ could bring together the prevention-focussed medical profession, the harm-minimisation approach, and those from the IPED-using subculture to develop a platform whereby

they can take an inter-disciplinary approach then an opportunity exists to do a lot of good.

References

- Berry, M. (2018). *Technology and organised crime in the smart city: An ethnographic study of the illicit drug trade*. *City, Territory and Architecture*, 5(1), 1–11. <https://doi.org/10.1186/s40410-018-0091-7>.
- Coomber, R., Pavlidis, A., Santos, G., Wilde, M., Schmidt, W., & Redshaw, C. (2014). *The supply of steroids and other performance and image enhancing drugs (PIEDs) in one English city: Fakes, counterfeits, supplier trust, common beliefs and access*. *Performance Enhancement and Health*, 3(3–4), 135–144. <https://doi.org/10.1016/j.peh.2015.10.004>.
- Dunn, M., Henshaw, R., & McKay, F.H. (2016). *Do performance and image enhancing drug users in regional Queensland experience difficulty accessing health services?* *Drug and Alcohol Review*, 35(4), 377–382. <https://doi.org/10.1111/dar.12363>.
- Frude, E., McKay, F.H., & Dunn, M. (2020). *A focused netnographic study exploring experiences associated with counterfeit and contaminated anabolic-androgenic steroids*. *Harm Reduction Journal*, 17(1), 1–10. <https://doi.org/10.1186/s12954-020-00387-y>.
- Gibbs, N, Cox, L, & Turnock, L (2022). *Anabolics coaching: Emic harm reduction or public health concern? Performance and Enhancement Health*. (In press).
- Griffiths, S., Murray, S.B., Mitchison, D., & Mond, J.M. (2016). *Anabolic steroids: Lots of muscle in the short-term, potentially devastating health consequences in the long-term*. *Drug and Alcohol Review*, 35(4), 375–376. <https://doi.org/10.1016/j.drugalcdep.2016.05.003>.
- Grönbladh, A., Nylander, E., & Hallberg, M. (2016). *The neurobiology and addiction potential of anabolic androgenic steroids and the effects of growth hormone*. *Brain Research Bulletin*, 126, 127–137. <https://doi.org/10.1016/j.brainresbull.2016.05.003>.
- Harvey, O. (2020). *Male anabolic androgenic steroids users: A mixed-methods study: The voice of the AAS user [Bournemouth]*. <https://eprints.bournemouth.ac.uk/34446/>
- Harvey, O., Parrish, M., Teijlingen, E., van, & Trenoweth, S. (2020). *Support for non-prescribed anabolic androgenic steroids users: a qualitative exploration of their needs*. *Drugs: Education, Prevention and Policy*, 1–10. <https://doi.org/10.1080/09687637.2019.1705763>.
- Hauger, L.E., Westlye, L.T., & Bjørnebekk, A. (2020). *Anabolic androgenic steroid dependence is associated with executive dysfunction*. *Drug and Alcohol Dependence*, 208 (January), 107874. <https://doi.org/10.1016/j.drugalcdep.2020.107874>.
- Havnes, I.A., Jørstad, M.L., & Wisløff, C. (2019). *Anabolic-androgenic steroid users receiving health-related information; Health problems, motivations to quit and treatment desires*. *Substance Abuse: Treatment, Prevention, and Policy*, 14(1), 1–13. <https://doi.org/10.1186/s13011-019-0206-5>.
- Havnes, I.A., & Skogheim, T.S. (2020). *Alienation and lack of trust men who struggle to cease anabolic-androgenic steroid use*. *Journal of Extreme Anthropology*, 3(January), 94–115. <https://doi.org/10.5617/jea.7046>.
- Kanayama, G., Brower, K., Wood, R., Hudson, J., & Pope, H., Jr. (2009). *Anabolic-androgenic steroid dependence: An emerging disorder*. *Addiction*, 104(12), 1966–1978. <https://doi.org/10.1111/j.1360-0443.2009.02734.x>.
- Kanayama, G., Hudson, J., & Pope, H., Jr. (2009). *Features of men with anabolic-androgenic steroid dependence: A comparison with nondependent AAS users and with AAS nonusers*. *Drug and Alcohol Dependence*, 102, 130–137. <https://doi.org/10.1016/j.drugalcdep.2009.02.008>.
- Lloyd, C., & Godfrey, C. (2010). *Commentary on Pinkerton (2010): Drug consumption rooms - Time to accept their worth*. *Addiction*, 105(8), 1437–1438. <https://doi.org/10.1111/j.1360-0443.2010.03027.x>.
- Pope, H., Jr., Kean, J., Nash, A., Kanayama, G., Samuel, D., Bickel, W., & Hudson, J. (2010). *A diagnostic interview module for anabolic-androgenic steroid dependence: Preliminary evidence of reliability and validity*. *Experimental and Clinical Psychopharmacology*, 18(3), 203–213. <https://doi.org/10.1037/A0019370>.
- Quaglio, G., Fornasiero, A., Mezzelani, P., Moreschini, S., Lugoboni, F., & Lechi, A. (2009). *Anabolic steroids: Dependence and complications of chronic use*. *Internal and Emergency Medicine*, 4(4), 289–296. <https://doi.org/10.1007/s11739-009-0260-5>.
- Smith, D., Hale, B., Rhea, D., Olrich, T., & Collier, K. (2009). *Big, buff and dependent: Exercise dependence, muscle dysmorphia and anabolic steroid use in bodybuilders (Ed.)*. In L., Katlin (Ed.), *Men and addictions: new research*. Nova Science Publishers.