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The ethics of enhancement among image and performance enhancing drug coaches

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ABSTRACT

This research examines image and performance-enhancing drug (IPED) use, specifically focusing on the emerging role of IPED coaches. Situating drug use within broader assemblage theory, we investigated how these coaches, often operating in an online context, function as enabling environments, influencing practices, and contributing to harm reduction in a broader social context within and for IPED communities. Ten IPED coaches were interviewed, with this work focusing on their legal, ethical, and moral considerations, risk assessment, and harm reduction strategies of their practices. We employed a critical realist approach, following flexible coding to identify and develop themes which were further framed an enabling environments framework. Coaches operated along an ethical tightrope, emphasising the conscious regulation of conduct within established norms and the nuanced assessment of risks aligned with individual goals and motivations. Power dynamics and responsibility concerns unfolded through the lens of collaborative decision-making, where trust emerged as an essential element of these relations within contextual risk assessments. IPED coaches play a role in harm reduction by fostering trust and informed decision-making, balancing clients' goals with health considerations. These findings emphasise the potential for collaboration between IPED coaches and the health workforce to enhance health promotion and support within IPED communities.

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Introduction

Drug harms are influenced by social contexts, highlighting the need for population-level interventions to address health disparities. Social contexts are recognised as significant factors influencing human interaction and contributing to cultural change (Parkin, 2016; Wacquant, 2002). A significant body of research now highlights the diversity in drug use behaviours and their social contexts (Bardwell et al., 2018; Duff, 2011; Ivsins et al., 2019). Post-structuralist perspectives emphasise the active and constitutive nature of drug use contexts, emphasising local practices and rituals (Duff, 2007, 2011).

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This underscores the importance of understanding drug use as an embodied activity shaped by cultural norms and spatial settings (Draus et al., 2015; Piatkowski et al., 2023a). Such practices are influenced by broader economic, political, and cultural structures, leading to the establishment of unique principles and procedures for consuming drugs among individuals and groups (Duff, 2016; Seear, 2023). Although negotiation of these practices has been explored for some forms of injecting drug use (Dennis & Farrugia, 2017; Rance et al., 2018; Rhodes et al., 2017), for people who use image and performance enhancing drugs (IPEDs), far less is known about the contexts which facilitate harm reduction, and how these have been embedded in broader cultural structures.

IPEDs encompass a diverse array of substances, including anabolic-androgenic steroids (AAS), thermogenic compounds like clenbuterol and dinitrophenol, human growth hormone (hGH), and various synthetic peptides (McVeigh & Begley, 2017). Recent scholarship has questioned the framing of substance use solely as a public health concern (McVeigh & Begley, 2017), highlighting the normative nature of enhancement practices in contemporary society (Latham et al., 2019). This discourse accentuates the role of these practices in shaping modern health ideals, challenging traditional narratives (Nourse et al., 2024). For instance, studies illustrate how IPED practices are perceived as avenues for both aesthetic enhancement and self-transformation (Latham et al., 2019; Monaghan, 2002). Scholars have asserted that people using IPEDs are rational, self-aware individuals actively managing their perceived state of health (Fomiatti et al., 2020; Fraser et al., 2020). However, hindering effective management, a notable gap exists between the IPED-using community and medical professionals (Piatkowski et al., 2022, 2024b). This disparity, driven by consumers' greater knowledge about IPEDs compared to medical professionals (Fraser et al., 2020) and compounded by stigma (Cox et al., 2024), exacerbates inequalities. Consequently, several harm reduction strategies, including DIY-type interventions, have arisen to address these challenges (Henning & Andreasson, 2022; Turnock et al., 2023). Further to these DIY practices, and heavily facilitated by increasing social media and online networks related to IPEDs (Cox et al., 2023; Cox & Paoli, 2023), is the emergence of IPED coaches.

IPED coaches are individuals providing paying clients with information, advice, and protocols specifying which IPEDs to use, in what quantities, and over what duration (Gibbs et al., 2022; Piatkowski et al., 2024a). While the services offered by IPED coaches vary and appear adaptable to suit their clients' needs, coaches require a comprehensive understanding of the substances they recommend and play a crucial role in drug use and associated harms, which we posit may align with public health and harm reduction responses. Although the legality of possessing certain IPEDs, like AAS, is a criminal offence in numerous countries (Collins, 2019; Paoli & Cox, 2024; Piatkowski et al., 2024b), many nations, such as the UK and Australia (Bates et al., 2019), adopt a harm minimisation approach. Taking a nuanced perspective, we suggest that some IPED coaching can align with harm reduction frameworks that emphasise both 'safer' and 'effective' drug use practices. In the context of IPED-specific harm reduction strategies, the distinction between 'safer' and 'effective' drug use need not be seen as oppositional but rather complementary (Henning & Andreasson, 2022). However, although some IPED coaches play an important role, this should be captured within the wider harm reduction landscape. Moreover, the services of some coaches span the spectrum of legality (Paoli & Cox, 2024) and should be questioned. For instance, some provide

clients with IPEDs, breaching criminal law in most jurisdictions, while others only offer advice on drug use, making the criminality less clear. Due to these ethical and legal tensions and the scarcity of research on IPED coaching, further exploration is warranted.

Duff (2010, 2016) has suggested that drug use should be conceptualised as an assemblage involving space, embodiment, and practice, wherein the interconnection of these distinct elements inherently influences their localised contextualisation. This theory of drug use contexts, specifically the idea of an 'enabling' place (Duff, 2010; Moore & Dietze, 2005), is where we situate the framing for interrogating the role of IPED coaches in the broader social context of harm reduction. Understanding the dynamics of space, embodiment, and practice requires considering their intersection, connections, and the qualitative excess that shapes drug use experiences. The emphasis on affect, the active energy in spaces, offers a lens to understand how contexts influence practices. Spaces are not static; their coordinates continually shift in the dynamic act of inhabiting them (Duff, 2011). An ecology of enabling places underlines the material and relational creation of place, rejecting fixed space for a relational logic of dwelling. Drawing from this 'dwelling perspective', enabling environments are actively constructed from diverse social, affective, and material resources (Duff, 2009, 2011). Therefore, we aimed to understand the role of the IPED coach, as an 'enabling environment', and how they navigate the risk, culpability, and responsibility of reducing harm through their shaping of drug use experiences among the community.

Methods

Sampling and recruitment

For recruitment, we employed a targeted approach, leveraging the personal and professional networks of the first and second authors to identify potential IPED coaches. Utilising purposive sampling and word-of-mouth strategies, we sought out individuals with expertise in IPED use and coaching practices. The final sample comprised 10 male participants aged 25–39 (*Mean Age* = 31.2, *SD* = 4.5). Criteria for inclusion included being over 18, having a history of personal IPED use, and were paid to advise clients on IPED use and practices. The majority resided in Australia ($N = 7$), with the others ($N = 3$) located in Europe. Noteworthy is the global accessibility of their services despite geographic locations – coaches' services were available online, with few restrictions, meaning coaches were able to access a global client base virtually, without ever meeting face-to-face. Ethical clearance was obtained from the Griffith University Human Research Ethics Committee (Approval: 2023/243).

Materials and data collection

Participants engaged in individual semi-structured qualitative interviews exploring the ethical and moral dimensions of drug coaching. They explored the assessment of risks to an individual and others, examining culpability and risk assessment. Example questions included: 'What's the culpability around drug coaching?' 'Have you considered whether you could be held accountable if your client were to experience harm due to your advice?' 'What are some of the common discussion points with other users?' and 'How do you assist them in "doing it properly"?' Discussions also covered demographic

information, and interviews were conducted on MS Teams, recorded, transcribed, and analysed using NVivo (QSR, v12). Interviews ranged from 32 to 57 min (*Mean Length* = 43:32, *SD* = 7:22).

Data analysis

Utilising a critical realist approach in this research, the analysis and discussion of findings were shaped by the understanding that the social world is theory-laden rather than theory-determined (Fletcher, 2017). That is, while critical realism acknowledges the existence of a real social world that can be explored through philosophy and social science (Danermark et al., 2002), it recognises that not all knowledge holds the same degree of accuracy in reflecting reality (Fletcher, 2017). This approach allows for the development of theories that can vary in their approximation to truth. These theories are crafted through rational judgment of social events, aiding in the identification of causal mechanisms underlying social phenomena (Archer et al., 1998). Unlike the natural world, social structures are activity-dependent, meaning causal mechanisms exist within and are understood through empirical phenomena, highlighting their relevance for scientific inquiry (Fletcher, 2017). By prioritising explanation and causal analysis over descriptive detail, this approach offers a valuable framework for analysing social problems and proposing solutions for societal change. In the context of this research then, change is envisioned as shifts in societal attitudes, policies, and practices related to IPED use and harm reduction. This includes better understanding of harm reduction strategies which have emerged out of necessity among individuals managing their health (Fraser et al., 2020) and enhancement practices (Latham et al., 2019) in relation to IPED use.

The coding process primarily followed a flexible (i.e. 'directed') approach (Hsieh & Shannon, 2005). Initially, a set of codes was derived from the literature and the data, however, this coding framework remained adaptable, allowing for modifications, adjustments, eliminations, and the addition of new codes throughout the process, particularly through research team consultation and discussion to navigate through bottlenecks and points of ambiguities. Each piece of text was coded, treating the deductive codes to refine the existing model or theory, drawing from the literature and theoretical foundation. Drawing on realist approaches (Maxwell, 2012), several provisional codes were established, encompassing categories like 'Harm reduction', 'Lived Experience', 'Peer Conduit'. These organisational codes served as topic-based draws for sorting and storing information. Theoretical codes, derived from prior theory and literature, were created to align with critical realism concepts. As the coding process unfolded, the initial codes expanded, showcasing the flexibility and adaptability of the deductive coding approach. During the second coding cycle, these codes were systematically re-organised into thematic categories, such as 'Ethics', 'Morality', ' Risk Assessment', and 'Client Narratives', forming a conceptual map informed and underpinned by critical realism. Dominant codes, identified through NVivo coding queries, laid the groundwork for uncovering patterns and demi-regularities, such as the nuanced roles of drug coaches in harm reduction and ethical considerations. Following the identification of primary empirical findings through coding, the subsequent step involved theoretical redescription (Danermark, 2019) where empirical data were reframed using concepts from enabling environments frameworks (Duff, 2011). Collectively, this process elevated theoretical

engagement beyond detailed empirical descriptions, strengthening nuanced understanding of the data set.

Findings

Ethical parameters

IPED coaches adopted a strategic and pragmatic approach to the embodied practices within IPED-using communities, emphasising the importance of knowledge, including lived experience, and skill in navigating the boundaries of acceptable, appropriate, and justified conduct.

> P5: [People can] use all the drugs if that's really what they want to do with their life. But I guess when it comes down to 99.9% of the population, particularly in powerlifting and bodybuilding, you can go really far being pretty damn healthy these days if you know what you're doing. This is what my understanding is of those boundaries. Outside of those boundaries you're now playing with fire.

The idea of engaging in drug use within the context of transforming (Foucault, 1988) the body is framed as a conscious and deliberate practice, echoing Simons' (2013) perspective on practices as intentional choices and corresponding actions. This aligns with notions of body transformations (Latham et al., 2019) being realised through concrete practices, highlighting how individuals in these communities actively regulate and establish their own conduct to achieve a certain level of 'individuality' within the recognised norms (Piatkowski et al., 2023b; Simons, 2013). References to boundaries in IPED coaching acknowledge limits and potential risks. However, coaches sometimes extend beyond these boundaries, highlighting the balance required in navigating risks and respecting client autonomy.

Coaches' references to structural constraints resonated with de Certeau's (1984) concept of practice as a continuous effort to make sense of the world and find meaning within the constraints of everyday life.

> P6: We have to deal with the structures of the current system we live in. When the greatest solution to the problem is much deeper, to come up with a more optimal solution, which is most likely not going to happen within [our lifetime].

Related to IPEDs, coaches aligned their development of values and significations through acting and adjusting to their circumstances (Crouch, 2010). The acknowledgement that the optimal solution may not be feasible within the given time frame reflects the notion of coaches, engaging in 'making do' as they navigate and adapt to the dominant cultural economy (Duff, 2009). Coaches shape their relations by strategically adapting the existing structures to suit their practices.

IPED coaches operated along an 'ethical tight rope' with clients, attempting to combine ethical practice together with client empowerment. This manifested as collaborative decision-making, collectively negotiated between clients and coaches, balancing the needs and desires of the client, with the expertise and knowledge of the coach.

> P7: There's always a moment of informed consent with me, with all of my clients. There's a discussion centred around what drugs are the drugs that would be preferentially used and then we would go through that whole discussion of human use and safer use model.

When discussing drug preferences, coaches provided clients with information and acted as gatekeepers, controlling access and dissemination within the coaching context. Their approach underscored the emphasis on individual autonomy and responsibility while attempting to integrate IPED effectiveness and harm reduction strategies. Of course, this is not to say all coaches operate under these parameters, with diverse and significant differences inevitable within the profession, but rather it is reflective of the coaches included within the current study.

> P10: When people sign up to my coaching there is a disclaimer, which is like, the information provided here is … it's still your choice whether you do this and that's all the training, that's the nutrition it's like this is advice and guidance that is being provided. However, this is your own responsibility. There is a disclaimer there somewhat based on all the information that I provide, regardless of whether it's anabolic [IPEDs] use or not.

Drawing on Foucault's (1988) conceptualisation of 'conduct', he pertains to the specific methods through which authority endeavours to govern the behaviour of individuals and, by extension, entire populations (Foucault & Simon, 1991). This highlights the external regulation of individual behaviour through legislative mandates and societal controls. In the realm of IPED coaching, power extends beyond state mechanisms, intricately weaving into diverse relations, influencing culpability within this context. Clients are influenced by the *expert* status of coaches, who may hold considerable status and respect within the community, underscoring the substantial role of power in the domain of IPED coaching.

The aspect of culpability within these partnerships is intriguing, as IPED coaches navigate their operations with apprehension, anticipating potential repercussions. The liability aspect of the services offered by coaches was something that restricted coaches' work, with some individuals reluctant to be associated with the profession. This was particularly evident with coaches apprehensive to be known as IPED coaches, something that possibly stems from AAS-related stigma (Kimergård & McVeigh, 2014; McVeigh & Bates, 2022) or culpability and potential criminal proceedings if something were to ever go wrong under their guidance. These fears have been realised within the bodybuilding community, with harms and even deaths linked to one coach (Abelson, 2022).

> P8: I know that guy who told that woman to take a whole bunch of gear [IPEDs]. The [redacted] guy ended up, she ended up dying, but he didn't get charged for it. He was quite a big coaching name … but he got away because it was suggested, not prescribed. The only way he got away with that, but it took like two or five years in court for him to get to the point where they decided that yeah, it was that and it was either he goes to jail for manslaughter … she did it all based on a recommendation, did it to herself.

> P5: I'm okay to help people out and give them generalised advice … if they fucking have a heart attack in five years, I'll feel really upset.

Coaches were aware that the services they provide could have potentially detrimental impact on their clients. Though their aims were to navigate around potential harm, there is only so much a coach could do within these partnerships. On this basis, some coaches distanced themselves from the occupation and wished to maintain space from clients, that is, not to be seen 'instructing' them or their IPED use. This reluctance to fully engage may stem from an acknowledgment that despite their guidance, negative health effects could still occur. To a certain degree, this came at a detriment to the services provided, with coaches withholding and not fully committing their expertise.

Responsibility (balancing power)

When coaches underscored their perceived authority and influence when directly instructing someone, they also drew attention to the power dynamic in the coach-client relationship, seemingly recognising the importance of this role and authoritative and dominant position they held within the partnership.

> P3: If I'm directly telling somebody to do something, I have a lot of authority over them. They're paying me for advice and to learn and to be told what to do.

We acknowledge the economic transaction involved, where the client expects guidance and direction from the coach, something that also fosters trust between the two individuals. However, any entity has the potential to be an actor, independent of direct human involvement (Law, 2008). Objects, when ascribed function and characteristics through human interaction, become active agents in various contexts, such as IPEDs, influencing interactions and even shaping courses of action. Therefore, through the balanced application of power (Bielenia-Grajewska, 2011), the function of IPEDs is shaped by the human actors (Duff, 2007) to become an active agent by virtue of the interaction.

When considering the responsibility for advice given, we draw on theoretical perspectives that integrate contextual decision-making in drug settings (Duff, 2016). Coaches acknowledge that decisions are influenced by the specific affective environments in which they occur.

> P7: What responsibility does the coach hold for the advice given, versus the ownership of the individual who's using the drugs? If we were to try and draw a parallel with recreational drug use, I would imagine that technically speaking you would be in the same sort of like realm, in that an individual who doesn't provide the drugs to the person using them isn't responsible for their use, even though they may have given them advice to snort X amount of grams of cocaine. That's probably not their choice, at the end of it. But it is tough because I think like there has to be some responsibility, but I just don't know.

The parallel drawn with recreational drug use emphasises the complexity of attributing responsibility, echoing Duff's (2016) assertions that decisions are not solely products of reflective analysis but are significantly influenced by contextual factors which include human and non-human objects with their own valence. Coaches in this study similarly recognised the nuanced responsibility they hold for the advice given, yet some expressed reluctance towards fully embracing the position of gatekeepers.

Exploring the responsibility dynamics further, other coaches introduced the notion of individual agency and trust in the coach-client relationship. There was an emphasis on an individual's autonomy in decision-making, echoing the theoretical perspective that decisions involve a dynamic interplay between the affective context and individual choices (Peters et al., 2006). Coaches stressed the importance of clients' agreement with advice, highlighting a nuanced balance between autonomy and responsibility. Clients, often seeking coaching due to knowledge gaps, actively participated in decision making and coaches foster autonomy while overseeing client outcomes.

> P9: To be fair, it's kind of also up to the human, the individual, to be like "oh do I agree with this?" You don't have to take whatever it is. It is also your decision to not do it. You should also, as an individual understand that "OK, I've been with my coach for a little bit now. Can I trust him on this?"

Trust, essential in broader drug contexts, forms a framework for safety and care within peer networks (Rhodes et al., 2019) and is central to ethical drug coaching relationships. In IPED coaching, trust is built through actions and outcomes, where 'results' – such as physical development and absence of adverse health events – are key. This dynamic prompts consideration of whether a coach's outcomes reflect clients' perceived goal achievements.

Even when clients may not fully comprehend the information provided by coaches, particularly given the lack of knowledge surrounding IPEDs even in healthcare settings (Fraser et al., 2020; Piatkowski et al., 2024b), a foundation of trust serves as a crucial element in navigating the uncertainties of IPED coaching.

> P5: There's no prescription for this [IPED use] anywhere in the world. I think there should be some informed consent from the client, but I think it's also difficult, because a lot of clients don't know what they don't know. So, you can explain all these things and they're just like cool, man. I trust you.

Within these specific contexts, trust can be understood within an element of 'encapsulated interests', (Hardin, 2002) or self-interest, where the individual is motivated to maintain some type of relationship. IPED coaches, driven by self-interest, prioritise maintaining client relationships for personal gain, whether related to client wellbeing, financial or sociocultural capital. In an industry driven by reputation and fierce online competition for clients, trust emerged as a component in their business models. Coaches dedicated time and resources to build trust and relationships with clients. Their actions fostered client engagement and also served as a marketing strategy, highlighting their ability to work effectively with diverse individuals. With both parties relying on different elements of trust, this concept appears a fundamental element within formation and continuation of these partnerships.

Risk assessment and morality

In contemplating the tools available in IPED coaching, the notion of care emerged as a critical component, transcending conventional depictions of service delivery. This aligns with research which challenges simplistic views of care. According to Tronto (1998), care is concerned with meeting the needs of others and Ruddick (1998) adds that it is a commitment to wellbeing. Coaches acknowledge the risks and consequences of IPED use, drawing parallels between their array of tools, clients' goals, and the assessment of variables and risks.

> P6: I think you have all these tools at hand. You start to see that you can look at the individuals' goals and look at every variable that works towards that goal and not looking at it from just a gear [IPED] perspective.

When discussing assessments of risk and culpability with IPED use, coaches suggested there were pragmatic considerations of potential health consequences for clients. There was a need to relate these risks back to the individual's goal, something that reflects the situated nature of care in ethical relationships, where the meaning and exercise of care are contingent on the actual contexts in which ethical issues, such as health risks, emerge (Rhodes et al., 2003). The coach's risk considerations in the goal-oriented framework highlight the dynamic, context-dependent nature of risk assessment in IPED

coaching. However, this assessment is influenced by imbalanced knowledge between coach and client. The client relies on the coach's risk assessment, given the divergent knowledge levels. How the coach emphasises risk likelihood and severity significantly influences the client's assessment.

> P10: The risks [of IPED use], obviously, skewed lipid profile, elevated blood pressure, increased cardiovascular risk, things like this. Those are the main ones. There are other fringe risks, and so you need to relate it back to the goal.

It is also pertinent to acknowledge that this domain can be perceived through alternative lenses, including those of opportunity and profit. The motivations of coaches may encompass a variety of factors beyond care, such as financial gain and professional advancement. As such, while care is an aspect, it does not negate the potential influence of profit-driven motives in shaping the landscape of IPED coaching practices.

When evaluating client health and the potential risks associated with IPED use, coaches prioritise assessing the client's overall condition, considering factors within the broader context of their existing health status. For example, this includes coaches analysing the client's diet, weight, and sleep to craft a better understanding of variables outside of the use of IPEDs which might contribute to successful partnerships and better client wellbeing. This approach may be driven by the fact that clients in good health initially may be better equipped to mitigate the adverse consequences of IPED use.

> P8: If someone's already significantly overweight, their blood pressure is already quite high, and their lipids are all skewed. Well, then it's like, this [IPEDs] is the last thing you need. So, you need to look at those on the whole and be like, okay. Are they in good health? Yes. So, do they understand the risks and the rewards? Yes. What financial access do they have now? Okay, well, now we've got those figured out, now we can start mapping out what a potential cycle would look like.

We believe this approach is somewhat reflective of Foucault's (1984) aesthetic care concept, emphasising an understanding that avoids normative constraints and acknowledges contingencies shaping care practices. The coach's engagement with care practices is characterised by trust and reciprocity, aligning with an aesthetics of care that enable ethical elaboration without relying on authoritarian structures (Duff, 2015). Assessment of the client's health, and the subsequent mapping of IPED usage decisions, illustrates how conduct is ultimately shaped by risk assessment and some abstract measure of responsibility.

Human agency does not just enforce morality; it emerges and evolves through interactions involving human, object, spatial, and textual actors within a given conflict (Cole & Littlejohn, 2018). The potential for various actors in any situation is theoretically vast, but it is through communication that these relationships are expressed, and agency comes to the forefront (Sayes, 2014). As an example of this 'expression', coaches were unanimous regarding moral approaches to engaging in IPED use and consultation around the topic.

> P3: If I'm talking to clients about it [IPED use], then I definitely assess their age, where they are in training, we talk about potential side effects, both short term things that are somewhat reversible, but also long-term things of like worst case, this could be an issue.

When dealing with younger clients, coaches stressed the importance of evaluating progress without resorting to IPEDs. This involved engaging in dialogue and discouraging

IPED use when alternative avenues for physical enhancement exist. Some coaches emphasised the risks associated with IPEDs, potentially acting as gatekeepers to prioritise the safety of younger people who use IPEDs and steer them away from potentially harmful decisions. While some coaches are more cautious and refuse to coach some clients using such substances, ethical practices vary within the coaching profession.

> P2: If a sixteen-year-old came to me and said I want to use steroids, the first thing I'll be doing is talking about it. Are you making progress without it? Yeah. OK, wait. You know, you're sixteen, you've got a lot to do. [When I think about myself] at sixteen - there's no way I was ready to make that sort of decision.

In considering the clientele they engage with, some IPED coaches delineated boundaries based on perceived levels of client maturity and capacity to make informed decisions regarding IPED use. This includes recognising the complexities surrounding adolescent decision-making processes and acknowledging the societal discourses that may portray adolescents as inherently irrational or prone to risk-taking behaviour (Farrugia & Fraser, 2017). Consequently, coaches seem to tailor their messages to meet the diverse needs of the IPED community, balancing autonomy and risk perception. By adapting their approaches, they aim to provide a mixture of support which both enhances the effectiveness of IPEDs and provides some level of harm reduction which is suited to each client's circumstances.

Conclusions

Scholars have suggested the creation of enabling environments occurs in activity and through practice (Evans et al., 2015; Ivsins et al., 2019). In extending our understand of IPED coaching with current models of care, we find synergies. IPED coaches adopt a proactive role, providing instruction and facilitation. In this model, cessation of use is not a goal; to the contrary, continued use is at the direction of the coach. The IPED coach's primary focus is on improving the client's physical appearance or performance, while secondarily minimising adverse effects. This approach aligns with the broader remit of harm reduction efforts, where professionals provide free, tailored advice aimed at enhancing health outcomes and reducing risks associated with substance use (Keane, 2003). Particularly in an Australian context, where harm reduction programs are integral to creating enabling environments (Duff, 2010; Moore & Dietze, 2005), IPED coaching affords the potential of promoting safer and effective use as coexisting within health outcomes, moving beyond a dichotomy of safety versus efficacy. Within the remit of this enabling environment, several elements contribute to the 'coming together' (Crouch, 2003) of IPED coaching practice, adding to extant work which emphasises the need to move beyond conventional harm reduction discourse and acknowledge that drug use can be intertwined with practices of health (Duff, 2015; Fraser et al., 2020; Rhodes et al., 2019). The framing of IPEDs as active agents, influenced by power dynamics, adds complexity, portraying substance use as shaped by the interaction itself (Sayes, 2014). Considerations for IPED consumers extend beyond health norms, reflecting deliberate body transformation practices within these communities (Latham et al., 2019; Piatkowski et al., 2023b). This discourse challenges traditional notions of responsibility and emphasises the multifaceted nature of decision-making,

with IPED coaches highlighting the importance of individual agency among clients (Farrugia et al., 2021; Rance et al., 2018). They acknowledge that trust does not, in fact, circumvent this agency, but instead accentuates the centrality of client autonomy through well-informed decision making. However, this information has the potential to cause harm, given the motivation to produce results for the client. Coaches seek to establish and maintain trust by balancing the production of results for the client while maintaining their health. In this context, therefore, trust is fundamental within these partnerships.

In navigating these elements of collaborative decision-making, it is important to recognise that IPED coaches may not uniformly advocate for cessation but instead draw upon a variety of sources, including scientific literature and personal experiences, to inform their perspectives on safer use. At this point, a crucial aspect is the potential civil liability confronting IPED coaches when clients experience health complications or fatalities. While coaches may employ signed waivers and informed consent documents to deflect liability, the inherent power disparity between a knowledgeable coach and a client lacking a comprehensive understanding of risks raises the possibility of lawsuits. These legal actions might allege that the coach inadequately informed the client, underscoring the complexities of liability in these coaching relationships. The unique and fluid nature of the enabling environment represented by IPED coaches warrants further investigation, considering their role in harm reduction and health promotion within communities.

IPED coaches, informed by personal experience and insight, offer a pragmatic alternative to medical professionals' paternalistic dissuasion of IPED use. Consumers often perceive themselves as more knowledgeable about IPEDs than physicians (Fraser et al., 2020; Piatkowski et al., 2022), highlighting a gap in medical engagement that neglects the unique needs and perspectives of IPED consumers unless serious adverse effects arise. IPED coaches, despite ethical concerns and legal implications, present an opportunity to bridge gaps between traditional health promotion, harm reduction, and the needs of IPED consumers, potentially enhancing safety and support within this complex and stigmatised subculture (Cox et al., 2024; Harvey & van Teijlingen, 2022). Extending on this, there is a nuanced option within harm reduction strategies, where dedicated workers provide free advice aimed at enhancing health outcomes without necessarily advocating for cessation. This approach is crucial in Australia, where harm reduction programs are prominent, yet the workforce remains underprepared to engage effectively with IPED consumers (Piatkowski et al., 2022, 2024a). IPED coaches represent a community-driven approach which is conducive to fostering open discourse of harm reduction within IPED communities (Piatkowski et al., 2024a). Therefore, collaborative partnerships between reliable IPED coaches and harm reduction workers present a synergistic opportunity for intersection and collaboration. For instance, those unable to access IPED coaching could benefit from free harm reduction programs at needle service providers, expanding access to tailored support for safer IPED use. IPED coaches could be encouraged to partner with scholars and offer harm reduction training and workshops alongside researchers and healthcare professionals, specific for the harm reduction workforce.

While this study offers valuable insights into the complex dynamics of IPED coaching, certain limitations should be acknowledged. The sample size, predominantly homogeneous in terms of geography and gender, limits the generalisability of findings. Additionally, the absence of truly international perspectives raises questions about the cultural universality of the observed practices. Furthermore, the study predominantly

represents male perspectives within the IPED community, potentially neglecting the experiences of female participants. Despite these limitations, this research marks a pioneering exploration into the relatively uncharted territory of IPED coaching. By exploring the intricate interplay of power, responsibility, and trust within this context, it lays a foundation for future investigations. The study encourages a shift beyond conventional harm reduction discourse, recognising the potential intertwining of drug use with practices of health.

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