“The general concept is a safer use approach”: How image and performance enhancing drug coaches negotiate safety through community care

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Abstract

Background: Drug coaches are a novel extension of traditional personal trainers who play a significant role providing support and shaping drug-related behaviours for people who use image and performance enhancing drugs (IPEDs). They constitute a critical domain for everyday risk management, where substance use, and its associated harms are influenced by social exchange. This study investigated how IPED coaches negotiate safety within the community through the provision of their services and the partnerships they form with clients. *Method:* Ten IPED coaches, selected through purposive sampling, engaged in semi-structured interviews (32-57 minutes in length) exploring the way in which they operate in their field of practice. Iterative inductive analysis was applied to the transcripts, enhanced by discussions among researchers and an independent coder. *Results:* The findings are organised under three categories, revealing the nuanced strategies and identities of IPED coaches, emphasising harm reduction and optimising 'gains' in IPED use. These coaches play a significant role in harm reduction, wielding their 'chemical capital' and lived experience to integrate nuanced harm reduction strategies into their partnerships with clients. *Conclusion:* Embodying a model of peer-driven knowledge exchange and emphasising open and inclusive discourse IPED coaches offer a vehicle toward integrated harm reduction strategies.

Keywords: harm reduction, image and performance enhancing drugs, injecting, negotiated safety, steroids.

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Introduction

The scope of image and performance enhancing drugs (IPEDs), within the context of substances classified as 'drugs,' encompasses a broader range of compounds and substances including anabolic-androgenic steroids (AAS), thermogenic compounds (such as clenbuterol and dinitrophenol), and various other synthetic peptides like hGH (human growth hormone) (Dunn et al., 2021; Hope et al., 2021). AAS are said to be the most commonly used IPEDs and are associated with a range of harms—including both physical (Zahnow et al., 2017) and psychological (Chegeni et al., 2021; Piatkowski et al., 2023c) issues, leading to their identification as a growing 'public health' issue (McVeigh & Begley, 2017). Various harm reduction strategies have arisen, including 'DIY' type interventions (Henning & Andreasson, 2022). As identified by Gibbs et al. (2022), IPED coaches are individuals who provide paying clients, information, advice and protocols detailing which IPEDs to use, in what quantities and over what duration. Thus, they play a crucial role in influencing behaviours of people who use AAS (PWU-AAS) and other IPEDs (PWU-IPEDs), outside of official public health responses (Kimergård, 2015; Santos & Coomber, 2017). Thus, coaches ought to be considered within the wider context of harm reduction as significant players capable of influencing the choices and behaviours of PWU-AAS.

Trust is crucial in client-healthcare professional dynamics (Treloar et al., 2013), influencing healthcare-seeking behaviour, treatment adherence, interaction quality, disclosure, and behavioural modification (Pacquette et al., 2018). It operates within the client-healthcare professional relationship and extends to trust in the broader healthcare and social systems (Ward & Coates, 2006), especially pertinent for individuals using illicit substances. People who use illicit substances have a history fraught with distrust of healthcare providers (Atkinson et al., 2021; Dunn et al., 2023; Pope et al., 2004) leading to a longstanding therapeutic barrier (Richardson & Antonopoulos, 2019), including PWU-IPEDs. Fraser and

colleagues (2020) highlighted the limited engagement between PWU-AAS and medical authorities, suggesting a shift towards a concept termed 'connoisseurship'. This recognises the community's expertise in AAS use and suggests moving beyond traditional doctor-patient dynamics. IPED consumers, as per bodybuilding subcultures described by Monaghan (1999), build up their knowledge through ‘ethnopharmacological methods’ (Monaghan, 2002b) drawing on a detailed stock-of-knowledge of pharmacological properties, dosages, administration routes, and effects. Such ethnopharmacological approaches within bodybuilding subcultures illustrate the depth of knowledge and self-regulation mechanisms that individuals develop to navigate the complexities of IPED use (Monaghan, 2002a, b), further underscoring the need for healthcare professionals to engage with these communities in meaningful and collaborative ways (Fraser et al., 2020) to promote harm reduction and health promotion initiatives.

In the IPED community, coaches play a central role, acting as both mentors and peers due to their physical and social advantages (Piatkowski et al., 2023a, b). They possess socio-cultural and ‘body’ capital (Monaghan, 2002a), which they use and draw upon to shape and influence community practices and norms (Gibbs et al., 2022). Through habitus, individuals internalise these regulations and norms, influencing their behaviours within the community (Bourdieu, 1984). Thus, habitus provides a framework for comprehending how social domains influence and alter the behaviours of individuals within them. In their role as advisors to PWU-IPEDs in their respective pursuits, IPED coaches wield capital to command social exchanges around drug consumption within the community. Coaches leverage their lived experience and knowledge to advise PWU-IPEDs effectively in their pursuits, shaping social exchanges around drug consumption. Therefore, the present study sought to interrogate this phenomenon, utilising a qualitative approach to further understand the experience of

IPED coaches in negotiating safety and professionalism among the community through partnership.

Theoretical Approach

Intimate partnerships among PWU-drugs play a crucial role in providing care, support, and stability among people who use illicit drug (Rhodes et al., 2017; Treloar et al., 2016). Partnerships significantly influence drug usage behaviours (Rhodes & Treloar, 2008), representing a crucial arena for everyday risk management where interpretations of substance use shape behaviours (Rance et al., 2018). The concept of 'negotiated safety' (Kippax & Race, 2003) emphasises risk as a product of conflicting interpretations and social exchanges. Initially applied to sexual risk-taking (Holt, 2014), it has been extended to couples who inject drugs (Rance et al., 2018), highlighting the fluidity of risk and safety practices and promoting critical reflection on agency and decision-making.

Examining risk and safety practices through the lens of negotiated safety provides a platform to explore diverse perspectives, including those that challenge conventional mainstream viewpoints, particularly concerning the extensive drug knowledge among PWU-IPEDs. In this way, we build on Fraser et al.'s (2020) concept of 'connoisseurship' and Monaghan's (1999) ethnopharmacological concepts. Explorations of the nuanced relationship between medicine, knowledge, and IPED practices, has previously revealed how participants disregard medical perspectives on the drugs they use (Monaghan, 1999). These prior findings have underscored that medicine holds just one of many authorities in shaping individuals' decisions surround IPED use (Monaghan, 2022b). By building on concepts from Rance et al. (2018), who demonstrated how PWU-drugs interacted with and adapted medical knowledge to create their own prevention tactics, we interrogate a parallel dynamic within the realm of IPED coaching, wherein coaches intricately blend diverse strands of knowledge,

encompassing and experiential insights. Instead of outright dismissal, IPED coaches appear to integrate these multifaceted knowledge sources, leveraging them to guide clients toward their physique enhancement or performance goals. Therefore, we aimed to explore how IPED coaches understand their role in facilitating harm reduction among PWU-IPEDs.

Methods

Sampling and recruitment

A sample of 10 IPED drug coaches were recruited through purposive sampling techniques, leveraging the existing personal and professional networks of the first and second author. These participants had to have used IPEDs, be over the age of 18, and have experience providing advice to clients regarding their IPED practices. Further, the criteria and considerations employed in the purposive sampling included attempting to sample from diverse geographic locations, with varied motivations for IPED use and coaching. Those interested and eligible completed informed consent procedures. Ethical approval was granted from the University Human Research Ethics Committee (Approval: 2023/243).

Materials and data collection

Participants engaged in one-on-one semi-structured qualitative interviews that explored various aspects of their knowledge, practices, and beliefs related to IPEDs. Example questions include: How have you gained the knowledge about IPEDs and best practice? Can you tell me a little about a time you provided advice to another person who uses IPEDs? Could you tell me a little bit about the right and wrong ways in which people use IPEDs?. Participants were also asked for demographic information, such as their age and gender, as well as IPED and AAS use. These interviews took place on the MS Teams platform, where audio recordings were transcribed automatically. These transcripts were checked for errors and imported into NVivo (QSR, v12) for further analysis.

Data analysis

Immediate reflective notes were recorded after each interview to enhance the reliability of final transcripts. These were followed by preliminary reading and analysis using deductive conceptualisation (Neale, 2021), where the first author generated notes to identify themes, interconnections, and prioritise codes, before proceeding to systematic, inductive line-by-line analyses (Neale, 2016). Following an initial review, the first author organised and prioritised coded points in a logical narrative, laying the groundwork for subsequent interpretive work (Neale, 2016). A research assistant analysed a random subsample of transcripts (n=3) and generated preliminary codes (Paulus et al., 2010). The first author then met with the independent researcher to review findings and discuss any disparities, aiming to enhance the analytical process through 'meaning making' discussions (Paulus et al., 2010). Subsequently, the research team convened to scrutinise coding decisions, reflect on emerging themes, and identify patterns collaboratively.

In the second stage, the first author completed analysis files, identifying recurring points and categorising them into higher-order concepts or typologies (Neale, 2016). These categories served as an organisational framework for presenting the subsequent findings. The analysis also involved examining variances in perspectives on different IPED coaching methods, including distinctions among sub-groups within the coaching community, and documenting these distinctions throughout the analytical process. At this point, the first author considered applicability to subsets of data and began theory testing, drawing on abductive conceptualisation (Neale, 2021) and began linking findings to established literature, ensuring broader relevance and theoretical generalisability.

Results

The participants' (*N*=10) ages ranged from 25 to 39 years (*Mean age*=31.2, *SD*=4.5). All participants were male. They predominantly resided within Australia (*N*=7) with other participants from Europe (*N*=3). The 'hybrid' nature of these coaching relationships meant coaches interacted with clients in online-only and mixed online and face-to-face settings. It is worth noting that while these individuals live in a particular country, their services are accessible online and around the globe. The coaches provided various fee structures tailored to individual client needs. This included hourly fees covering training, nutrition, and IPED advice for some, while others offer monthly packages with separate hourly consultation fees for IPED-related guidance.

The duration of the interviews ranged from 32 minutes to 57 minutes (*Mean length*=43:32, *SD*= 7:22). The participants comprised a diverse group of coaches, each possessing varying degrees of experience in the field (*M* = 5.84 years), and all of whom had engaged with various forms of AAS and other IPEDs. Notably, several participants boasted substantial social media followings primarily on platforms such as Instagram. Utilising existing social media following typologies, 7 participants could be classified as micro-influencers (<10000 followers) while the remaining 3 were meso-influencers (<1 million followers) (Harrigan et al., 2021). Participants quotes are presented alongside their age and years coaching experience [age, experience].

Constructing the IPED Coach: Navigating Identity and Knowledge

Participants reported that clients often initiate their engagement with an IPED coach seeking assistance primarily in training and over time, as the coaching relationship develops and trust is established, discussions regarding IPEDs are introduced into the conversation.

> *P3 [35, 9]: It [IPED coaching] tends to come later on. I've had people 'on' with training and then a year later they're like, hey, I'm thinking about doing this [IPED*

> *protocol]. Or if people jump on with coaching, they're like, OK, this is what I was doing, this is what I plan on doing… then we discuss what the best options would be.*

Echoing Gibbs et al.'s initial findings, many participants did not solely wish to identify as 'IPED coaches' and instead perceived themselves as 'comprehensive' coaches, wherein an understanding of drug usage was conceptualised as just one aspect of a wider epistemic armoury. The emphasis on drug understanding stems from the practical necessity of addressing the prevalent usage within the consumption context (Duff, 2012), positioning drug knowledge as an essential, but not exclusive, component of their professional identity. The ability to reconcile the lived experience of drug use with societal perceptions that marginalise individuals into stigmatised categories has a long history (Douglas, 1966). This ability to navigate the dichotomy reflects the reluctance observed in fully embracing the identity of an IPED coach, given the associated societal stigma and preconceived notions.

> *P10 [35, 6]: I don't put it out there. I'm not like, oh, I'm the drug guy. I'm a coach...but I know in terms of in terms of manipulating body composition, that is an angle.*

> *P7 [36, 9]: I see myself as a contest prep coach 100%. By virtue of being one of those, I have to understand drugs because literally every one of my clients uses them. If I didn't have control over the drug use, but I did over the nutrition and the training, there would be a misalignment, especially when we consider the fact that drugs will have some health consequences.*

In the realm of IPED coaching, individuals construct a distinct persona through knowledge acquisition and presentation. This persona reflects their expertise and positioning within the domain (Bakken et al., 2023), establishing a unique identity that showcases their depth of understanding and prominence in the field. Being a 'true' IPED coach involves an extensive

assimilation of ethnopharmacological (Monaghan, 1999) information from various reputable sources. Building on this earlier work, coaches appear to have in-depth engagement with academic research and literature (see also Cox & Paoli, 2023), the persistent quest for learning, and the insistence on viewing IPEDs as medicines designed for specific purposes. Collectively, these underline the essence of IPED coaching persona.

> *P8 [39, 10]: People, they're so hungry to get the results, especially in this instance where someone goes "take two of these a day", they don't question it. They just go OK, like my coach said. Well, who's your coach? Has he got a university degree or PhD or is he done a six-week course? Where did he get his information from?*

> *P2 [28, 3]: Constantly looking at studies that are coming out, constantly talking to people and continuing the research.. So, there is a lot of engagement with academic research and literature... this stuff is a medicine. It was designed for a purpose. We're just doing it off label.*

There is an active and organic nature of peer-driven knowledge exchange within the community of coaches, PWU-IPEDs, and manufacturers (Piatkowski et al., 2023b). Coaches emphasise a reciprocal process of seeking and sharing information within the community, highlighting a constant commitment to self-improvement and staying updated on the subject. In this sense, our participants echoed the contemporary corporate notion of 'continuous professional development' that has become such a robust injunction for those in careers ranging from hospitality to office work, to medicine and academia.

Further, experimentation holds significant importance, with suppliers of AAS been shown to conduct self-testing and seeking evaluations from proficient users to assess the effects of their products before selling (Turnock, 2021). Analogously, IPED coaches appear to adopt a comparable approach in their coaching practice.

P6 [33, 10]: There's another guy he used to actually make gear [steroids]. And he knew a lot about it as well. He knew a lot about bloods. He was like one of the blood experts. I learned a lot off him.

P2 [28, 3]: I've got a friend who's also a coach, we're constantly challenging ourselves asking, you know, "Oh yeah, So what is the function of this drug? How is it getting through the body?" Having that communication with someone means we're going to be constantly learning and updating what we know and making sure that the people that we coach and the people around us are going to be getting the correct information.

IPED coaches garner recognition and clientele primarily through their demonstrated ability to aid others effectively, leading to a network effect through referrals. Wacquant (2002) initially introduced the term 'street habitus', referring to the enduring and often subconscious predispositions developed by individuals immersed in the street economy due to prolonged engagement within that environment. We contend a form of habitus is in effect for IPED coaches and sets them apart from PWU-IPEDs who may offer advice but lack the professional standing and track record that attracts individuals seeking guidance. The nuanced characteristic of being sought out by others underscores the credibility and specialised knowledge that IPED coaches possess, affirming their unique role as trusted facilitators.

P6 [33, 10]: The reason people come to me is because I've helped people, and the word of mouth gets around.

Building 'chemical capital'

We note the concept of body capital in this context (Monaghan, 2001). These coaches often market their services leveraging their present or past physical appearances, particularly

if they have a history of competitive bodybuilding or a similar background. As a result, they have employed several IPEDs during their involvement in these environments as means of attaining what Kotzé and Antonopoulos (2021) term ‘boosted bodily capital’.

> *P2 [28, 3]: There's quite a long list of things that I've tried, so I've been using for I would say five years now. I mean, I can give you a big list: testosterone, Masteron [Drostanolone], Nandrolone, Trenbolone, Turinobol [Chlorohydromethyltestosterone], Dianobol [Metandienone], Superdrol [Methasterone], Halotestin [Fluoxymesterone]. HGH [Human growth hormone] and insulin.*

Following on from this, comprehending the nuances of the IPED domain without direct personal engagement was raised as an important point. The coaches noted that knowledge, or ‘street habitus’ (Wacquant, 2002), alone is insufficient in providing guidance to IPED-using clients. By stressing the significance of witnessing and experiencing the outcomes firsthand, they speak to the unparalleled authority and credibility conferred by their lived experiences – what we introduce here as ‘chemical capital’. This builds upon the body capital which IPED coaches' harness and to showcase their credentials, underpin their work and reinforce their expertise.

> *P3 [35, 9]: I think it'd be very hard to convincingly know like what's right, what's wrong, or what's the best way to approach it if you haven't done any of it. But that's like everything in life, right? You could sit there and say don't do this because this will happen. But if you have an experience…it's very hard to like, dispute that.*

Anderson (1999) employs the phrase 'code of the street' to underscore the significance of comprehending the behavioural, visual, performative, and sartorial norms within a particular culture. Similarly, this was the prevailing approach to building chemical capital. This underscores a two-fold process: the first being the practical engagement with these substances, i.e., lived experience, and the second involving peer interactions and information-sharing. The process of "try it yourself" privileges the idea of experiential learning as a foundational element in understanding the effects and implications of these drugs. The coaches' reliance on informal networks, such as friends and acquaintances who have achieved notable physical transformations ("jacked"), then reflects the peer-driven nature of knowledge acquisition in this community.

> *P1 [35, 7]: It was more like try it yourself and then talk to someone. Every now and then you bump into a mate and he's jacked. So you kind of talk to him get as much information off him as you can at the time. So there's forums, websites, uhm, mates of mates that were huge. And that was pretty much all of the information that you could get at the time.*

There were caveats to building up chemical capital, however. In retrospect, coaches acknowledged the value derived from their past mistakes and the physical and psychological toll they endured. These experiences served as profound lessons, enriching their understanding of the consequences associated with various drug-related decisions. This narrative of health sacrifice was a selling point for some coaches who justified previous experiences of harm on the basis that others would not have to make the same mistakes. Importantly, the coaches express a pragmatic sense of 'lessons learned' regarding their past actions, as these experiences now enable them to guide others effectively. They recognise their own lived experience as a form of currency (Parkin, 2016), a price paid for their

expertise, which uniquely positions them to offer nuanced advice that prioritises harm reduction. This dynamic showcases their capacity to translate personal hardships into valuable insights for the betterment of the community, embodying a transformation from past transgressions to present-day harm reduction advocates.

> *P5 [26, 4]: In hindsight I learned a lot from doing dumb things. Getting really hurt and yeah, learn from that. I think it was very useful for me. I don't regret anything in that sense because.... I can help people who are in my shoes as a coach now. I can talk from experience too. I can say I have done this, this and this resulted in this.*

Balancing the strength of lived experience, coaches offer a more nuanced perspective, emphasising that their consumption should not stand in isolation as the sole basis for providing guidance to PWU-IPEDs. Coaches emphasise that while safer practices are possible, it is crucial to acknowledge that even these practices are not entirely free from risk. This recognition represents a more responsible and informed approach to harm reduction. By juxtaposing lived experience with research-backed insights, they advocate for a holistic approach to coaching and peer education. The coaches' emphasis on the amalgamation of these elements underscores their commitment to ensuring the wellbeing of their peers within the community. They view their role as educators, drawing from a rich tapestry of knowledge that encompasses both personal experiences and evidence-based understanding.

> *P7 [36, 9]: It's by no means at all considered safe. So, then that's where I think the lived experience component of this, coupled with at least the capacity to understand the research and understand mechanisms that you can do it safer than what is typically being done. Usually lived experience is the only thing that's considered, and not the amalgamation or the combination of all of these things together… and then*

outside of that it's typically then going to be coming from either mentorship from individuals that have, a lot of experience or through various online platforms.

"Less is more": A nuanced approach to harm reduction

PWU-drugs are frequently stigmatised when accessing health care (Paquette et al., 2018). However, identity and social capital can play pivotal roles as mediators of agency for PWU-illicit drugs, particularly in the context of navigating and challenging stigma associated with drug use (Brookfield et al., 2019). The underlying stigma associated with IPED consumption is not new (McVeigh & Bates, 2022), however, and underscores a notable dichotomy between IPED coaches and other service providers. An essential facet of this distinction lies in how IPED coaches approach stigma—Attempting to engage PWU-IPEDs and promote best practice in a non-judgemental fashion.

P1 [35, 7]: I think there's a lot to be said for the stigma. I mean, but the stigmas, even in the worst of places, you go to a GP and they're doing the same thing. They're saying the same stuff as the media outlets.

This fundamental difference enhances trust and acts as a foundational aspect of the identity of an IPED coach, setting them apart and reinforcing their unique 'insider' role

P7 [36, 9]: I just think like this is the way forward is to try and reduce the stigma through greater conversation… having more open discussion... is likely going to make this easier to talk about.

The coaches took a meticulous and systematic approach in monitoring and managing their clients' drug use. Using spreadsheets, they engaged in a structured form of drug 'prescription' tracking, including various categories of IPEDs, general health supplements,

medications, and the scheduling of doses. The coaches also emphasised the importance of monitoring clients' health over time.

> *P6 [33, 10]: So [client] prescription through Excel spreadsheet, which I use to track the prescription. So I break it into a few categories so we've got androgenic and non-androgenic list. I have general supplementation like for general health and then what their medications are. I track its life cycle, so the total dosages and see where the peak, highest dosages are.*

Within their protocols, coaches placed a strong emphasis on the historical and clinical use of substances in human medicine. They advocated for the utilisation of compounds that have a well-established track record of use in medical practice (e.g., Testosterone). By drawing a clear distinction between substances intended for human use and those utilised in veterinary contexts (e.g., Trenbolone), they steered their clients toward a more informed approach.

> *P10 [35, 6]: I think leaning in towards substances that have been used within human medical practice for extended periods, that's generally a smart move. Using something that was used on cattle, and compare that with using something used on humans, you're probably better off using something that's used on humans.*

Within their remit, many coaches spoke to the fact that there exists an opportunity to influence individuals' decisions regarding initiation and dosage of AAS. Building on identity and capital, with what has been identified previously by Rance et al. (2018), the dynamic of 'trust' surrounding drug use practices plays a pivotal role in negotiating and managing drug practices. The coaches, through a process of situated knowledge and chemical capital, can exert expertise and guidance, and potentially dissuade some individuals from embarking on AAS use altogether.

> *P1 [35, 7]: I think that you can change some minds about whether to get on [IPEDs] at all. And how much to take if you are getting on [initiating use].*

The process of negotiating safety in relationships can be understood as an expression of trust and familiarity (Seear et al., 2012). In understanding the significance of trust, it is essential to acknowledge not only its emotional, relational, and social aspects but also its historical evolution. Trust is continually reshaped by the lived experiences of individuals within the context of evolving biomedical knowledge and other related understandings (Rhodes et al., 2017). Drawing these concepts together, the negotiation of safety occurs through the integration of biomedical expertise and intimate relationships—blending biomedical understanding with social acumen, manifested in practical approaches.

> *P1 [35, 7]: They run 750 mg a week and it's been a year and a half. And I'm like are you still doing this stuff? Like, yeah. I'm like, take a break. Just jump off. Go get your bloods done.*

> *P5 [26, 4]: I have a bunch of online blood testing companies who can actually write me reports and I can read through the reports. I will then research some of the things that might come up and look into it myself, to give them advice and feedback.*

They emphasised the recognition that none of these drug use practices are entirely safe, and clients come seeking guidance to make them 'safer.' Therefore, we posit that IPED coaches and their clients engage in a form of 'negotiated safety' akin to a biomedical perspective outlined by Rance et al. (2018). This involves minimising risks by leveraging shared knowledge, particularly concerning the client's health status, within the context of IPED consumption. This approach is rooted in the recognition that the use of these substances inherently carries risks, potentially shortening one's lifespan through both direct and indirect mechanisms. While acknowledging the inevitability of harm to some extent, their focus lies

in mitigating these risks and promoting safer practices. In this way, the presence of biomedical 'evidence' (Rance et al., 2018) facilitated the application and practice of trust relationships, constructing a framework of ‘safer use’.

> *P7 [36, 9]: The general concept [of IPED coaching] is to try and have a safer use approach… Try and minimise the maximum amount of damage that you can while using things that are undeniably going to likely decrease the time that you live on this planet.*

These safety negotiations, put into action, occurred within dynamic and ever-changing relational and social contexts. Some of the cohort illustrated their clients’ previous engagement in a perilous cycle of escalating drug use to counter side effects, which in turn leads to a compounding of substances. It is worth acknowledging that a degree of polydrug use can have beneficial aspects (Griffiths et al., 2017). The guidance provided by coaches in directing individuals toward substances that effectively mitigate harm, as opposed to those that pose additional risks, is a noteworthy consideration.

> *P6 [33, 10]: If you get to a point where you're taking so much shit that you can't even eat, that you're just sick. And then they end up taking other drugs that help and just improve appetite. It's just stacking more drugs to mask more drugs, which then causes more problems.*

As a result, a key harm reduction negotiation strategy employed by coaches was emphasising the principle that 'less is more' when it comes to IPED use. Essentially, coaches advocated for lower dosages and limited use of these substances as a means to reduce the potential health risks associated with their use.

> *P1 [35, 7]: I think less is more when it comes to this stuff.*

Central to this understanding is the potential for achieving significant performance enhancement while minimising adverse effects through the judicious use of lower drug doses. The objective extends beyond risk reduction to optimising gains relative to associated risks. It is essential to underscore the misconception that higher IPED doses inevitably translate to substantial performance improvements compared to a moderate dose. The core argument revolves around a nuanced consideration of the risk-to-reward ratio, emphasising the necessity for clients to grasp the concept of diminishing returns beyond a certain threshold, challenging a simplistic approach of mere risk reduction, which implies complete abstinence.

> *P2 [28, 3]: Telling someone that, no, you don't need 500 milligrams, you can get away with 300 milligrams.*

Discussion

Current health systems are failing to adequately portray IPEDs in public health frameworks (Piatkowski et al., 2024), with scholars arguing for provision beyond what is available for them (Bates, et al., 2021), mostly situated around safe injecting (Underwood, 2019). This is particularly salient given the low rates of risky injecting behaviour and blood-borne infections among PWU-IPEDs (van Bekk & Chronister, 2015). Given the strength of peers as a conduit for harm reduction (Piatkowski et al., 2023d), IPED coaches emerged (Gibbs et al., 2022) to fill the ever-present lacuna of public health responses for this unique group of PWU-IPEDs. While coaches provide a range of services that can be considered to fall within the realm of harm reduction, the unregulated nature of the profession provides opportunities that contradict this notion (Paoli & Cox, 2024). Similar concerns have been identified by Cox and Paoli (2023) who state that IPED influencers on YouTube openly share information and advice that has the potential to shape drug use and associated behaviours. Nevertheless, knowledge translation and harm reduction predominantly transpire through the

firsthand accounts of individuals who have acquired capital. For IPED coaches, the process of negotiating safety was a combination of wielding chemical capital alongside the delicate task of harmonising the aspects of their partnerships with their nuanced harm reduction objectives (Rhodes et al., 2017), where the care practices within couples who inject drugs (Rance et al., 2017; Rhodes et al., 2017). For the PWU-IPEDs, this further insulates them from healthcare providers, whilst simultaneously providing them with specialised oversight informed by lived experience. In this way, our interviews substantiate Rhodes et al.'s (2017) notion of 'counter-care' concerning the concept of normalcy. They portray partnerships among PWU-IPEDs and coaches as an expression of physical and psychosocial support, through harm reduction. This dynamic illustrates the community's dependence on experiential learning and peer-based sharing as primary mechanisms for the transmission of information, ultimately shaping the emergent organic harm reduction response (Francia et al., 2023) and emphasising open and inclusive discourse, IPED coaches may contribute to safer practices within this community.

In a healthcare landscape where traditional providers often fall short in engaging with the IPED community due to stigma and a knowledge gap (Dunn et al., 2023; Piatkowski et al., 2024; Richardson & Antonopoulos, 2019), IPED coaches have emerged as crucial figures. This gap arises from the unique nature of IPED-related concerns, which deviate from conventional medical ailments, making specialised guidance challenging. In particular, one study reported from 134 UK-based doctors ranging in seniority, that 97% had received no formal training related to IPEDs (Hill & Waring, 2019). As a result, IPED coaches play a vital role in addressing the distinctive needs of the IPED community, navigating the complexities that stem from societal stigmatisation and a lack of understanding within the healthcare system. PWU-IPEDs face numerous challenges and their experiences often clash with prevailing stereotypes of 'roid rage' and conventional depictions of 'steroid junkies' as

marginalised individual (James & Wynn, 2022; McVeigh & Bates, 2022). This builds upon a narrative of harm, primarily driven by media outlets which adversely affected their engagement with public health provision (Bates, et al., 2021; Dunn et al., 2023; van de Ven et al., 2022). While not all PWU-IPEDs may encounter severe harm or adverse side effects, some will experience negative health consequences (McVeigh & Begley, 2017). It is crucial to recognise that this social stigma is not just a societal attitude but also translates into structural harms, perpetuated by disparities in material resources and access to essential services such as treatment (Goodyear et al., 2021). Among other cohorts of PWU-drugs, these disparities are believed to create a constant state of vulnerability, necessitating a primary emphasis on coping strategies (Rhodes & Treloar, 2008). Similarly, our data underscore the pervasive stigma surrounding IPED consumption, also associated with healthcare settings, which can hinder open discussions. Coaches stress the urgency of reshaping societal attitudes and policies toward drug use, emphasising the need for destigmatisation through open dialogue.

In several countries, including Australia, discussions around the use and consumption of IPEDs are ensnared in a legal conundrum. The Australian context, characterised by punitive measures against IPED use, amplifies the prevailing stigma linked to these substances (Piatkowski et al., 2023a). This legal categorisation, intertwined with societal stigma fuelled by media representations (James & Wynn, 2022), further exacerbates the reluctance of PWU-IPEDs to openly communicate about their consumption, even in regions where personal possession of AAS is legally permitted, such as the UK (Kimergård, 2015). The complex interplay of sociocultural factors, legal frameworks, and healthcare structures in different jurisdictions, like Australia and parts of Europe, where coaches from this study reside, results in varied outcomes (Harvey et al., 2019; McVeigh & Bates 2022; van de Ven et al., 2022). Consequently, this legal framing obstructs the integration of IPED-

related discussions into routine healthcare dialogues, hindering comprehensive understanding and management of IPED use within traditional healthcare paradigms. In addressing the intricate legal and societal dynamics surrounding IPED use, IPED coaches play a role as intermediaries by offering consultancy services that operate independently from traditional medical paradigms. This neutral ground enables individuals to engage in open discussions and receive guidance regarding IPED use, effectively circumventing the challenges posed by legal and social factors. Therefore, a key finding from this research is the call for future harm reduction and intervention initiatives should consider incorporating individuals with chemical capital through lived experience in the IPED community as essential collaborators. Policymakers need to shift their attention towards formulating more nuanced and inclusive drug policy that prioritises harm reduction and acknowledge the expertise of peers in this domain.

This research is not without limitations. We acknowledge the narrow representation of a global phenomenon with a sample of 10 individuals, predominantly from Australia. However, although the study's sample was modest, PWU-IPEDs are notoriously secretive and resistant to outsiders, requiring a high level of sociocultural capital to be allowed 'inside' the community; IPED coaches even more so – perhaps driven by the dubious legal status of the services they provide (Paoli & Cox, 2024). Therefore, this research represents a world-first dedicated exploration into the detailed narratives of IPED coaches, utilising an international sample. It is also crucial to recognise that the IPED coaching community discussed in this study operates in a legal grey area, and there is little understanding of the culpability, an area which warrants further investigation. Our study highlights the significant role of IPED coaches in the harm reduction efforts within the IPED community, bridging the gap in public health responses. These coaches wield their chemical capital to harmonise nuanced harm reduction within the dynamics of their partnerships, echoing the concept of

'counter-care' and challenging prevailing norms of PWU-AAS and other IPEDs. Their peer-driven knowledge exchange model and emphasis on open discourse may offer potential pathways to safer practices within this community and beyond, while recognising the pervasive impact of stigma on PWU-IPEDs and the need for destigmatisation through open dialogue.

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