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HED Matters

Theme: Sexual Enhancers

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Image by Jerzy Górecki from Pixabay.

HUMAN ENHANCEMENT DRUGS

Editorial

Welcome!

The HEDN team has been working hard to put together what we hope you will find to be another engaging and informative edition of HED Matters. Once again, we are fortunate to have fantastic contributions from a variety of individuals. The HEDN is thankful for their willingness to contribute and we are appreciative of the dedication of their time.

In this issue we explore sexual enhancers. First up, we have Kerryn Drysdale who discusses the use of crystal as it relates to pleasures and risk around sex. This is followed by our very own Jim McVeigh who examines the fine line between therapy and enhancement. We then hear from Wesley Inman, bodybuilder, power sports athlete and owner of an online supplement store, who is featured in our Q&A. Last but not least we have Orlanda Harvey contributing to the ECR spotlight where she reflects on the trajectory of her work, and Sam Keitaanpaa in the practitioner's corner covering the unregulated practices of offering premature treatments.

We would also like to take this opportunity to highlight a symposium hosted at the UNE Paramatta campus, Sydney on the 11th of February. This symposium is connected to a **special issue in the International Journal of Drug Policy** (IF: 4.244 / Q1) on human enhancement drugs. Through these outlets, we will be exploring emerging issues around human enhancement drug use, and the challenges of responding to the use of drugs for human enhancement. For those who can't make the trip, participants are welcome to attend via Zoom.

More information can be found here: https://humanenhancementdrugs.com/hedinfo/events/ijdp/

We would like to thank our members for their continued support and thought-provoking work on human enhancement.

Yours sincerely
The HEDN Board


Dr Katinka van de Ven


Dr Kyle Mulrooney


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All contributions reflect the author's point of view. Inclusion does not confer endorsement by the HEDN Board.

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Recent Advances in HED Research: Podcasts as resources? Yes! Collaborative research translation concerning gay and bisexual men who use crystal for sex

By Kerryn Drysdale, Research Fellow, Centre for Social Research in Health, University of New South Wales, Australia

Crystal Clear: Negotiating pleasures and risk around sex on crystal is a series of podcasts discussing crystal methamphetamine use among gay and bisexual men in Australia, especially where use is combined with sex.

These podcasts are the result of a three-year collaboration between researchers and community health organisation partners, and form the backbone of research dissemination efforts from the *Crystal Pleasures and Sex between Men* research project. Podcasts were identified by the research team as an appropriate way to disseminate this research, and we specifically designed these podcasts to provide information and resources in non-judgemental way and to avoid sensationalising the issue or inducing panic.

Project background

The crystalline form of methamphetamine (also known as “crystal”, “ice” and “meth”) is a commonly used illicit substance associated with sexual activity among a minority of gay and bisexual men in Australia. The correlation between crystal methamphetamine and poor health outcomes include risks of drug dependency, mental health issues, heart and other physical health factors, and increased transmission of blood-borne viruses such as HIV and hepatitis C.

Of concern is the fact that Australian gay and bisexual men report higher rates of crystal methamphetamine use compared with the general population, with HIV-positive men more likely to use and inject crystal than their HIV-negative peers. This suggests that that there may be particular modes and patterns of use specific to this group of people. To date, little was known about the specific ways that gay and bisexual men use methamphetamine in Australia, and how particular forms and patterns of drug use related to perceptions of risk and harm.

To explore these associations further, the *Crystal Pleasures and Sex between Men* research project was conducted between 2017 and 2019, and examined gay and bisexual men’s crystal use in four capital cities in Australia (Sydney, Melbourne, Perth and Adelaide). Its aim was to develop a nuanced understanding of the ways in which crystal is used, the pleasures these men associated with having sex on crystal, and the strategies they employed to reduce the risks associated with its use.

Data was drawn from individual in-depth interviews with 88 gay and bisexual men residing in each of those cities, as well as telephone interviews with 35 key informants working in the health policy, sexual health, harm reduction and blood borne virus prevention fields.

From analysis to dissemination

Podcasts were based on data that revealed diversity in how gay and bisexual men used crystal for sex. Crystal methamphetamine use varied in terms of frequency, where they used, who they used with, and how they administered the drug—and these patterns changed as men moved within and between different networks. When we consider the multifaceted and intertwined factors that can mediate men's patterns of use we can also identify how these factors might shape the pleasures and risks of sex on crystal in various ways, including those that might change over time.

> "... crystal methamphetamine use takes place in social and sexual contexts as a group or collective, rather than as an individual activity."

At the same time, our analyses showed that crystal methamphetamine use takes place in social and sexual contexts as a group or collective, rather than as an individual activity. In particular, we took an analytic approach that privileges 'sex-based sociality' as a foundational premise of understanding gay and bisexual men's combining of sex and drugs (that is, how drug-taking practices can shape sexual activity in networks of gay and bisexual men through the particular meanings communities and their members attach to sex and drugs).

This includes identifying the role of peers in the dissemination of information, support and resources within sex and drug-taking networks. We found that modes of peer engagement can take place in tandem with, or even exist in the absence of, access to formal service provision.

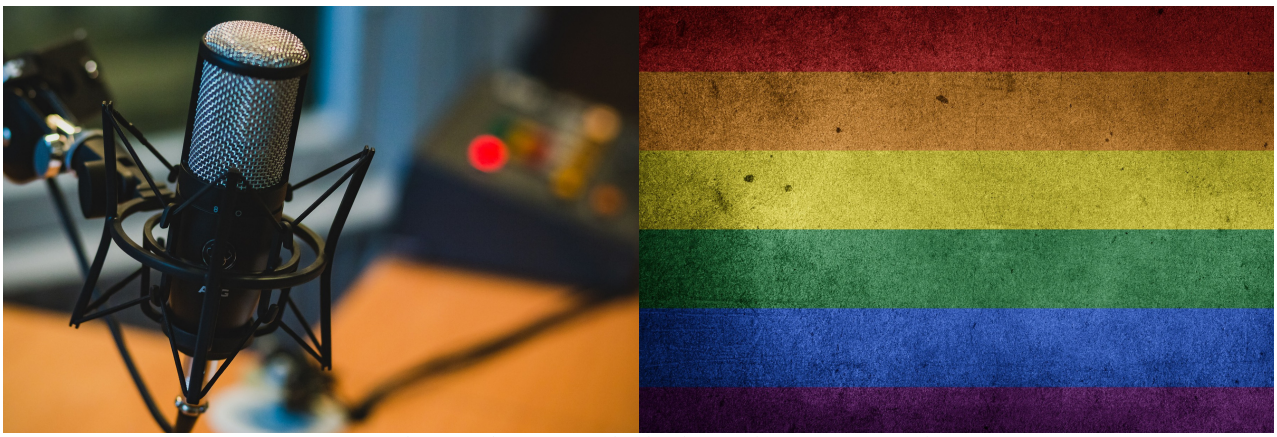
Acknowledging the complex intertwining of drugs, sexuality, and sociality can provide opportunities to develop innovative programs in response to gay and bisexual men's drug use in the context of sexual activity.

At the forefront of research dissemination efforts

It was also clear that access to, and engagement with, peer-led support, information, resources and harm reduction provisions was uneven across the study population. Podcasts were seen as a potentially simple and expansive way to reach populations who might experience barriers to accessing current services and information.

And as many of us who work in health know, effective research translation requires engagement with target audiences in authentic and resonant ways. The project team felt that podcasts privileging experiential, peer-to-peer knowledge could disseminate health promotion and harm reduction strategies.

We hope that these podcasts demonstrate how research findings can connect with affected communities to allow for more meaningful engagement with individuals who may be concerned about their own or others' crystal use, and to enable stakeholders to adapt research material for more targeted responses.



Images by StockSnap and Chickenonline from Pixabay.

Three podcasts feature data from the research with expert commentary from community members and health workers in three key areas related to gay and bisexual men's use of crystal for sex: 1. Strategies for managing crystal use and opportunities for intervention; 2. Support needs of those who themselves support these crystal users; 3. Workforce development and engagement between health promotion, harm reduction, and AOD sectors in response to crystal use.

Collaborators, funders and acknowledgements

The project team is led by Prof. Carla Treloar and includes Prof. Gary Dowsett, Dr Max Hopwood, Prof. Martin Holt, Dr Toby Lea, Prof. Peter Aggleton, A/Prof. Joanne Bryant, Dr Kerryn Drysdale, Mr Brent Mackie, Mr Colin Batrouney and Dr Helen Calabretto.

Crystal Clear: Negotiating pleasures and risk around sex on crystal podcasts were produced by the Centre for Social Research in Health, at UNSW Sydney, in partnership with ACON, Thorne Harbour Health, South Australia Mobilisation and Empowerment for Sexual Health, and Western Australian AIDS Council.

Crystal, Pleasures and Sex between Men is a research project run by the Centre for Social Research in Health at UNSW Sydney in partnership with the Australian Research Centre in Sex, Health and Society at La Trobe University, ACON, Thorne Harbour Health, South Australia Mobilisation + Empowerment for Sexual Health, and Western Australian AIDS Council. This research is supported under a National Health and Medical Research Council Project grant and by a grant from the Western Australia Health Department. The Centre for Social Research in Health and the Australian Research Centre in Sex, Health and Society also receive funding from the Australian Government Department of Health and Ageing.

You can find more information at:

- https://csrh.arts.unsw.edu.au/research/projects/crystal-pleasure-and-sex-between-men/
- https://www.crystalpleasuresex.org.au/publications/

Crystal Clear:

a podcast about negotiating pleasures and risk around sex on crystal

soundcloud.com/crystal-clear-podcast

Episode 1. Crystal: The Beauty and the Trap

Episode 2. Cultures of Care: Conversations with people who provide support to crystal users

Episode 3. What Workers Say: Health care professionals engaging gay and bisexual men using crystal for sex

Produced by the UNSW Centre for Social Research in Health, in partnership with ACON, Thorne Harbour Health, South Australia Mobilisation and Empowerment for Sexual Health, and Western Australian AIDS Council.

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A PARTNERSHIP BETWEEN SHINE SA & THORNE HARBOUR HEALTH

WAAC
Western Australian AIDS COUNCIL

Institutional Spotlight: The Fine Line Between Therapy and Enhancement: The Case Example of PrEP

By Dr Jim McVeigh & Dr Jennifer Germain, Public Health Institute, Liverpool John Moores University

Research report on Human Enhancement Drugs published in April 2012 by Liverpool John Moores University.

While human enhancement drug (HED) use is by no means a new phenomenon, we are still at the very early stages of defining and refining the categorisation of this form of drug use. For over twenty-five years, I (Jim McVeigh) have had the privilege of collaborating with many researchers and practitioners in this area, initially concerning the use of anabolic-androgenic steroids before taking a wider view of the use of HEDs.

Ten years ago, I, together with Michael Evans-Brown, attempted to form the classifications of HEDs. Perhaps the most difficult category was mood enhancement drugs as some of the most prevalent psychoactive substances such as alcohol, tobacco, cannabis and cocaine could all fall within this category. Even the more straightforward categories were not without their complications.

When it comes to musculature, there can be little debate regarding anabolic-androgenic steroids, but what about "synthol"? – a site enhancement oil that does not contain active pharmaceutical ingredients (other than alcohol and a local anaesthetic). Are dermal fillers HEDs? This led me to the question: does a HED need to be a drug at all?

Eventually, consensus was achieved, and despite some unease we published the report *Human enhancement drugs: the emerging challenges to public health* and the paper *Human enhancement drugs and the pursuit of perfection*.

Where does therapy end, and enhancement begin?

The main dilemma for me surrounded the definition of enhancement and its delineation from treatment. For many, enhancement is merely a restoration of optimal capacity – the very essence of treatment to combat injury, illness or deficiency. However, the issue of differentiation between enhancement and prevention is something which until now, I had not considered.

Jennifer Germain has worked at Liverpool John Moores University (LJMU) for over a decade as both a PhD student (examining women's use of unlicensed weight loss drugs) and as a researcher. It is working with her regarding the use of HIV pre-exposure prophylaxis, or PrEP as it is more widely known, that led me to reconsider another aspect of the widely accepted categories of HEDs. PrEP is a daily course of antiretroviral drugs which is taken by HIV negative people to reduce the probability of infection if exposed to HIV. Trials have shown PrEP to be effective with daily dosing reducing the risk of contracting HIV by up to 99% and event-based dosing by approximately 86%.

Current literature is unclear concerning whether PrEP encourages 'riskier' sex or changes sexual risk behaviours. However, whilst PrEP clearly sits within the field of prevention, it can also fit within an enhancement context, particularly when considering sexualised drug use or chemsex. Chemsex refers to the use of drugs, often crystal methamphetamine, mephedrone and/or GHB/GBL, commonly used by men who sex with men (MSM) within a sexual context. The combination of these drugs can facilitate and enhance sexual parties or sessions which can last several hours or days and involve multiple sexual partners.

The addition of PrEP to chemsex drug regimens can confer a highly effective harm reduction strategy but also obvious practical benefits over other preventative measures such as condoms. For all sexual activity, where HIV infection is a risk, regardless of whether under the chemsex umbrella or not, users of PrEP are taking control of their own sexual health, which could have positive affective changes such as reducing sexual anxiety and allowing for 'sex without fear'.

This view of PrEP as an enhancement drug highlights the difficulties that we have in defining and categorising this form of drug use. The current structure of HED categories has been a useful and novel tool for taking a fresh look at a long-standing phenomenon. However, the example of PrEP as both a prevention and enhancement drug adds to the long-standing dilemma of separating psychoactive and enhancement (motivations for use and effect) and the blurring of enhancement and treatment (the restoration of optimal function).

Calling for theoretical papers on HEDs!

Therefore, we conclude that the current definitions and categorisation of HEDs needs to be reassessed and requires a comprehensive re-evaluation of what constitutes a HED. We call on scholars within this field to explore the theoretical basis for what constitutes or defines a HED and to potentially, take advantage of the opportunity to publish in a special edition of the International Journal of Drug Policy.

Read more about the special edition here:

- https://humanenhancementdrugs.com/hedinfo/events/ijdp/

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Q&A with Wesley Inman on his personal use of sexual enhancement drugs

Wesley Inman is a bodybuilder, power sports athlete and owner of an online supplement store

Source: Wesley Inman.

Could you briefly introduce yourself and how you became involved in bodybuilding and power sports?

I started lifting weights when I was 8 years old after having had a fracture to my elbow's growth plate. This event was the starting point for my 23 years of competing in the Competitive Strength and Fitness Industry.

The doctor suggested weight lifting, so I got one of those Kmart sets, where the weights had sand in them, and started working out ignorant of what I was doing. I then read Arnold Schwarzenegger's Encyclopedia of modern bodybuilding and various other books on training such as Ivy and Portman's Nutrient timing and Bill Phillips' Body for Life.

All this meant that very quickly I learned the ins and outs of nutritional supplements, performance-enhancing drugs and exercise. Also, having played sports in high school and at college, I had an ongoing relation to weight lifting. Upon entering college, I was introduced to and started training with a juiced-up (steroid-using) Lacrosse team. They inspired me to start competing in powerlifting and bodybuilding. Eventually I transitioned to strongman and also to highland games competitions.

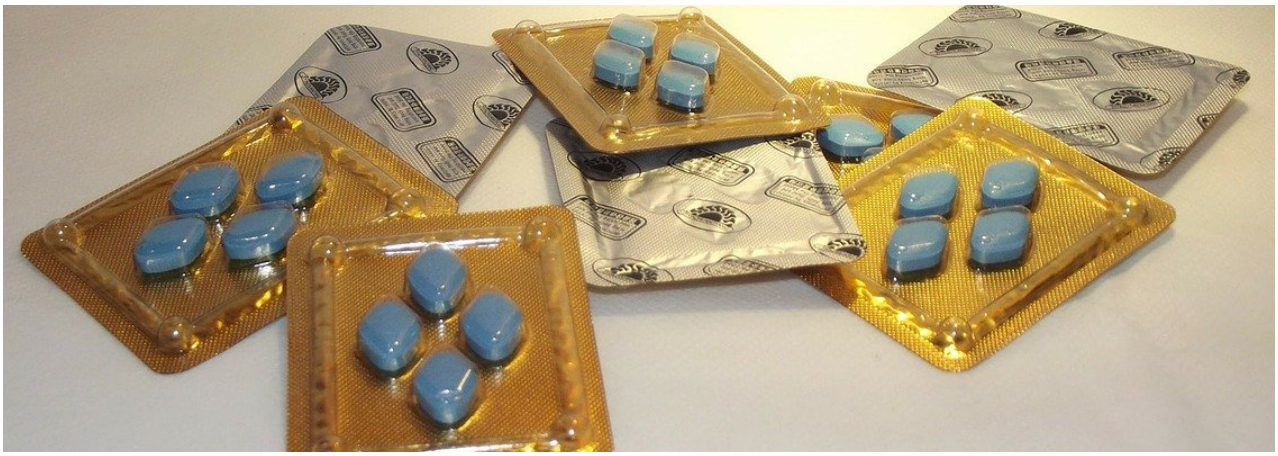

Image by PublicDomainPictures from Pixabay.

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700 lbs squat. Source: Wesley Inman.

What is your experience with sexual enhancement drugs?

I actually had Testosterone and Cialis prescribed at a pretty young age – 23 perhaps. I underwent a legitimate medical procedure, varicocele surgery, and the doctor was convinced that I would suffer from erectile dysfunction for a while after the procedure. This was the reason why I received my first prescription, and I have used the drug since then. I probably take 5-10 mgs of Cialis two times per week. The fact is that I never suffered from erectile dysfunction as a result of the the procedure, but the benefits of the product were excellent and I therefore requested to retain my prescription, which I was granted with no questions.

I have also used Cialis for pre-workout purposes, which is very common in the United States among bodybuilders, although the primary reason that I use this prescription is the sexual advantages it affords. I don't need to take it more than 2-3 times per week since it has a long half life and stays in the body for several days. The most commonly prescribed dosages of Cialis are 5 miligrams per day or 20 miligrams PRN (i.e. when necessary).

Where do you obtain these substances and how do you know they are reliable?

I have a prescription but there are many ways to obtain these drugs through other channels. There are black market sources and also private medical sources. These sources will do a Skype session with you and a physician and get you prescribed and ship your erectile dysfunction pills to your house. The mark-up is extraordinary. A bodybuilder can buy a gram of Cialis for $5-10 bucks from a raw material supplier. This equals approximately 50 pills of Cialis or of a similar drug. If you purchased the same from a pharmacy store you would have to pay $1,000. From a privately prescribed resource you would have to pay around $100-200.

In terms of reliability, you know these suppliers are legit because of word of mouth. There are various well-shared companies that bodybuilders use, which have had thousands of customer feedback reviews and lab test results. It is very easy to obtain authentic medication for erectile dysfunction from the black market. You will even see companies that market products with a mixture of Cialis, Viagra and fast-acting anabolic steroids, such as Testosterone Base, although the mainstream athletic systems and athletes are unfamiliar with these products.

How do you benefit from taking them?

I benefit from these drugs in two ways. First, my erections are improved and I even get a bit of libido boost from taking them. Also, most men appreciate these effects because if they drink alcohol and suffer from weak erections, these drugs can prevent that from occurring.

Second, in terms of pre-workout benefits, drugs like Cialis gives a great pump to the muscle and makes the user “fuller” for an hour or two after
the workout. Both of these types of effects are physically and emotionally pleasing to the user and this is the reason why the use of sexual enhancemenet drugs is so widespread in some communities. I have also seen and heard of women using these drugs.

Have you had any negative experiences using these drugs?

Yes, when taking high doses of Viagra (50-100 miligrams) most users, myself included, will experience a very stuffy nose and headache. We also know that it is not advised to use these drugs if the individual has an underlying medical condition.

Wesley performing the Strongman event called "Conan's Wheel of Pain" named after the famous movie Conan the Babarian. Source: Wesley Inman.

Do you think they should be legally available for non-medical reasons? Why/why not?

I think these substances should be de-criminalized together with other performance-enhancing drugs. I am not sure that they should be over-the-counter, however, because there are many over-the-counter pills that include these compounds or contain other ingredients, which are actually more dangerous than just, say, Levitra, Cialis, or Viagra. These are PDE-5 inhibitors and we do know we have several over-the-counter options that are just as good. For instance, if you purchase some 98% icariin’s, aka Horny Goat Weed, this will have just as good effects as, say, Levitra or Cialis would, and would probably also be safer overall. It is actually more difficult to obtain a legal 98% Goat Weed than it is to obtain some raw Tadalafil or Sildenafil aka Cialis or Viagra.

Thanks for taking the time to share your experience!

Thank you for giving me the opportunity to share my personal account!

User's voice: Steroids in the Bedroom: 'I felt like an overworked porn star'

By Kees

I had been on 600mg of testosterone cypionate and 50mg of Dianabol for 5 weeks when I "felt it"... an increased sex drive... Increased sex drive is a well-known side effect of the hormones I was experimenting with – but "side effect" doesn't really describe what I had been feeling for the past week, nor what I would feel in the weeks to come.

It was a NEED for sex that I just couldn't shake off. By week 12, I would be craving sex every second – my partner and I were having sex four times or more per day and masturbation was a necessity for the in between.

Before this, sexual activity averaged 4 times per week – now I was sexting with her, looking at pornography at my office, and having marathon sex sessions...

Where it all began

I started using anabolic steroids when I was 25 years old, nearly 5 years ago now. The reason I started was quite simple: I wanted to get bigger, stronger and faster without having to wait for the results – I have lifted weights on and off since I was 15 years old. My results were positive, but I just wanted more results, and faster.

It didn't mean much to me at the time, but I felt a frequent lack of energy. My sex drive seemed normal, but I experienced periods where I felt a lack of interest in sex. I would back out of social events because I didn't feel like I had the drive and/or energy to go through with them. I felt down, not depressed, but less "up" than I wanted to feel.

To do or not to do, that is the question

I had been on the fence about doing a "cycle" of steroids. I had read the book Anabolics by William Llewellyn, scoured online forums with a focus on threads and posts that provided citations. I became better than the average person at deciphering hormone-based studies, analyzing bloodwork and became familiar with google scholar – I considered myself humbly well-informed.

I decided to check my bloodwork, which I ordered privately myself, and if my testosterone levels were above average I would forgo the cycle. My bloodwork looked normal – until I got to the bottom where my testosterone levels were listed. They were just a few points higher than the lowest end of the reference range.

It was tough for me to see this – was this where all that wasted effort was going? Was this why I didn't feel that "alpha" feeling that I sometimes felt lacking? It turned out to be the perfect excuse for me to move forward, full steam ahead.

I sourced my testosterone and ancillaries from online sources that I found through a steroid forum on which I had spent months as a contributor. I bought the erectile dysfunction (ED) medication Cialis on a whim because it has been shown to lower blood pressure, and mine was running on the upper side of normal at the time – the side effect of better pumps in the gym and rock solid erections were fine by me too (I must add the obligatory male comment that "I've never had any problem with that").

Feeling like a sex god

By week 5, I felt it. I couldn't help but turn my head every time a female walked by due to an undeniable feeling of attraction to the opposite sex. This wasn't necessarily new, but my sense of attraction was noticeably heightened.

I felt a growing sense of connection to my partner, whose sex drive was also increasing – most likely due to her growing sense of being wanted more. I felt like a porn star, I could have sex back to back after climax. I was always ready; I could go as long or as short as the situation called for. I felt that I could tap into my partners sexual fantasies in a more creative way – and this made sex more pleasurable for both of us.

The Cialis I was taking was as advertised, it wasn't needed at all with the amount of testosterone in my body – but it was a fun addition. It turned a strong erection into an enhanced one, I experimented between 5mg and 30mg, eventually settling on 5mg per day.

I was beginning to grow weary of the sex drive that was consuming me – a 600mg dose of testosterone is approximately three times higher than what would be typically prescribed for hormone replacement, for some patients it could be even six times higher.

As for her, she simply never had a chance to keep up with me but she did her best during the 14 weeks. She was worn out, and what at first she found cute, sexy and a little funny, was becoming a chore for her because it was so excessive.

Sex four times per day was sometimes just not enough, my brain felt physically tired due to the constant barrage of sexual thoughts that raced through my mind. I felt like an overworked porn star now, or a sex addict. It was time for the cycle to come to a close.

Change in sexual interests

5 years later – I am now on self-administered testosterone replacement therapy at 200mg per week.

Image by Nietjuh from Pixabay.

I later tried Viagra; it was sent as a free gift from a source and I was surprisingly unimpressed.

Needing a sex break

Seven weeks later both my partner and I were growing tired of my cycle and needed a sexual hiatus. There is only so much sex that a person can have and still enjoy, and we were skirting the line.

The previously mentioned lack of energy has disappeared, I rarely feel periods of low sex drive however, it doesn't consume me like it did during my first cycle unless I drastically increase my dosage or add other compounds such as trenbolone.

I have experimented with approximately a dozen different anabolic hormones, however, testosterone still reigns king with regard to sexual enhancement to me with trenbolone a close second.

Approximately half of the compounds I take are sourced from a brick and mortar pharmacy in Europe, the rest are sourced from a raw material distributor in China and Icompound the hormones myself.

I feel my sex life is enhanced by taking the hormones, and after asking my partner, she seems indifferent aside from the fact that she feels more desired when I have an enhanced sex drive – which is quite powerful itself.

The most interesting side effect to me is that some of my sexual interests have changed – I'm more open to sex acts that I was completely indifferent towards in the past, or even completely against.

I am much more intrigued by the idea of group sex, swinging, or even an open relationship at some point – something that I would have been very much against prior to these hormones entering my body.

I feel as if there was a primal sexual switch that flipped when these hormones initially took hold, or perhaps I just feel more sexually confident. I feel it's important to mention: no hormone has ever made me consider pushing the boundaries of consent – but I do wonder if someone with a misguided moral compass could.

I found these sexual enhancement side effects completely by accident, I was expecting them but not to this extent – but now that I have them, they are amongst the top three reasons that I will remain taking them for the rest of my life.

ECR Spotlight: From Social Work to Studying Steroids

By Orlanda Harvey, PhD student, Bournemouth University, United Kingdom


Source: Orlanda Harvey.

If someone had told me ….

…20 years ago, when I was standing on the Royal Air Force (RAF) parade ground, that later in my life I would be sitting having coffee with a Professor discussing libido and anabolic-androgenic steroid (AAS) use, I would have been more than a little bemused. After several years working as a training practitioner in a number of organisations including the RAF, Amazon, and both Cranfield and Bournemouth Universities, I saw the light and became a qualified social worker.

As part of my Masters in Social Work, I spent six months with a Drugs and Alcohol Team which included working in needle exchange programmes in the UK. Here, I encountered people who use AAS accessing a harm minimisation service. What struck me was that they seemed very different from the more traditional users of the service. This sparked my interest, which was further fuelled by the harm minimisation team lead.

In none of the elements of my Masters were these substances discussed, which inspired me to explore in my thesis if there was a need for social workers to have knowledge on AAS use. Of particular interest were motivations for use, risks to self and others, and support provision. Little did I know that this would lead me in a whole new direction for the next couple of years.

My dissertation concluded that social workers should have an understanding of steroid use, particularly as it relates to young people who may also have had a history of adverse life experiences (Harvey 2018, Harvey and Parrish 2019). It also seemed that support was needed but that current UK provision was inconsistent and not always tailored to the needs of this group.

My experiences of talking to those people who use steroids in the needle exchange never really left me, so when the opportunity presented to return to Bournemouth University as a PhD student, I jumped at the chance. My PhD study investigates the support people who use AAS want and users' perspectives of their motivations and experiences of use.

Embarking on the PhD!

Social workers are encouraged to take a psychosocial perspective and a person-centred approach to substance use, viewing the drug user as the expert in their use (Galvani 2012). So, from the outset I wanted the users' voice to be at the heart of the research. This led to reflections on how AAS use is viewed in society, how the risks are presented by government agencies and the impact that society's views have on service provision.

I am currently approaching the end of my PhD and I can tell you, it has been a journey with many twists and turns including a significant rethink of my data collection method due to local authority changes and shifts in support service provisions (no surprises there, I think, for anyone working in the field). This has meant that rather than working solely with my local needle exchange, I have also sought participants from across the globe, via needle exchanges but also via gyms and social media. The latter constitutes a whole new learning experience in itself - the world of bodybuilding and Instagram was a revelation - which has led me to talk with some very thoughtful and insightful people along the way. I also owe a great deal of thanks to several gatekeepers who made my research possible.

From muscles to masculinity, from steroids to sex...

So, I am imagining by now that you are asking what all this has to do with human enhancement drugs and sexual performance? Well, emerging from my data is the theme of side-effects of AAS on sexual performance and libido. It has been widely documented that side-effects from stopping AAS use - causing a decrease in testosterone levels - may include erectile function problems and reduced libido; likewise, side-effects from using AAS include self-reports of increased sex drive. Increased sex drive appears as a reason for use in the literature but is not reported as a main motivator.

"Sexual side-effects as a reason for continuing to use AAS or returning to use after a drug-free period was unexpected as I had not found an extensive narrative on this in the literature. To be honest, I also had not foreseen such a frank discussion. Sex is often a taboo topic and something that is not often openly talked about."

The impact of side-effects of low testosterone, relating both to reduced sex-drive and/or feeling anxious or experiencing a low mood, was something that many of my participants wanted to share as part of their experiences of using steroids. Sexual side-effects as a reason for continuing to use AAS or returning to use after a drug-free period was unexpected as I had not found an extensive narrative on this in the literature. To be honest, I also had not foreseen such a frank discussion. Sex is often a taboo topic and something that is not often openly talked about. There was a message around the need for a greater understanding of the impact of low testosterone on men.

Testosterone Replacement Therapy, sexual function, sex drive and masculinity

Testosterone replacement therapy (TRT) is also something that has recently been picked up by UK media as illustrated e.g. in a recent article entitled 'My energy is back': how testosterone replacement therapy is changing men's lives (Hill 2019). There have been some interesting and conflicting opinions on the merits of TRT in the academic literature and AAS users in my study were keen to advocate for TRT.

It may seem unusual for a researcher with a feminist perspective to be curious about this aspect of use, but it seems that just as certain aspects of female health have long been overlooked, the impact of low testosterone on men's health may be an area that has not been seen as significant; this could be linked to social gender norms, as loss of libido can impact on a men's notion of masculinity (Chambers et al. 2017).

Moreover, men may not feel able to share or speak about vulnerabilities that are connected to perceptions of manliness, and part of my thesis will reflect on the links between sexual function, sex drive and masculinity. Hopefully, the insights from my research will lead to better understanding of the information and support requirements of people who use AAS and also challenge stereotypical perceptions of those who use AAS.

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Bournemouth University

Practitioner's Corner: The Long Hard Truth of Unregulated Medical Practices Offering Premature Treatments

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Recently, I have witnessed the rise of the 'anti-aging' clinic. These clinics operate with a specialist focus on therapies to reduce ailments commonly associated with, unsurprisingly, the aging process and often heavily feature treatment of sexual dysfunction through hormone replacement or bespoke formulations of existing medicines which require compounding by specialist pharmacies.

The efficacy of these treatments in comparison to standard therapies is widely debated. As non-registered products they do not have the premarket studies on their efficacy and do not need to conform to the same regulations that licenced medicines do and there is almost no data on the rate of adverse effects of these medicines or about the long-term risks of their use.

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The Grey of treating going grey

Diving deeper into accessing novel sexual enhancement medicines or indeed the more ambiguous 'anti-aging' category of medicines, this semi-regulated environment becomes more like a market bazar. There are businesses, mostly online, who advertise a 'one stop shop' for a range of substances which are either scheduled medicines or research chemicals all touted as improving sexual function, increasing libido or altering body composition.

Given that it is illegal to supply scheduled medicines directly to the public, these services use compounding pharmacies to manufacture and supply medicines for the individual patients, circumventing Therapeutic Goods Administration (TGA) regulation. These services also require a prescriber to make this process legal and most, if not all, advertise they use 'anti aging' clinics.

There has been significant pushback from specialist endocrinologists who question the therapeutic merit of these clinics, but there are no standards about their operation. Pharmacies are expected to conform to their professional standards about providing medicines that are safe and effective, and the manufacture of these products must be sanitary and within the scope of practice of the pharmacist.

Both groups are also expected to practice in a way that protects the image of their professions and protects the public at large.

The risks of a developing model

In the case of sexual dysfunction, especially erectile dysfunction, it is as much a psychological as a physical problem, and even within the physical causes there are significant modifiable risk factors. The use of medicines has an important place, but many cases can be managed without them. Similarly, in roughly half the cases where a conventional medicine is reported to be ineffective, incorrect dose or dose timing is to blame and correcting this resolves the issue.

Optimally managing diabetes, hypertension, smoking, diet and mental health are also well established to improve sexual function. Where the cause is not a physical one, sex therapists routinely improve patients' sexual function and libido through counselling and relationship mediation. While some specialist anti-aging clinics offer access to these services, it is by no means the norm, and the business model itself is often not centred around routine disease management like a GP is or referring on to specialists.

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In my experience, these clinics become known as ones that are open to prescribing medicines which others do not and the pharmacies become known as the access point for medicines which would raise eyebrows in a regular community pharmacy. If you ask any person who has worked around these practices, they will tell you of calls from patients wanting to fill prescriptions for performance- and image-enhancing drugs, prescribers seeking access to treatments with little to no evidence, being pressured to supply illegal products and, equally worryingly, patients whose treatment is woefully suboptimal.

This is not to say that both of these business models are unethical. In fact, there are just as many doctors who specialise in hormonal dysfunction and sexual health and many compounding pharmacies who provide a much-needed service for dose alteration and specialist medicines. Similarly, there are specialist services who provide a holistic service to manage all aspects of the patient, including sexual health. But how does this apply to consultations, prescribing, dispensing and supplying of medicines with no actual interaction with the patient?

Looking forward to the future

As health professionals we must remember that our obligations are not just to the safety of a single medicine or treating a single condition in isolation. In some cases, our treatments may carry more risk than we realise. While it may not be our intention, operating and advertising these services has a strong implicit conflict of interest as they can be financially rewarding. Similarly, we are more at risk of biases in our professional judgement when we provide care to people that 'mainstream' medicine is not managing.

When offering these specialist services, we need to be more diligent than we would be in regular practice, not least because there is less guidance. This is doubly so around how it impacts our professions. It's often not until you are on the other end of a call with a discredited sports scientist before you reflect on how you got there.

Sam is a community pharmacist practicing in the Northern Territory of Australia. He is undertaking his PhD around prescribing behaviour and medicine supply and has delivered education to health practitioners around performance- and image-enhancing drugs, medicinal cannabis and PrEP as well as the importance of medicine management in remote areas and the role of the pharmacist. He is a strong advocate for pharmacists practising to their full scope and ensuring medicine supply meets the needs of patients while protecting their rights.

Source: Sam Keitaanpaa.

Upcoming Events and Conferences

15-17 January 2020:
International Conference on the implementation of the revised World Anti-Doping Code (Limburg, the Netherlands): https://www.icic2020.nl/conference

11 February 2020:
Human Enhancement Drugs Network (HEDN) Symposium (Sydney, Australia): https://humanenhancementdrugs.com/hedinfo/events/hednsymposium/

9-11 March 2020:
6th Global Alcohol Policy Conference (Dublin, Ireland): https://www.gapc2020.org/

17-18 March 2020:
WADA 2020 Annual Symposium and Athlete Session (Lausanne, Switzerland): https://www.wada-ama.org/en/events/2020-03/wada-annual-symposium

2-5 April 2020:
American Society of Addiction Medicine Annual Conference (Denver, CO, USA): https://www.eventscribe.com/2020/ASAM/

20-22 May 2020:
The International Society For The Study Of Drug Policy (Aguascalientes, Mexico): http://www.issdp.org/conferences-and-events/

18-19 June 2020:
11th International Conference on Sport and Society (Granada, Spain): https://sportandsociety.com/2020-conference

15-18 October 2020:
13th National Harm Reduction Conference (San Juan, Puerto Rico): https://harmreduction.org/conference/

22-24 October 2020:
Global Conference on Addiction Medicine, Behavioral Health and Psychiatry (Orlando, FL, USA): https://addiction-behavioral-conferences.magnusgroup.org/

Let us know!

... if you are aware of any upcoming conferences and events

Publications by HEDN members

The human enhancement drugs network represents a diverse group of productive scholars from different academic disciplines. Below you can find the most recent work published by the members of the network. Image by Pexels from Pixabay.

Peer-reviewed journals

Andreasson, J. & Johansson, T. (2019). Fitness
Doping in Transition. Historical Transformations and Contemporary Challenges. Social Sciences.

Andreasson, J. & Johansson, T. (2019). Negotiating Female Fitness Doping. Gender, Identity and Transgressions. Sport & Society. Culture, commerce, media, politics.

Bates, G., Tod, D., Leavey, C., & **McVeigh, J.** (2019). An evidence-based socioecological framework to understand men's use of anabolic androgenic steroids and inform interventions in this area. Drugs: Education, Prevention and Policy, 26, 6.

Bates, G., Begley, E., Tod, D., Jones, L., Leavey, C., & **McVeigh, J.** (2019). A systematic review investigating the behaviour change strategies in interventions to prevent misuse of anabolic steroids.. Journal of Health Psychology, 24(11), 1595-1612.

Boardley, I. et al. (2019). A qualitative investigation of coaches' doping confrontation efficacy beliefs. Psychology of Sport and Exercise, 45.

Erickson, K. (2019). "Athlete suspended for presence of banned substance": A storied approach to protecting student-athletes from doping in sport. Journal for the Study of Sports and Athletes in Education, 13(3).

Dursun, S., **Dunn, M.**, & McKay, F.H. (2019). The availability and acquisition of modafinil on the internet. Drug and Alcohol Review, 38, 699–702

Fomiatti, R. [...] **Seear, K.** et al. (in press). A 'messenger of sex'? Making testosterone matter in motivations for anabolic-androgenic steroid injecting. Health Sociology Review.

Harvey, O. (2019). 'Shades of Grey': The Ethics of Social Work Practice in Relation to Un-prescribed Anabolic Androgenic Steroid Use. Social Work in Action, 31(4).

Kiepek, N., & Baron, J.L. (2019). Use of substances among professionals and students of professional programs: a review of the literature. Drugs: Education, Prevention and Policy, 26(1).

McVeigh, J. (2019). Engaging with people who use image and performance enhancing drugs: one size does not fit all.. International Journal of Drug Policy, 71, 1-2.

Richardson, A., & Antonopoulos,G.A. (2019). Anabolic-AndrogenicSteroids (AAS) Users on AAS Use: Negative Effects, 'Code of Silence', andImplications for Forensic and Medical Professionals. Journal of Forensic andLegal Medicine, 68.

Thomas, N., **van de Ven, K.**, & **Mulrooney, K.J.D.** (forthcoming). Barriers to harm reduction in rural contexts: a multi-dimensional exploration of rural risk environments. International Journal of Drug Policy.

Books

Andreasson, J. & Johansson, T. (2020). Fitness Doping. Trajectories, Gender, Body Ideals and Health. Chamstoke: PalgraveMacmillan.

Van de Ven, K., Mulrooney, K.J.D., &McVeigh, J. (2019). Human Enhancement Drugs. UK: Routledge.

Other published articles

Chatterjee, A. (2019, July). Cognitive Enhancement Is Okay, But Wait Until You Graduate. PsychologyToday.

Availble here: https://www.psychologytoday.com/us/blog/brain-behavior-and-beauty/201907/cognitive-enhancement-is-okay-wait-until-you-graduate

Vandenabeele, E. (2019, October). Why it's better we don't discuss anti-doping. And yet, I'm doing it again. Fitness.be.

Available here: https://humanenhancementdrugs.com/publications/blogs/

Van de Ven, K., & Mulrooney K.J.D. (2019, May). It's not all gym junkies and 'roid rage' –people use steroids for a variety of reasons.

Available here: https://theconversation.com/its-not-all-gym-junkies-and-roid-rage-people-use-steroids-for-a-variety-of-reasons-114981

Want to become involved?

Membership
HEDN is an international group of multi-disciplinary researchers with an interest in human enhancement drugs from various universities. We seek to strengthen working relationships between academic sectors, governmental agencies, NGOs, users groups and others interested in human enhancement drugs, performance and image enhancing drugs, and doping substances.

You can find the entire Human Enhancement Drugs Network on our website, where you can apply for membership: http://humanenhancementdrugs.com/hednetwork/

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