Clashing Masculinities: Steroids and the Law

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Abstract

In Australia, steroids are increasingly used, licitly and illicitly, by a range of men and women. A new law targeting anabolic steroids, *Crimes and Other Legislation Amendment (Assault and Intoxication) Act,* was introduced in 2014, but only severely punishes illicit users. Given the increasing licit use of steroids in Australia, the severity of the punishment for illicit possession can only be explained by looking at the law as operating on the symbolic level, with steroids symbolising a deviant, violent masculinity. Ethnographic accounts of a range of illicit and licit steroid users show how people are differentially impacted by this new law. Beyond the law, biomedicine and gender are two other significant institutions shaping the experience of steroids in Australia. This research brings a range of steroid users into conversation with each other to unpack how institutions differentially shape the steroid experience depending upon who is using the drug and to what end.

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Chapter 1

Introduction

Background

It was around 10pm on the 7th July, 2012, a mid-Winter night in the heart of Sydney. Thomas Kelly was casually walking down a street in Kings Cross with two female friends, while talking to another friend on his phone. They were all heading to a friend's birthday. Their path happened to pass by 19-year-old Kieran Loveridge; Loveridge was drunk, agitated, and acting aggressively. Thomas was in the wrong place, at the wrong time. Before he knew it, Loveridge stepped out from the wall he was against, punched Thomas in the face and sprinted off in search of another fight. Thomas was on the ground unconscious. Two days later he died. Hospital scans of his head revealed a massive fracture at the back of his skull and brain injuries. The day before Thomas' funeral Kieran Loveridge was charged with manslaughter and sentenced to gaol for at least seven years and two months, with a non-parole period of just over five years. There was no established connection between Loveridge and steroids and this is significant.

Metres from where Thomas was struck by Loveridge in 2012, another one-punch assault occurred with fatal consequences for Daniel Christie. This time it was New Year's Eve in 2013. Daniel was 18 and Shaun McNeil was 25. At around 9pm Daniel was walking down the street towards a nightclub, with his brother, when McNeil struck both brothers; Daniel was punched once in the face with a closed fist, causing him to stumble backwards, hit his head on the road, and lose consciousness. Daniel spent the next eleven days in St Vincent Hospital in a coma until his family decided to turn his life support off.

A curious connection between both assailants was that in media reports about them, their connections to sport are noted; Loveridge was a rugby player, while McNeil a mixed martial arts fighter. McNeil's appearance and connection to sport led to some reporters inferring that he may have used steroids, but, like Loveridge, there is no known connection between McNeil and steroids. In the media the hyper-masculinity of McNeil was continually emphasised: "McNeil is an inked-up, pumped-up, mixed martial arts-loving gym junkie" (Pentherbery 2014). This repeated caricature of McNeil reinforced the public perception that there was a "moronic new breed of man" on Australian streets (*ibid*). This new man understood masculinity as bound to sports, alcohol, steroids, and violence.

Daniel Christie was the 15th fatality from a 'king-hit' punch in six years. Overblown media coverage of these assaults focussed public attention on just these types of assaults and their

occurrence on Australian streets. In response to the perceived prevalence of these assaults, the father of Thomas Kelly pleaded with the government to do more, "It's time that this state, that Barry O'Farrell, finally did something about alcohol-fuelled violence to make a difference, to make us all safe so that we don't have to see these situations continuously happening in the city" (Block 2013). Echoing his words, Daniel Christie's father, talking at Daniel's funeral, also called for the government to do more to stop alcohol-fuelled violence. Furthermore, not wanting their son's death to be in vain, the whole Christie family urged the public to rebrand the 'king-hit' to the 'coward punch' (ABC 2014). With media making a frenzy of these assaults the discursive campaign gained momentum and the "king-hit" officially became the "coward punch".

Daniel Christie's death was the case that propelled the public discussion on violence. However, this public discussion happened to be taking place at a time when androgenic anabolic steroid (herein referred to as only steroids), consumption was escalating rapidly in New South Wales (NSW). A 2013 national survey of drug injecting behaviour reported that performance and image enhancing drugs (PIEDs) - a drug category largely comprised of steroids – was the most common drug last injected amongst those that had only recently started injecting drugs (Iverson & Maher 2013). In NSW results were even higher, with a staggering 67% of new injecting drug users injecting PIEDs, up from 39% in 2009 (*ibid*). Further demonstrating this growth in the demand for steroids over the last decade the number of PIEDs detected at the Australian border increased 751% (ACC 2014). This spike in the illegal consumption of steroids became enmeshed in the discussion of one-punch assaults, as journalists posited that steroids were a key factor in the "epidemic of violence" sweeping across Australia (Gregor 2014). Even Tony Abbott, the prime minister of Australia, speculated on the potential connection between steroids and violence on Australia's streets (Daily Telegraph 2014). The public perception of a causal relationship between steroids and violence gathered enough groundswell to compel politicians to tackle this issue head on. The illegal use of steroids was an escalating issue that needed to be dealt with anyway; the one-punch assaults just provided the currency and impetus for politicians to deal with the issue now.

Amidst this mounting pressure, the premier of the state of NSW, Barry O'Farrell, decided to introduce new laws targeting one-punch assaults and alcohol-fuelled violence. These new laws, formally the *Crimes and Other Legislation Amendment (Assault and Intoxication) Act 2014* (NSW), but commonly referred to as the "One-Punch Laws", introduced strict operating conditions for bars and clubs within Sydney's notorious precincts, including lock-outs. For anyone that fatally punches someone, while under the influence of alcohol or drugs, there was now a mandatory eight-year prison sentence. For steroids, possession and sale jumped from a maximum two year sentence to a

maximum twenty-five year gaol sentence. This new law specifically targets steroids, while nearly all other prohibited drugs remained under the *Drug Misuse and Trafficking Act 1985*. Under this act, that previously housed steroids, possession carried just two years maximum imprisonment. The One-Punch Laws differentiated steroids as a particular type of drug distinct from other recreational drugs; the substantial disparity in penalties implied that steroids are a more serious public health issue, posing more risk than other drugs. Discussing the opium law reforms in nineteenth century Australia, Manderson (1988a: 433) noted:

> Laws are beguiling things. The political expediencies that may have required their enactment are soon forgotten, the novelty of their form or content quickly fades. The stark statutory words alone remain, abstract and perfect, treated as eternal truths devoid of social exigencies or political chicanery that gave birth to them.

The peculiar context that brought about these recent changes to steroid laws will soon be forgotten. Instead the act will stand on its own, removed from the context that provoked politicians to enact these laws. For now, however, with the context fresh in our minds, it is understood that this radical jump in sentencing for steroid use and possession hinges on the premise that there is a relationship between steroids and violence.

The connection between steroids and violence is controversial. Speaking to the media an Australian criminologist, Don Weatherburn, claimed that the escalating male violence on the streets could be the result of mixing performance-enhancing drugs, like steroids, with alcohol (Hansen 2014). Supporting this theory, many studies have found that men do exhibit increased aggressiveness and violent behaviour with steroid use (Beaver *et.al.* 2008; Kristiansson & Rajs 1997; Su *et.al.* 1999). However, this aggressiveness and violence often only affects some users, while leaving most other users unaffected in terms of psychosocial behaviour (Thiblin & Petersson 2005; Thiblin *et.al.* 1997; Yesalis *et.al.* 1993). In many cases the validity of these studies is questionable as these studies rely on anecdotal evidence and users self-reporting their behaviour. In an alternative drug trial that was randomized and placebo-controlled, testosterone was administered in doses rising to 600mg per week to 56 men over a six week period (Pope *et.al.* 2000). This high dosage reflects a quantity similar to doses typical of illegal users. Throughout the study, and at the end, aggression and psychiatric outcomes were measured: 42 of the 56 men exhibited little psychological change, 6 displayed mild change, while 2 developed marked psychological effects. Another clinical study (Yates *et.al.* 1999) produced similar results: researchers found that the majority of men experience minimal psychological effects from testosterone cypionate doses up to 500mg per week, but a minority may experience adverse psychological effects at this dose or higher, while using the steroid. In yet another study, contradicting previous results, 43 men were administered either 600mg testosterone enanthate or a placebo weekly for 10 weeks; at the end of the study no mood or behaviour changes

were noted in any participant (Bhasin *et.al.* 1996). A recent study, with female respondents, that goes some way to potentially explaining these conflicting results, found that behaviour changed when respondents believed that they received testosterone, rather than placebo; due to their preconceived ideas about the effects of testosterone they acted more unfairly when they thought they ingested testosterone (Eisenegger *et.al.* 2010). In other words, the respondent's belief in the effects of testosterone negatively impacted her behaviour, even though testosterone administration actually caused a substantial increase in fair bargaining behaviour and an increase in the efficiency of social interaction. All of this research, when analysed together, highlights how complex the relationship is between steroids and aggression or violence; hormones are just one variable that interacts with other variables like environment and experience to shape behaviour (Sapolsky 1998:156).

Although the newly introduced laws hinge on a connection between steroids and violence, whether this connection actually exists is not as important as the general public's belief that this connection exists. Steroids as inherently violent culturally resonates with a public familiar with notorious descriptions of steroid fuelled aggression known as "roid rage". With the help of the media, the link between steroids and the violence on Australian streets is not a big leap for the public to make:

> "He is young, fit, works out at the gym and likes a drink. Yet he also has low self-esteem, is vain, may take steroids and predominantly comes from a broken home. And he is angry... Medical professionals are growing increasingly concerned about a new generation of image-driven, angry young men. Short on self-esteem, they will seek out short cuts to masculinity - for some it's steroids, for others bikie affiliations and tattoos." (Hansen 2014b)

Through these media accounts, steroids stand in as a symbol for a young and violent Australian man.

The way steroids are being imagined in public discussion almost mirrors the way steroids are discussed in academic literature. In Keane's (2005) diagnosis of the male illegal steroid user, as conceived of in medical and psychological journals, she finds that there are two frameworks shaping this discussion. The predominant discursive framework constituting the steroid user is as a hyper-masculine, antisocial illicit drug abuser: "a muscular and hormonally saturated juvenile delinquent" (194). This framework resonates with the Australian media depiction of illegal steroid users, and overlaps with the public's perception of the imagined one-punch assailants. The alternative framework discursively constructing illegal users, identified by Keane, is as overly concerned with aesthetics and suffering from a body image disorder: this is a damaged and feminized male (189). Both of these frameworks constructing users are to do with disordered masculinities, or masculinities in crisis. Both of these frameworks also establish illegal users as subjects that can be managed by legal or medical authorities. In the current Australian context, by conceiving of illegal users as anti-

social drug abusers they become a threat to public and the tougher steroid penalties are justified (197). By further classifying illegal users as addicts they are co-opted into the established medical discourse of disease and recovery; by submitting to psychological and medical expertise the addict can be restored to health (197).

Medical and psychiatric discourse assumes that the inherent properties of steroids make them a serious problem (Keane 2005:190). However, this perspective clouds the presumptive and normative judgements made about health, from which steroids obtain this problematic drug classification. According to Johns (as cited in Keane 2005:190) a drug is "a chemical other than those required for the maintenance of normal health, which on administration alters biological function". By first defining normative health, steroids are classified as a drug when used illegally, but when prescribed legally they are not a drug, they are purely medicine. This perspective is in line with Reinarman's (2011:183) discussion of the medicalisation of marijuana, where he highlights that it is "morally acceptable to use drugs to bring oneself up from illness to normal, but not to bring oneself up from normal to better-than-normal". An athlete's or otherwise healthy male's use of steroids does not cohere with the medical paradigm's condoned use of a substance. Consequently, their steroid use is judged as morally illegitimate. On the other hand legal steroid users are bolstered with moral legitimation with their medically approved use of steroids.

This conflation between medical authority and social approval is a result of particular historical circumstances. Manderson (1988b) describes the process of the medical profession becoming the sole authority on all matters concerning sickness and health in Australia. The expanding power of the medical profession took place at the start of the 20th Century. At this time the medical profession began to exert a monopoly over drugs, by appropriating access to drugs from the population, who previously used drugs as they chose (455). This appropriation was contingent upon the medicalisation of drug use: only under medical supervision were drugs legitimately used. Consequently, a whole group of drug users were now acting illegitimately and were criminalised for their drug consumption (463); they became a drug problem. But, this problem was iatrogenic, it was a problem produced by medical redefinition (463). These historical circumstances go some way to explaining why so much academic literature continually represents an athlete's use of steroids as abuse (Copeland *et.al.* 2000; Wemyss-Holden *et.al.* 1994; Wilson 1988).

While non-medical use of steroids is often critiqued, the legal prescription of steroids is also under heavy critique (Braun 2013; Handelsman 2004; Handelsman 2012; Schwartz & Woloshin 2013; Vitry & Mintzes 2012). The critique levelled at testosterone over-prescription is based on the medicalisation of natural male aging, a condition labelled either "andropause", "low testosterone" or

"testosterone deficiency". Marketed as analogous to menopause, andropause is allegedly mitigated by long-term, if not lifelong, use of steroids to alleviate a collection of very general symptoms: tiredness, grumpiness, moodiness, reduced sex-drive, reduced muscle-mass, etc. This newly marketed condition resulted in a 4.5 fold increase in total annual expenditure on testosterone products in Australia from 1992-2010, after accounting for population growth and inflation (Handelsman 2012). While consumption of testosterone products markedly increased, medical conditions for which testosterone prescriptions were approved did not change. Schwartz and Woloshin (2013) describe the development of "low testosterone" as a medical condition as the template for how to sell disease. They claim that selling low testosterone as disease involves three strategies: lowering the bar for diagnosis, so that previously ordinary life experiences necessitate medical intervention; raising the stakes so that people want to get tested; and promoting the evidence of the efficacy of treatment. From a pharmaceutical company's perspective steroids, for the treatment of "low testosterone", are an ideal drug: they are taken chronically, ensuring life-long consumers, and the drug does not cure the condition (aging), but negates the symptoms associated with the condition.

The success of marketing "low testosterone" as a condition requiring treatment is contingent upon a public that defers to the authority of biomedicine. An unspoken but critical aspect of selling low testosterone is its reliance on masculinity. Borrowing from Klein (1993:17), "masculinity is socially etched onto the body" and "society's institutions line up in service of genderizing biological males and females". The ubiquity of masculinity means that it is often ordinary, rather than extraordinary (Matza 2009: 24). One leading testosterone therapy clinic in Sydney, explaining the benefits of testosterone supplementation, claims:

> "When you lift your testosterone levels you can regain your zest for life, enjoy your work and home environments, look at yourself and be happy with what you see and have an overall good sense of well being." (The Testo Clinic 2014)

This claim describes the everydayness of what it feels like to have "normal" testosterone levels; testosterone supplementation allows patients to access normative masculinity.

While aging men can allegedly bolster masculinity through steroids, younger males using the same drug illegally are constructed as masculinities in crisis, prone to violent outbursts, and a threat to public health. Given that drugs generally produce a whole range of effects, particular effects are emphasised when steroids are used illegally versus when they are used legally. The illegal steroid user as imagined by both the new One-Punch Laws and biomedicine is a threat to the public. However, this image of the illegal steroid user is far too simplistic: it is simply a generic stereotype

and hardly reflective of the diverse types of steroid users. The social reality of the illegal user is much more complex and nuanced then this image permits. In a scathing critique of the recent 'one-punch laws', Quilter (2014:81) argues that:

> ...the Act represents another example of criminal law 'reform' that is devoid of principle, produces a lack of coherence in the criminal law and, in its operation, is unlikely to deliver on the promise of effective crime prevention in relation to alcohol-fuelled violence.

However, the new law does more than lack coherence: it demonizes a drug, legitimates the medical monopoly over drugs, and pushes certain understandings of masculinity.

Research Methodology

This research is situated amidst a climate of increasing media scrutiny focusing on a specific population of illegal steroid users, while other populations use steroids with scarce media scrutiny. The media focus on just illegal steroid users, parallels academic research into steroids, which nearly always focuses on just one group of steroid users, ignoring all others. The three distinct groups of steroid users analysed in this study are: male and female illegal steroid users; female-to-male transgender users; and males accessing steroids for testosterone replacement therapy (TRT). My deliberate investigation of multiple steroid user groups potentially limits my ability to meticulously analyse one particular group, but the premise of the study is to bring a range of steroid users into conversation with each other, to unpack how institutions differentially treat various steroid users. Using ethnography, depth interviews, and netnography, the research specifically aims to investigate how alternative steroid users experience steroids given their particular legal and medical contexts. Beyond their legal and medical contexts, the research also investigates how their steroid use intersects and transforms their understandings of gender.

The illegal steroid users were predominantly members of strength and bodybuilding communities. These steroid users included: elite athletes competing internationally; amateur athletes; and more peripheral community members, consisting of individuals with no intention of competing that nevertheless classify themselves as members of these communities, and use steroids for performance reasons. The illegal informants varied in age from 22 years old to 37 years old. The strength athletes included powerlifters and strongman competitors. These athletes were grouped together as "strength athletes", as there was an overlap between the sports, with powerlifters sometimes competing in strongman competitions, and strongman competitors sometimes competing at powerlifting meets. These strength athletes also opt for similar steroids and use them in a similar pattern and dose. Bodybuilders were a categorically different type of illegal steroid user, as their steroid doses were often much higher than strength athletes, and steroids were used for

aesthetic enhancement, rather than strength gains. Furthermore, bodybuilders combined their steroid use with a range of other drugs, like diuretics, to assist in aesthetic enhancement.

Both strength and bodybuilding communities normalised steroid use as a relatively innocuous practice. Given that steroid use was considered an everyday practice for these informants, formal depth interviews provided the appropriate space to ask questions that could be considered potentially awkward or deemed assumed knowledge (Monaghan 2002:697). In total fourteen depth interviews were undertaken with illegal steroid users from these communities, five of which were female illegal users. These communities are male dominated, so the choice to include female informants was to allow a minority group to have a voice. While the bulk of the data collected came from these interviews, participant observation also undertaken complemented these findings. Participant observation involved an active membership role in these communities. This included physically training in gym facilities specifically catering to strength athletes and bodybuilders, attending competitions, and socializing with informants outside of the gym. My membership in these communities was regular and ongoing. Being accepted as a peripheral community member offered methodological advantages: it provided unique access to a drug subculture that is underground and relatively hostile to outsiders. Other researchers have expressed difficulty in getting athletes to open up about their drug use, allowing them to only just glimpse the underground subculture (Pope & Katz 1988, cited by Yesalis 1992:16). My active membership in these communities facilitated recruitment of informants, while formal depth interviews allowed me to sustain my identity as an academic researcher.

Depth interviews were also the primary methodology amongst the female to male transgender informants. Transgender men use steroids to transition from phenotypically female bodies to male bodies, to accord with their gendered perception of themselves as men. Steroids provide the male secondary sexual characteristics that serve as proof of maleness. Seven transgender informants from different states across Australia participated in this research, ranging from 20 years of age to 60 years of age. All informants legally accessed steroids through medical prescription. However, the legal and medical process of accessing steroids was governed by state governments, rather than federal government, so informants had very different experiences obtaining treatment. As the transitioning process from a female body to a male body is often a sensitive topic for transgender men, depth interviews provided the best environment to thoroughly explore each man's transition. Recruitment for these informants was via snowball sampling of personal contacts, as well as messaging men that posted online about their transitioning experience. The five transgender informants in New South Wales participated in face-to-face depth interviews, while three interstate

informants participated in online depth interviews. These interviews ranged from thirty minutes to two hours.

Men accessing steroids as part of TRT, legally use steroids to negate the natural decline in testosterone that occurs as men age. Testosterone supplementation via steroids restores their natural testosterone levels to a range considered medically "normal". This group represents an increasing pool of men legally using steroids; however, this group proved to be the hardest group to recruit. This could be because these men are behaving legally and in a medically routine way, so their normalised behaviour means that their steroid use does not differentiate them from the mainstream. Furthermore, their use of testosterone to "pass" as normal means that they perhaps do not want their steroid use to be an identity marker that segregates them from other non-steroid using men. Unlike the other steroid users, where steroids are just one commonality amongst members of their communities, TRT users are a disparate group of men that only connect to other TRT users to discuss their treatment or barriers to treatment.

As TRT users discuss medical treatment online with other TRT users, netnography was the primary methodology opted for with this user group. Netnography is ethnography adapted to the study of online communities (Kozinets 2002). This methodology is naturalistic and unobtrusive as it allows a researcher to just observe an online environment with very little research interference. Online discussions of TRT were extremely active and easy to find, as men receiving treatment often communicated online to discuss their treatment. As men experienced differing levels of success obtaining treatment, online TRT users advised other men on where to go, and where not to go, for treatment. For this research two online communities were focussed on: *Peak Testoterone* and *Men's Health*. Both of these communities advocate for TRT and are opposed to the illegal use of steroids. *Peak Testosterone* is a website solely dedicated to TRT, and the forum discussing testosterone replacement has over 3,000 conversation threads. *Men's Health* is a forum connected to the international men's magazine with the same name. Within this forum there is a "Your Health" section, with a very active conversation thread discussing low testosterone and TRT. This thread contains 5, 471 responses. These forums combined describe the experience of countless men on TRT, or trying to obtain TRT, from across the globe. When sorting through these posts I specifically searched for men that were posting regarding their treatment in Australia.

Some men seeking TRT visit their own physicians to ask for treatment, while other men visit specific clinics that specialise in TRT. To compliment the data that was collected via netnography, I visited three different TRT clinics in Sydney. These clinics, positioned as anti-aging clinics or medical rejuvenation clinics, offered TRT as an anti-aging and medical rejuvenation treatment. While

transgender men also legally obtain steroids, these clinics do not cater to transgender patients; these clinics only provide steroids to men specifically for hormone replacement therapy. Using these clinics as a research site allowed me to speak with consulting staff regarding who their TRT patients typically are, and how they go about receiving treatment. Speaking with the staff of these clinics also meant that I could verify the data collected from the online TRT communities.

Research Aims and Thesis Outline

The aim of this research is to bring stories from a range of steroid users into conversation with each other, as previous research treats steroid users as discrete populations. By concentrating on a range of users, the research aims to analyse how institutions differentially shape the steroid experience depending upon who is using the drug and to what end. The three institutions being analysed are: biomedicine, the law, and gender.

The first chapter groups steroid users together by looking at how they navigate the medical system. The majority of informants rely on a physician to either grant them access to steroids, or to monitor their hormones and blood work in relation to their steroid use. This reliance on physicians imbues them with a lot of power and in some instances allows them to act as gatekeepers to the realm of biomedicine. This gate-keeping model grants access to steroids for TRT users, tolerates the illegal use of steroids, and stifles the passage for transgendered men. Illegal users, who do not rely on physicians to access steroids, question the authority of biomedicine.

The second chapter turns to the legal context of steroid users. The new law targeting steroids makes the research both timely and significant. Anecdotal reports suggest substantial recent increases in the number of people injecting steroids in NSW (Iversen *et.al.* 2013). Drastically more men are also legally using steroids as part of TRT (Handelsman 2012). With more people using the same drug, but facing differing levels of legal risk, this chapter analyses how the law is operating. I argue that to explain the severity of the new law, the law must be understood as operating on the symbolic level, with steroids standing in as a symbol of deviant masculinity. However, as a symbol of deviant masculinity, the image of the illegal steroid user does not resonate with the illegal users in strength and bodybuilding communities. Consequently, these illegal users legitimate their right to continue using steroids by contrasting their steroid use favourably to others.

The last chapter looks at gender and how steroids transform or reinforce people's understandings of their gender. Unlike any other drug, steroids, as synthetic testosterone, are intimately connected to maleness and masculinity. For some users the androgenic effects of steroids are categorised as "effects" and are put to work in their performance of their gender; for other users,

female athletes, the androgenic effects are categorised as “side-effects” and are mitigated or tolerated. For these female users steroids do not impact their identity as women, even though they are in many cases taking higher steroid doses than transgender men.

Ultimately, this research is about three very different groups using the same drug, but for alternative purposes. Bringing multiple steroid users together allows the research to focus on the impact of institutions on steroid use. The institutions of biomedicine, the law, and gender differentially shape users’ experiences of steroids. The accounts of users as they interact with these institutions reveals that those with the most need for the drug often experience the hardest time accessing or using the drug, and often receive the least community support.

Chapter 2

Steroids, Biomedicine, and Physicians as Gatekeepers

Hanging directly above my head in a garish gold gilded frame is a knock-off Michelangelo-esque nude reaching out longingly to someone out of frame. From my white leather bucket seat I can spy multiple mirrors and I get the sense that appearances matter here. Slowly circling around in the glass display cabinet next to me is stretch mark cream, scar therapy cream, teeth whitening pastes, Clomid, Anastrazole, and Primoteston. Clomid and Anastrazole are drugs taken to inhibit oestrogen production, after doing a steroid cycle, and when taken by men, these drugs help to kick-start the natural production of testosterone. Primoteston- a popular anabolic androgenic steroid made of testosterone enanthate – advertises a price of $150 for the box. I am dumbfounded that just a thin pane of glass separates me from such a powerful and life-altering drug. For transgender men this drug is the gateway to an existential transformation; one informant spent decades of his life manoeuvring through and against a medical system stacked against him, just seeking a prescription for this drug. Illegal users - or those lacking a physician's script - risk 25 years imprisonment for this drug. And here it is in front of me, within arm's reach.

The consultant who greets me explains that they are not exclusively an anti-aging clinic, they provide laser treatment, microdermabrasion, weight-loss treatments, and they have a popular hydro chamber; testosterone therapy is just one anti-aging treatment offered by the clinic. Carefully arranged on the glass coffee table next to me are a collection of women's beauty magazines and a selection of *Men's Health* magazines. It is perhaps not coincidental that one of the largest forums dedicated to discussing low testosterone online is a forum hosted by this very same men's magazine. The consultant explains that the patients she treats with testosterone are usually men in their late 40s, suffering from andropause, low testosterone, nagging illnesses, and tiredness. In this Western Sydney area a lot of her patients are former labourers – or as she explains, "their bodies are worn out". To ease these worn out bodies testosterone is prescribed alongside human growth hormone.

The consultant herself is not a medical physician; in fact, no physicians work at this anti-aging clinic, just trained consultants. People come to this clinic seeking treatment for a variety of age-related conditions, and the consultants either assist them with treatments that do not need medical practitioners, or, as is the case with testosterone, they rely on a physician that works exclusively with the clinic to provide scripts and treatment. When I ask how many men would actually know of the newly coined condition, 'andropause', the consultant explains that the Internet is a valuable tool that really educates people about conditions. As a result, quite a few of her clients come to her well informed and seeking testosterone; others need to have the condition explained to them. After a

male patient is suspected of having some kind of hormonal or age-related issue, he is sent to the clinic's preferred physician to have his hormone levels checked via a blood test. If the blood test confirms the diagnosis, then the clinic dispenses testosterone through a nearby pharmacy. If the blood test does not confirm low testosterone levels, then the patient likely will receive human growth hormone, instead of testosterone, as an anti-aging treatment. The consultant continually reminds me that the physician operates under strict guidelines from the Health Department, and he can only prescribe medication if a blood test confirms the diagnosis. After receiving the treatment for one month, a blood test is performed to ensure that the treatment is working. If the patient wants to continue treatment, he needs to come in for a consult and an additional blood test every six months to check his hormone levels. From the moment he initially walks in until he gets his first script for Primoteston it is usually 3.5 weeks.

In contrast, for Will, a transgender man, the journey to Primoteston spanned over four decades. Will knew he was a male from the age of 4, but growing up in rural Australia, for him to identify as anything other than his biological gender was impossible. Living as a farm girl in the 1970s, Will resolved that it was time to come out and explain these feelings of dysphoria to his family physician. The physician reiterated that he had known Will his whole life, and he was a girl, but to satisfy Will, he would perform a quick test to help get the whole idea of being male out of his head. Swiftly pulling out a cotton bud and swabbing inside Will's cheek, the test came back as female, and the physician found the scientific proof he was after: "See, there you have it, biologically you're female. You're female. However, you are a lesbian, so you should be happy living as a lesbian". As a consolation prize to his female body, being able to live as a lesbian was a testament to how accommodating and cosmopolitan the biomedical model was.

Growing up transgendered meant developing a catalogue of coping mechanisms to negate the dysphoria. Each day after school, Will was in bed by 4pm, and a fantasy world would come alive where he could inhabit a different body. He avoided looking at his reflection in a mirror. His posture was hunched to hide bulging breasts, and clothing was always loose. Whenever Will happened to find a newspaper article about someone deciding to change gender, he swiftly cut it out and placed clippings around the house to act as a hint for his family.

At 34, Will started seeing a psychotherapist, knowing that he had to engage with the medical and legal system if he was to ever transition to life as a man. In the small city he relocated to, a trans-friendly therapist was extremely rare. The weekly treatments confirmed that Will was transgender; however, the progressive therapist did not believe in hormone therapy, or doing anything at all

about being transgendered, so Will was to live in a body that looked nothing like the Will that existed in his head. Therapy continued weekly for another ten years.

When Will reached his fifties, his partner died. At the same time his menopausal body started subverting all the strategies he had used to deny its femininity – he felt like an old woman with strength slipping away. At 54 years of age, it was time to finally be the man he had always been inside, so the journey to medical and legal transition recommenced yet again.

Will has been taking Primoteston for 5 years now; since starting the drug, he has finally reclaimed a body from which he was completely disconnected. Looking now at family portraits, he proudly considers himself the best looking male in his family. Speaking fondly of his injections he claims, "This is my injection to freedom. This is my injection to reality."

Steroids are socially embedded phenomena. With a diverse range of groups using the drug and usage skirting both sides of the law, its lifecycle is necessarily complex. Multiple actors, social systems, and institutions determine who gets to use steroids, for what purpose, when, and why (Cohen et al. 2001). However, often the only time a user will personally confront or negotiate with these institutions and laws is through medical practitioners.

This chapter tells the story of medical practitioners as gatekeepers in the realm of biomedicine. Whilst acting as biomedical gatekeepers, these physicians are also agents of the state insomuch as their actions are informed by the law. Differing interpretations of the law, however, shape the ways that physicians relate to steroid users. Physicians and other medical practitioners typically mediate at least some aspect of the steroid experience for a range of users. For some, physicians willingly grant access to steroids and closely monitor the experience; for others, medical officials provide only advice and check-ups; and, for other users, they stifle passage and make access to steroids extremely difficult. Ethnographic accounts of how steroid users manoeuvre around the medical system highlight how the authority of biomedicine is contested.

The bulk of existing literature unpacking the recent upsurge in national testosterone prescriptions critiques biomedicine for medicalising the natural male aging process and fear mongering around normal symptoms of aging (Braun 2013; Handelsman 2004; Handelsman 2012; Schwartz & Woloshin 2013; Vitry & Mintzes 2012). This literature often fails to acknowledge that, while more men are legally consuming steroids, harsher penalties have been introduced to manage those consuming the same group of drugs illegally. Transgender men medically seeking steroids for gender transitioning purposes, for example, are completely unaffected by the recent surge in prescriptions for steroids and still face extreme difficulty accessing these drugs. The tougher penalty

for illegal consumption, combined with leniency towards physicians increasingly prescribing the same drug, produces an unusual phenomenon: the state simultaneously appears both to relax and yet apply more stringent restrictions on the same drug depending upon who is using that drug (and to what ends).

Selling Andropause

> **Matt4305:** I am a 50 year old married to a beutiful [sic] woman 19 years younger. About 8 months ago I decided to go have my t-levels checked as seen via the commercials. I was in the low 300's. My doc started me on testosterone cypionate, injected at her office. Within 2 days I felt 25 years younger, had energy I haven't seen in years and the sex drive went through the window, in fact my wife can't keep up with me in bed now.
>
> The injections of 1 mg were every three weeks with extreme highs and lows. I complained and she put me on the androderm patch, which irritated the skin and didn't work as well. I then asked for her to allow me to self inject (I am a medic also) She agreed so I have been self injecting for about 2 months now. I started working out and am seeing very good results, losing weight and feeling much better. I would try the injections as I have better results on these. I have noticed my testicles have shrunk, but being fixed I dont need them anyway.LOL Next trip to the doc I am going to ask to have all bloodwork done, for comparison. GOOD LUCK & Do it.

As suggested by this online post in this *Men's Health* forum dedicated to low testosterone, some men are finding androgenic anabolic steroids (or what is popularly simply called steroids) a potent new antidote for aging men undergoing testosterone replacement therapy (TRT). However, the recent growth in the prescription of testosterone is unusual given that the drug has been medically prescribed since 1933. As a "concentrated essence of masculinity" (Keane 2005:191), testosterone injections allow Matt4305 to feel 25 years younger, possesses energy unseen in years, and perform better sexually. More than 5000 posts in this forum dedicated to low testosterone attest to the widespread perception that testosterone supplementation is a highly effective drug to assist men to feel more like men: testosterone allegedly improves mood and energy levels, combats fatigue, enhances sex drive, encourages fat loss, and promotes muscle and strength gain.

Marketed as analogous to menopause, "andropause", "low testosterone", and "testosterone deficiency" are different names for the same condition allegedly mitigated by long-term, if not lifelong, use of steroids to manage a collection of very general symptoms. This newly defined condition is the major contributor to Australia's 4.5-fold increase in total annual expenditure on testosterone products (this increase accounts for both population growth and inflation) (Handelsman 2012). While consumption of testosterone products markedly increased in this period, there was no change in the medical conditions for which testosterone prescriptions were approved. The success of marketing low testosterone as a condition requiring treatment is contingent upon a public that defers to the authority of biomedicine.

The anti-aging consultant I described in the opening vignette continually reiterated the strict guidelines under which the physician worked. Only if a blood test confirmed that a man was below the low testosterone threshold, she insisted, could he receive steroids. While these guidelines may appear to bind the physician's hands and limit his powers, this is not the case. At times physicians can defer to "elastic guidelines" to subjectively determine if a male has low testosterone (Handelsman 2006). For example, while one measure of testosterone levels locates the normal range of testosterone between 300 and 1200 nanograms per decilitre (ng/dl), some physicians judge anything below 400 ng/dl as still qualifying as low testosterone and in some cases will still prescribe testosterone. Furthermore, given that testosterone levels tend to gradually decrease as men age, a man in his twenties presenting with a level of 350 ng/dl may be treated quite differently from a man in his fifties presenting with the same testosterone level; the man in his twenties presenting with 350 ng/dl is generally viewed as a likelier candidate for TRT then the man in his fifties. In contrast, a leading "natural men's health website" encouraged readers to completely disregard the normal ranges endorsed by physicians as every man's testosterone levels fluctuate frequently; the website suggested that it would be a struggle to live with anything below a level of 500 ng/dl.

However, while some physicians may operate according to these "elastic guidelines", many adhere stringently to guidelines. Numerous posts online from men that have been denied access to TRT are testament to the more rigorous physicians, but these men are often seeking online advice from other users to find other more lenient physicians. Nevertheless, despite how stringent some physicians may be in adhering to guidelines, the trend evident nationally is one of a general increase in prescribing, but with specific peaks that can be connected to industry promotional activity (Handelsman 2006:437-8).

In Australia, laws prevent direct-to-consumer advertising for prescription medications; however, this prohibition is easily circumvented through the sophisticated marketing of pharmaceutical companies (Vitry & Mintzes 2012: 619). By running unbranded disease awareness campaigns, pharmaceutical companies can educate the public regarding different conditions, their risk-factors, prevalence, and the effectiveness of treatment. Through these campaigns, conditions considered mild are often portrayed as serious illnesses (*ibid*).

Demanding Testosterone

A simplistic Foucauldian reading of the hierarchy of power at play within biomedicine would be: power resides in the discipline of biomedicine; this power is bestowed upon physicians; physicians then possess a power through their access to knowledge of biomedicine; and they wield this authority over patients (Angelides 2009:88). A more nuanced Foucauldian perspective

acknowledges that power is not just top-down, but is dispersed, rearticulated, and constituted through subjectivities (Lupton & Fenwick 2001). However, the physician's power is also contested: the continual growth of the pharmaceutical industry challenges the hegemony of the physician's power. Through disease awareness campaigns pharmaceutical companies seek to bypass physicians and communicate directly to patients, empowering them as consumers to demand or advocate for the companies' products (Dumit 2012:14). This pharmaceutical marketing inculcates a new kind of medical subject: a patient who self-diagnoses, self-disciplines, and scrutinises his behaviour for defects to remedy to make him a more perfect neoliberal subject. Consumers, armed with medical knowledge, can then self-diagnose and arrive at their physicians' offices with a clear agenda. Physicians constrained by their ability to keep up with rapidly changing information, and the time they have available to treat each patient are then left vulnerable to these demands (*ibid.*). In the online post cited above, Matt4305 tellingly admits that the physician agreed with his desire to self-inject at home. In other words, he went to the physician requesting a specific treatment plan and just needed the physician to agree with his plan. This story underscores men's attempt to control their own biomedical treatment. Matt4305 is still in the position of supplicant, at the mercy of the physician's final decision, but he is furnished with consumer power to shop for another physician, should she not agree to his agenda. Consequently he is not allowing the physician to easily wield her authority over him. Matt4305 further claims that during his next appointment, he will request to have his blood-work done so that he can compare his results to previous blood tests. This urge to compare his blood-work highlights how proactive he is as a patient; Matt4305 is what Dumit would label an "expert patient".

"Expert patienthood" is one mode of biomedical living, identified by Dumit (2012:183). In the expert mode the patient is driven by obsession and paranoia; he knows all his numbers, records them, and helps others to do the same. For the expert patient, health is the ideal for which to strive for always. In online forums dedicated to TRT, many men adopt the role of expert patients: they are ahead of the latest research in testosterone replacement and are confident in their ability to distinguish the good from the bad and decipher new research results. One expert patient checking his plan with other TRT users online writes:

> I have a few pages worth of notes to take in with me on Monday. I have a feeling I am going to end up injecting on my own or at the very least asking for a referral elsewhere. A follow up question, are there any supplements or vitamins I should be taking with my TRT? I do all of the standard vitamins, but was wondering if I needed to increase or decrease anything to make therapy more effective.

Rather than consult with a physician, these expert patients consult with each other, forming an alternative biomedical community. These users become such expert patients in the field that they feel a need to better inform their physicians:

> Runningwild, congrats! You have made huge progress with educating your physician already. Just getting him moving down the right path is huge! Now you are in control of your injection schedule. Who knows, maybe 100 mg every week will work for you. At least you have the power to adjust it. ... Who knows, maybe you can get your doc fully up to speed on TRT and they will actually wind up being a good person to work with.

From this expert patient's perspective, a TRT user typically needs to educate a physician until the physician is sufficiently informed that he or she is worthy of partnering. By working in conjunction with a complicit and educated physician, TRT users act as expert patients exerting control over their own steroid schedule, as this user explains:

> If she is willing to listen and learn and be open to suggestions from guys that have been through the drill, then I think you have a good doc. If she will not change your treatment plan, then I suggest you walk away and find a different doc that practices modern TRT. Problem there is that they are rare as hen's teeth.
>
> Here's what I suggest. You go back to here and tell her that you've done your research and that you would like to start with 0.2 ml (40 mg) every three days and then see what your labs look like in about a month.

Equipping themselves with knowledge, TRT users wrest some authority away from physicians. Any rigidity in the legal and medical guidelines is adeptly manoeuvred through by these expert TRT patients. Furnished with moral and legal claims to steroids, TRT users challenge the authority of physicians as biomedical agents, believing that their biomedical knowledge is superior to doctors.

Shifting Powers

The relationship between illegal steroid users and medical authorities is controversial. For years, medical and scientific authorities solely publicised the negative effects of steroid use, and downplayed or denied the drug's ability as an ergogenic aid to enhance physical performance (Hoffman & Ratamess 2006; Monaghan 1999). This tactic, rather than lead to fewer athletes using steroids, resulted in athletes and illegal users not trusting the advice and knowledge of their physicians, as the illegal users' steroid experiences completely contradicted medical and scientific opinion (Hoffman & Ratamess 2006). A recent study investigating the medical risk associated with steroids concluded that steroid risks may have been somewhat exaggerated in an attempt to dissuade athletes from using steroids (*ibid*). Consequently, instead of turning to physicians for medical advice, these illegal users turned to each other, to Internet sites, to coaches, and to drug suppliers (*ibid*.). Looking to each other for knowledge about steroids, rather than biomedicine,

produced a significant body of ethnopharmacological knowledge within strength and bodybuilding communities. By producing their own ethnopharmacological knowledge, illegal users challenge the authority of biomedicine.

One informant utilised this ethnopharmacological knowledge to repair a tendon in his arm. By performing a site injection of a steroid, nandralone, in the sore tendon he claims he was able to ease the tendon pain and continue strength training. Other informants similarly reported experimenting on their own bodies. These informants tried different steroids, at various doses, combined with other steroids, to calculate the most effective types and doses for their bodies. These users were essentially using their own bodies to collect empirical evidence. In other words, in the production of their own ethnopharmacological knowledge these illegal users depend on their own scientific rationality, while dismissing the science of biomedicine, which critiques their steroid use (Monaghan 1999). These ethnographic data support Monaghan's (1999:707) argument that "biomedicine is simply one 'authority' among many in the construction of the self and body within late modernity". Informants choose to champion biomedical authority when it suits them, and then choose to defend the authority of their own ethnopharmacological knowledge if that suits them.

The attitude that physicians do not medically or scientifically understand steroids was reiterated again and again throughout my fieldwork, with multiple informants citing instances when physicians confused corticosteroids for androgenic anabolic steroids – two very different drugs. Consequently, rather than rely on physicians to medically supervise the effects of their drug use on their bodies, informants frequently reappropriated biomedical knowledge to take control of their own bodies. Jason, an amateur bodybuilder and former pharmacist, medically monitored his own steroid use, and felt no need to disclose his steroid use to a physician. As someone who has competed in lots of different sports and used steroids for two years now, Jason feels as though he understands his body, and believes that his body will tell him if something is wrong. Accordingly, the lack of medical supervision does not concern him. He monitors his own blood pressure and requested just one blood test during a general check-up with a physician. He did not disclose steroid use to the physician and prefers to read and interpret his own blood test results. Jason's management of his steroid use and its impacts on his body exemplifies how illegal users are also often "expert patients".

As "expert patients," illegal users strictly monitor, control, and plan their pattern of drug taking. Certain steroids are used at particular times to ensure they maximise the effects of the drug. A number of informants, for example, explained that one week prior to a powerlifting meet or strongman competition they will increase their steroid dose, by adding a daily oral steroid to

supplement the steroids they are injecting. Illegal users are also often extremely preoccupied with health, ingesting a whole assortment of vitamins and supplements daily. To further monitor their health and progress, many steroid users consult with physicians to check their hormone levels and blood pressure. These bodily practices ensure that these users are at their physical peak, but also allow illegal users to believe that their drug use is to some extent medically controlled. While illegal users reject biomedicine's claims about the dangers of steroids, they also wholeheartedly accept biomedicine's categorisation of their drug use as recreational. Illegal users strictly control and monitor their steroid use, but never frame their steroid use in terms of medicine or health, despite many of the reported benefits of their illegal steroid use being identical to that of TRT patients: improved mood, increased energy, muscle gain, strength gain, and fat loss.

While many illegal steroid users reject the authority of biomedicine, many make use of biomedical tools to medically monitor their own steroid use. Some informants admit illegal steroid use to their physicians, but this is only done to ensure that the physician performs the specific blood and hormone tests that these informants request. Other informants claim that they request these blood and hormones tests from their physicians, but do not disclose steroid use; instead, they fabricate reasons to explain why they want these tests. In the first instance the physicians tolerate the illegal steroid use, and in the second instance the informants utilise biomedical tools, but rely on their own knowledge.

One particular illegal informant completely defers to biomedicine by consulting with a physician and candidly disclosing his illegal steroid use. Layne, a competitive bodybuilder, makes use of a physician sympathetic to illicit drug use to monitor his steroid use. Layne's physician also treats a number of patients with steroids for muscle wastage conditions. His physician's extensive experience with steroids negates the common problem that illegal users have: physicians not being familiar with, or knowledgeable regarding, steroids. Layne's physician is of the position that if people are going to be using steroids illegally, then he'd prefer that they be medically supervised. The physician monitors quite a few illegal steroid users because of his tolerant stance towards illegal drug usage. The physician is so complicit with Layne's drug use that he provides Layne with a prescription for TRT. Layne chooses to still purchase steroids illegally, despite this prescription, as it is cheaper to illegally purchase steroids, and the medically prescribed dose is much lower than his standard bodybuilding dose.

Unlike TRT users, who are furnished with legal and moral legitimacy, illegal steroid users do not attempt to educate their physicians regarding steroids. Instead, most illegal steroid users claim authority over their physicians by assuming that they, as expert patients, understand steroids and

hormones better than their physicians. As expert patients, some openly contest biomedical knowledge, while others attempt to reappropriate the authority of biomedicine by medically monitoring their own drug use. By relying on their own ethnopharmacological knowledge, illegal users challenge biomedical claims to knowing steroids and the body.

Obstructing Passage

Transgendered men's interactions with medical practitioners are not comfortable. As transgender treatment is not typically taught in conventional biomedical curricula, very few physicians are at ease treating transgender patients (Safer & Tangpricha 2008). When one informant explained he was transgendered to his physician, he had to explain what being transgendered meant, and then needed to explain why he was seeking treatment. Compared to TRT users and illegal steroid users, medical practitioners wield much more authority over transgender patients. Purchasing steroids illegally is not an avenue that illegal informants typically choose to go down. After listening to the transitioning experiences of informants, purchasing steroids illegally would be a much easier option, than waiting for medical authorities to grant them access. However, as one informant explained to me, other transgender medical interventions, like "top surgery", breast tissue removal, require transgender men to be on steroids for at least six months before the surgeon will agree to perform the surgery. Beyond this practical reason for legally obtaining steroids, I believe that transgender men want their male identities affirmed and recognised by authorities. If transgendered men obtain steroids illegally, then an institution with significant clout, is not acknowledging their claims to a male identity.

In most Australian states, medical practitioners are vested with more power when treating transgender patients as transgender patients are legally identified as different from other patient populations. According to many transgendered men, they feel that they must constantly legitimise their existence and seek permission from multiple medical and legal authorities. When negotiating with biomedicine, a transgendered man needs to apprehend the body as a biological and gendered object in the way that a medical practitioner perceives his body; then, he must mould his performance of the gender identity to match the practitioner's preconceived notions of what it means to be a transgendered male. If his performance does not meet the medical practitioner's expectations, then his access to steroids is likely to be denied.

For Stan, for example, access to steroids was obstructed as one of the main psychiatrists treating transgender patients in Melbourne did not endorse his desire to be male; Stan's endocrinologist suspected that his gender identity might just be a 'phase' that Stan was going through. Stan is 28 years old and now lives as a man, having transitioned socially over the past two

years. He works as a disability care worker but spends most evenings in the gym training in Muay Thai, a Thai martial art. As an introvert, Stan was not comfortable with the transitioning process required by medical authorities: the psychiatrist and endocrinologist insisted that Stan live as a male, adopting male pronouns in conversation and a male identity for a lengthy period before they would support medical transition. Not feeling confident to act as a man without steroids, this process was daunting and off-putting to him. Alongside needing to assume a male identity, Stan also needed to prove to the psychiatrist that he was financially and emotionally stable enough to go through the transition process. The psychiatrist found that Stan was financially and mentally capable of transitioning, but he was not confident that Stan really was transgendered, as Stan expressed a level of comfort with his body in its current condition. If Stan had not been entirely honest, and instead claimed complete dissatisfaction with his body, then he believes that the psychiatrist would have endorsed his desire to become male, and the endocrinologist would have prescribed him steroids.

All the transgendered men, I interviewed, believed that if they did not play the game according to the rules imposed by medical practitioners, then they would not get to be a man. Transgendered men are forced to act as subordinated subjects at the mercy of the institutions controlling steroid use. Their subordination is even more evident in certain states, especially South Australia and Western Australia, where legislation governs the transition process. In South Australia, *the South Australia Sexual Reassignment Act 1988* established certain bureaucratic hurdles that must be met by both patients and medical providers. This law stipulates that a person considering transitioning must first go to his or her physician to obtain a referral to a specific Adelaide clinic that handles gender dysphoria. Once the clinic has the referral, then the clinic will contact the patient for an appointment to be assessed for transitioning. If the patient is deemed suitable, then he will need to be continually assessed for a minimum of three months before he can be referred to one of two endocrinologists specifically prescribing steroids to transgender patients.

In 2010, further clarification from the Government of South Australia advised that psychiatrists and endocrinologists no longer needed to be approved by the Minister. However, speaking with men who had recently transitioned in this state, non-approved endocrinologists and psychiatrists hesitate to treat transgender patients. According to Adam, a recently transitioned man living in Adelaide, such a backlog of patients is currently waiting to begin the transition process with the primary clinic, that they assess patients based on the referral letters from the initial physicians, that is, without face-to-face consultation. As a result Adam claims that the more a patient can present as a “butch” female to the referring physician, the more likely she is to receive treatment; those that do not present as sufficiently ‘butch’ or overtly masculine in gender performance will

probably have to wait a while before being assessed for transition. From Adam's perspective the financial gains made by those profiting from this system ensure that this arrangement continues to exist.

In other states of Australia, the transition process is not governed by specific legislation, but is nonetheless still extremely cumbersome. At the very least a transgender man seeking steroids will need to consult with a physician, psychiatrist, and endocrinologist. This consultation process can take a few months, but can also extend for years. When Will decided to undergo "top surgery", breast tissue removal, the surgeon would not operate until he had a second approval from a psychiatrist that was not Will's current psychiatrist. The surgeon's reasoning was that Will might change his mind later on and potentially sue the surgeon, so he wanted additional assurance that this transition was really what Will wanted. When Will saw the second psychiatrist, the psychiatrist barely listened to anything Will said; at the end of the appointment, Will was told to come back next week for another appointment. Feeling frustrated and angry Will demanded a letter of approval for surgery. The surgeon dismissed Will telling him to pay $435 and relay what he needed to his secretary who could type it up and give it to him. After explaining the purpose of this appointment to the secretary, Will paid the fees, and the secretary provided the approval letter he was seeking. Will explained that if he was younger while going through the process, he probably would have complied with the psychiatrist's demands and kept seeing him for weeks in hopes of getting the letter of approval for surgery.

Many patients criticise this process of seeking consent from multiple authorities and confronting barriers to healthcare as undermining a transgender person's capacity to provide informed consent. The consultation process clearly treats transgender patients as distinctly different from other patient populations, who are not subject to such rigorous protocols to obtain treatment (Gillies 2012; Hale 2007; Kennedy 2008). This gate-keeping model focuses on preventing regret (Gillies 2012), but does not in many cases create a positive transition experience. In Edmond's (2010) account of plastic surgery, he describes how physicians in Brazil similarly worry about regret with plastic surgery patients undergoing permanent surgical interventions like breast reductions, breast augmentations, and labiaplasty. However, despite physicians' concerns regarding regret, these patients do not have to get through the same number of hurdles as transgender patients do just to get hormone treatment. While proponents may argue that the rigorous protocols that apply to transgender patients protect them from making irreversible decisions, I argue that these protocols are less about protection and more about regulating and disciplining transgendered bodies.

Conclusion

This chapter describes how medical practitioners act as gatekeepers to the realm of biomedicine. This gate-keeping model grants access to steroids for TRT users, tolerates the illegal use of steroids, and stifles the passage for transgendered men. TRT users demonstrate that it is too simplistic to simply describe patients as subordinated subjects at the mercy of medical practitioners through the discipline of biomedicine. Both TRT users and illegal users are able to exercise a sense of authority and power when interacting with physicians by becoming expert patients. Some TRT users, fortified with a sense of moral legitimacy and entitlement, attempt to better educate their physicians with the latest biomedical knowledge to gain control over their own steroid use and access. In so doing, these TRT users usurp the power from physicians acting as biomedical agents, but sustain biomedicine as a dominant system of knowledge. Illegal users, similarly, concede to a biomedical understanding of their steroid use and thus do not frame it in terms of medicine or health, despite the similarities between the benefits they derive and the benefits that TRT users derive. However, by turning to their own ethnopharmacological knowledge, illegal users contest the authority of biomedicine. Transgendered men seeking steroids for transitioning purposes, in contrast, are forced to comport themselves according to the rules imposed by medical practitioners in repeated performances of a closely scrutinised gender identity; if they do not pass these examinations, then they cannot gain access to steroids, and do not have the option to live as men. Transgendered men must submit to the authority of biomedicine, because the risk of questioning its authority is far too high. The differences in passage reveal that the authority of biomedicine is both contested and affirmed, while people's trust in physicians as biomedical agents is slowly eroding.

Chapter 3

Superman with a Bad Attitude: Steroid as Symbol

The severity of the laws levelled against steroids suggests that steroids are potent and dangerous, a public health risk to be swiftly managed, and harshly penalised. Possession of steroids in New South Wales carries a maximum gaol sentence of twenty-five years, while nearly all other prohibited drugs fall under the *Drug Misuse and Trafficking Act 1985* and carry a maximum sentence of just two years for possession. The new law targeting steroids is the *Crimes and Other Legislation Amendment (Assault and Intoxication) Act 2014* (NSW) and specifically associates steroids with violence. This act, commonly referred to as the "One-Punch Law", is the end-product designed to combat the reported surge of male-on-male, alcohol-fuelled violence.

Manderson (2005:35) highlights that the "crime of possession is the crime of being possessed". By this he means that the act of possession is a passive act requiring no outward gesture. Just retaining control of a drug is enough, without any intention to use, or sell it – even throwing a substance away is 'possession'. In New South Wales, the onus of proving innocence to the charge of possession lies with the accused. Proximity to the drug establishes a presumptive crime (36). In this way, the drug attaches itself to the user, and the user must work to remove the taint of the drug. Manderson explains that beneath possession laws is a fear of contamination: the fear that the possessor, coming into contact with the substance, is powerless to prevent the substance from contaminating him. Steroids, as they are imagined, provoke a fear that men coming into contact with the drug will be powerless to prevent transformation into uncontrollable, violent and super-powered antisocial actors. Consequently, the new steroid legislation is about safeguarding the public from an uncontrollable masculinity.

By focussing less on the reasons for the new law and more on the rhetoric put to work in the defence of these laws, the deeper symbolic meaning of steroids becomes clear. Manderson (1995:800), in discussing why drugs seem to matter so much, suggests we need to move away from the discourse of reason and toward the symbolic meaning of drugs. More than any other drug, steroids as synthetic testosterone are intimately connected to maleness and masculinity. Analysing steroids as a symbol of deviant masculinity explains the ferocity of the debate surrounding steroids laws and the severity of the Act.

Because of the law's treatment of the drug as analogous to a deviant masculinity, some illegal steroid users fail to identify themselves as targeted by the law. Instead they see the law as targeting other more deviant users, as explained by a female bodybuilding informant:

> These new laws are ridiculous. They [the law and law enforcement] are just using steroids as a scapegoat. This new law is just about young guys showing off – they need to talk about their cycles [steroid plans] to validate themselves and validate their notoriety

Illegal informants consider their own use to be justified and not a public health risk needing to be managed. Just as legal steroid users explain their steroid usage as legitimate in comparison to illegal steroid users, illegal users in the strength and bodybuilding communities favourably compare their steroid use to other the behaviour of those who use steroids and other recreational drugs illegally. By attributing deviant drug usage to other users, these communities of steroid users subculturally normalise their own steroid use. Ultimately, the disconnect between the premise of the law and particular steroid users' motives and management of their drug use, I argue, means that many users are unlikely to modify their behaviour as a result of the law. They simply do not recognise that their behaviour pattern is the target of the legal prohibition.

Steroid as Symbol

In unpacking the "changing ideology of marihuana," Jerome Himmelstein (1983) documents the radical shifts in the dangers connected to cannabis by analysing public discussion in the United States. Labelled at one time, "Killer Weed," the drug evolved over thirty years to become the "Drop-out Drug"; this evolution in significance involved changes not just to the dangers associated with the drug, but also to the image of the drug users and the drug itself (*ibid.:* 13). The dangers attributed to the drug provided the basis for the cultural construction of both the drug and the user. When the "Killer Weed" image dominated the conversation, cannabis was said to induce violence, aggressiveness, and criminality. At this time the "social locus", or primary users at the time, were Mexican labourers and other lower strata groups. These groups were already stereotyped as violent (*ibid.:* 17), so cannabis became known as the catalyst of that violence. Thirty years later, in 1960, the social locus of users shifted to middle-class youth, and cannabis became known as the "Drop-out Drug". As the "Drop-out Drug," cannabis allegedly led to amotivational syndrome: deadening of ambition and aim, the dulling of initiative, and a general failure to participate in capitalist consumer society. In both cases, the image of the drug helped to fashion the image of the user as a person, just as the primary social group associated with use lent its identity to the drug. Himmelstein argues that this transformation relied on three key factors: *entrepreneurship*, meaning the political actors working in drug control; *social locus*, or the supposed social background of users; and, the *symbolic meaning* connected to the drug (*ibid.:* 14).

The reframing of cannabis, described by Himmelstein, took place over a thirty year period, from 1930 to 1960. With steroids the reframing of the drug is occurring simultaneously and is largely driven by the medical profession and legislative policy. The drug has a kind of split social identity.

When used illegally, the drug is labelled “anabolic steroids”; when prescribed medically, the same substance is referred to as “testosterone”. The alternative terms for the same drug play a key role in producing two different images of the drug. By linguistically referring to the drug as “testosterone” for legal usage and “anabolic steroids” for illegal usage, the drug and its different users are easily demarcated, in theory if not in practice. The semantic difference between the terms is slight: “testosterone” is an androgenic hormone classified as a steroid hormone; “anabolic steroids” are drugs that mimic the effects of testosterone and dihydrotestosterone. When speaking with my informants, I found that legal and illegal users often would be using the same brand and type of testosterone. In spite of this, according to a legal steroid user online, testosterone injections as part of testosterone replacement therapy (TRT) are patently different to anabolic steroids: “this forum is not about using anabolic steroids to ‘get big’. It’s about medically necessary use of testosterone” (Men’s Health 2014). His choice of terminology neatly bifurcates legal usage of the drug (“testosterone”) from illegal usage (“anabolic steroids”). The different images of steroids and testosterone reveal how often the exact same drug is simultaneously imagined in two different ways to connote different masculinities.

Social Locus of Steroids

Younger males are typically identified as the main users of steroids illegally, despite evidence indicating otherwise (Cohen *et.al.* 2007; Copeland *et.al.* 2000; Ip *et.al.* 2011). The focus on adolescents and younger men as the primary users also characterises the profusion of academic articles that focus on this group (Buckley *et.al.* 1988; Faigenbaum *et.al.* 1998; Johnson *et.al.* 1989; Komoroski & Rickert 1992; Williamson 1993). In addition, popular media coverage also continually depicts this group as major steroid users. One recent news article titled, “Aussie blokes hooked on steroids”, profiled a Queensland construction worker who began using steroids when he was 23 (News.com.au 2013). The article goes on to claim that fifty percent of Queensland users are below the age of 24. In another newspaper article, an associate professor is quoted saying:

> We'd love to look at the link between steroids and alcohol. I mean you walk around and you can see them - that guy is on steroids, that guy is, you can spot the people who are taking some form of performance-enhancing drugs because they are massive, like 18-year-olds who are massively over-developed. (The Daily Telegraph 2014b)

Yet another article discussing the recent upsurge in illegal steroid use references Steve Hambelton, president of the Australian Medical Association, claiming that, “bulked-up sports stars are influencing young people to take steroids” (ABC 2014b). The association between younger men and steroids is pervasive in media coverage examining steroids in Australia. However, research specifically attempting to profile the primary demographic of illegal anabolic steroid use found results that

contradict the media image of illegal steroid users: according to Cohen and colleagues (2007), the typical user is 30 years of age, Caucasian, highly-educated, gainfully employed, and earning an above-average income. According to this research, users do not typically initiate drug use during adolescence but start later. Despite this evidence, the social locus most associated popularly with illegal steroid use is younger, even adolescent, males.

In Himmelstein's analysis, characteristics inherent in the social locus of drug users are transferred to the drug itself and are then described as an effect of the drug. Himmelstein's analysis stresses, however, that explaining the changing construction of cannabis sociologically does not mean disproving the underlying beliefs, or alleged drug effects; rather, he seeks to highlight how the veracity of the image is not crucial to its acceptance into public discussion. When discussing the illegal use of steroids, violence and aggression dominate the conversation:

> Jeremy will never know if it was the steroids that made him lose his hair, or if that would have happened anyway... but the acne, the fits of uncontrollable aggression, and a particularly terrifying Hep-C scare? That was all definitely from the juice. (News.com.au 2013)

Australian crime statistics evidence that younger men are the demographic most associated with violence and criminality, with males aged between 15 -24 being the group most likely to criminally offend (ABS 2014). Given that this group is already associated with violence and criminality, the connection between steroids and violence, not surprisingly, dominates the conversation when young men use steroids. One member of the public, feeling the urge to broadcast his views on the current drug climate, wrote to the newspaper claiming that, "whereas once the drug of choice may have calmed you down or made you hallucinate, drugs these days make you feel like Superman with a bad attitude" (*Sydney Morning Herald* 2014). Another reader wrote, "I propose that the excessive muscular development and risk of rage caused by steroid use gives such an overwhelming physical advantage over non-users that anabolic steroids should be considered akin to a deadly weapon" (*ibid*). Both commentators clearly associate steroids with violence. Similarly, when cannabis was known as the "Killer Weed," every other effect of the drug was interpreted according to this dominant image (Himmelstein 1983). The dangers attributed to steroids provide the basis for the cultural construction of the drug and the user; the muscular growth as a side effect of steroids is recast as a deadly weapon intrinsically connected to the drug and its inherent violence. Given that drugs generally produce a wide range of effects, particular effects are emphasised when steroids are used illegally in contrast to when they are used legally. Used illegally, steroids stand as a symbol of a youth, violence, and dangerous masculinity. Used legally, testosterone is a symbol of a healthy and normative masculinity.

Social Locus of Testosterone

The social locus of users consuming steroids for testosterone replacement therapy (TRT) is middle-class men, generally over 50 years of age. These men are in a position of much more authority and power compared to the illegal user, as he is typically depicted. Himmelstein (1983:16) explains that social locus is directly related to the moral and legal status of a drug: the lower the social position of the users, the more likely the drug will be seen as deviant and immoral; the higher the status of the users, the more likely the drug will be seen as moral and legitimate. In online TRT forums, legal users evidence a sense of superiority and morality regarding their use of testosterone over the illegal use of steroids. By constructing their steroid use strictly in terms of medical need, TRT users are able to co-opt the authority of biomedicine to bolster their claims to the drug.

TRT clinics push the notion that the aging male is not the man he once was. As explained by an Australian clinic, 'andropause' feels like:

> A downward spiral affecting physical health... Life becomes a struggle at work, home, and play. Pressures once easily coped with become a source of stress and anxiety and relationships suffer. Sexual activity may decline in both quantity and quality. (Well Men Clinic 2014)

Through TRT a man can achieve a healthy and normative masculinity and can be 'the man he used to be' — or even slightly better — but not so much more male that he is 'superman'. For TRT users, the primary effect of steroids is to bring the user up to "normal" testosterone levels, which results in an increase in energy levels, boost in sex drive, improved mood, increased muscle mass, and weight loss. Noticeably, aggression and violence are not noted as an effect of steroids when used by men on TRT.

As younger men are identified as the main group of illegal steroid users, males legally accessing steroids for TRT describe themselves in opposition to this group:

> The real premise of TRT is a medical treatment of an endocrine disorder, no different than treating diabetes. Your goal is to get hormones back in balance and within normal physiological ranges again. Anything else is steroid abuse, not to mention dangerous.
>
> I grow tired of living in the shadows of guys who abuse anabolic steroids. It makes it all that much more difficult for us guys who have a real medical need for the drug to obtain treatment legally. Worse, yet, the public doesn't (*sic*) see through the illicit usage and lumps us all together as steroid abusers.
>
> Sorry about getting on my soapbox and blowing off steam but I grow tired of living in the shadows and not being able to openly tell friends and family about my condition and my success in treating it. When I hear posts like wanting to feel like the alpha male and aggression I have to speak my mind. This is about simply wanting to feel normal again.

By describing the illegal use of steroids as inherently abuse, this legal user justifies his right to use steroids as it is both legally and medically sanctioned. Moreover, he rages against illegal users for

eroding the public acceptance of his legitimate therapeutic use. Another TRT user, calibrating against illegal steroid users, calculates an appropriate TRT dose based on a supposed standard illegal dose:

> Yea, 50 isn't enough. Generally 100mg a week is the avg [average] dose but 200 is kind of pushing it. Think about it this way, a steroid user does a avg [average] cycle with 400-800mg a week so doing half of that is really top of the spectrum, or in my opinion anyways, so you may have to go with the 50 to start, give it a couple doses and ask for more or as for a follow-up test for your numbers so you can convince him [the physician] that way.

By using illegal steroid users as the measure of over-use, this TRT user locates his advice on steroid dose as tempered and moderate. In online discussions of TRT, legal users consistently deploy illegal steroid users as the reference point, comparing themselves against illegal use, and exaggerate the image of the illegal user. In this way, the TRT community can claim a normative and ideal masculinity that is balanced and measured in relation to an imbalanced or exaggerated illegal pattern of drug taking.

Intensity of the debate

Given the upsurge in steroids being legally prescribed (see Chapter 1), we need to account for the intensity of the debate over the illegal use of steroids and the severity of the legislation applied to the illegal possession and sale of steroids. In *The Cult of Pharmacology*, DeGrandpre (2006) argues that America became a troubled drug culture, not because the government gave access to drugs to some and denied access to others, but because America was a fully fledged member of the "Cult of Pharmacology": the community truly believed in the ideology of the all-powerful drug. In this cult, the pharmacological essences replaced the magical essences previously attributed to drugs in the nineteenth century, so that "a drug's powers were still viewed as capable of bypassing all the social conditioning of the mind, directly transforming the drug user's thoughts and actions" (vii). Psychological and biological explanations came to replace magical explanations of drugs, but faith in transformative power held firm. These new explanations continued to load drugs with extraneous meanings. Drug scholars and researchers held that by entering the bloodstream and directly impacting the brain, drugs acquired special powers (*ibid.:* viii). With drugs laden with special powers, the government came to defend one side of drugs — pharmaceutical use — while trying to exterminate the other side — illicit drug use. DeGrandpre's analysis of drug culture in America provides a framework to understand the intensity of the debate and severity of the legislation dealing with steroids in Australia.

As steroids are specifically targeted in the *Crimes and Other Legislation Amendment (Assault and Intoxication) Act 2014* (NSW), and the premise of this law is to combat violence, the relationship between steroids and violence is cemented in law. The law assumes that steroids are capable of

bypassing social conditioning and can transform illegal steroid users; they are possessed by the drug. Manderson (2005) explains that beneath possession laws is a fear of contamination: the fear that the possessors, coming into contact with the substance, will be powerless to prevent the substance from contaminating them. I argue that this law is driven by the fear that drug users, coming into contact with steroids illegally, are powerless before the drug's effects and are overcome by an urge to express an uncontrollable and violent masculinity. The drug puts the steroid user's excessively muscular body to work as a deadly weapon. The hyperbolic nature of this fear is codified in the Act itself, in which possession of steroids results in a maximum sentence of twenty-five years, while assault causing death leads to a maximum sentence of twenty years. The fixation of the Act on the drug, rather than the theorised outcome from taking the drug, means that the gaze of the law is misplaced. The paradox of this law is that its severity imbues steroids with more potency as a symbol of a dangerous masculinity: the law implies that the object, the drug, is so powerful that the harshest laws are needed to prevent people from risking use. By fixating on the drug as the cause of violence, the steroid user, his social context, and his motives for use are largely ignored.

Justifications for Steroid Use

The *Crimes and Other Legislation Amendment* is built on a particular image of illegal steroid users. This law identifies steroid users as violent and dangerous and a public health risk to be swiftly managed. Given that the law is operating on the symbolic level, with steroids standing in as a symbol of deviant masculinity, many users do not associate their controlled and systematic use of steroids with the acts prohibited by the law. In the same way that legal users explain their steroid use as moderate and tempered in relation to illegal steroid users, certain illegal steroid users describe their drug use as justifiable in relation to other, less legitimate users. In conversations with strength athletes and bodybuilders, members of distinct subcultures strongly associated with illegal steroids, users fail to recognise the relevance of the new law, as they do not identify with the deviant, violent man imagined by the legislation. Consequently, the disconnect between the premise of the law and steroid users' motives and management of their drug use means that these users are unlikely to modify their behaviour as a result of the law.

Monaghan (2002) described the vocabularies of motive of illegal steroid use among bodybuilders in Wales; illegal steroid users in New South Wales describe similar motives when justifying their steroid use. Amongst informants in strength and bodybuilding communities, steroid use is not seen as deviant; instead it is subculturally normalised. These illegal users, as members of a subculture that normalises steroid use, justify, rather than excuse their behaviour. According to Scott and Lyman (as cited in Monaghan 2002), social actors opt for a justification defence when they

accept responsibility for the act, but do not consider the act morally wrongful; in contrast, people use excuses when they engage in a morally wrongful act, but do not accept full responsibility. Illegal steroid users justify their right to use steroids, and explain these justifications by emphasising the positive effects of steroids and dismissing their negative effects. By contrasting their use with deviance in others, Illegal steroid users in this athletic subculture portray their own steroid use as normal; ironically, this justification occurs in the same way that non-drug users locate themselves in relation to drug addicts as Manderson describes:

> The standard portrayal of the drug addict, stultified and immured in incapacity, reassures us of their absolute *otherness*. The solidity, the certainty, of our identity is shored up by vivid contrast with theirs. (Manderson 2005:424)

Illegal steroid users in strength and bodybuilding communities contrast their steroid use favourably against: others in their communities, users of other recreational drug, and others outside of their communities who use steroids.

Within strength and bodybuilding communities, working towards greater strength or improving the body becomes a higher goal over and above all other goals:

> Everything with my body is about getting stronger or better. I want to see how far the body can go; I don't need material things. I just want to push the physical body. I want to get bigger and stronger, and I'm driven by that challenge. I can't get to the levels I want without using, because the body can only go so far.

This strength athlete considers steroid use just as a means to an end — a transcendent aim — to help him achieve these higher goals. Similarly for many in the community, steroids become simply another aspect of a regimen that they need to follow to ensure that they are physically performing at their peak. For steroid users who have been injecting for years, the need to inject one to three times each week becomes onerous, a burden that they learn to tolerate in exchange for the performance gains they receive. One bodybuilder, who loathes injecting, now describes his body as just a 'pin cushion'; the process of injecting is almost enough to make him consider abandoning steroids. Because pursuit of these higher goals justifies drug use, illegal steroid users are often extremely critical of who uses steroids within their communities, and how they use steroids:

> I'm surprised by the number of athletes that are using steroids that are nobodies; people don't want to work hard any more. In the past you needed more determination to make it. You should train for at least five years before you even consider using steroids.

Another athlete echoing the same sentiment, that the justification of use is a right to be achieved, claims:

> Those not at an elite level shouldn't be using. They haven't worked hard enough in their own skin to start using drugs to make them better. They need to be the strongest and best that they physically can before they start thinking about drugs. Starting early is just wasteful and stupid.

This attitude that other "lesser" athletes have no right to use steroids is common, and even more pronounced among more elite athletes; because their justification is a need to transcend their limits, only working up to those limits can legitimate use. Fellow athletes and bodybuilders are also often criticised for naively using doses that are far too high.

Strength athletes and bodybuilders further protect their right to use steroids by competing in non-drug tested sports, federations, or divisions of sport. As they are not being tested, and their fellow competitors are not being tested, they claim that steroid use is implicitly sanctioned. As athletes averse to steroids can opt for drug tested sports, federations, and divisions, athletes who do use steroids feel further legitimated in their choice. This comparison between their steroid use and other athletes in their communities is what Monaghan (2002) labels a "constructive rationale". With constructive rationales users situate their drug use in relation to others. By situating their own drug use favourably in relation to other members of their own strength and bodybuilding communities, and by arguing that their use is moderate, appropriate, and earned, these users justify their right to use steroids.

Beyond their own communities, illegal steroid users often compared their steroid use to recreational drug users. One amateur bodybuilder began using steroids when his drug dealer offered him some for free one day: "I expected a high and euphoria, like other drugs, but didn't get that. Cocaine is all about the euphoria, the experience is fast and temporary. Steroids make you feel confident, but in a different way." The lack of immediate effects and perceived "high" or intoxication are used as proof that steroids are completely different to recreational drugs; steroids are a tool to pursue higher objectives, not simply a route to feeling a 'rush' or temporary euphoria. Another nationally competitive bodybuilder and former recreational drug user described himself as a 'reformed drug addict', after recently spending a month in rehab. He still currently uses steroids, and this use does not affect his self identification as 'reformed'. According to his own account, he was previously addicted to GHB (gamma hydroxybutyrate), a recreational drug used for its stimulant effects, but also commonly used by bodybuilders as they believe it increases the release of growth hormone. He contrasts his previous use of GHB to his current use of steroids: "I was addicted to GHB and other drugs, but steroids are different. Psychologically they're very different. They are a safe drug. " Although steroids are synthetic, their close connection to the natural hormone testosterone means that many male users consider steroids to be effectively 'natural', even though they are taking doses far beyond normal physiological levels.

In New South Wales many illegal steroid users source the paraphernalia they require from Needle and Syringe Program services (NSPs). NSPs provide injecting equipment to a range of drug users as part of a harm reduction initiative established in 1986. Illegal steroid users procuring their needles and syringes from NSPs are forced to interact with other drug users. One elite female bodybuilder dreads going to NSPs and mingling with other drug users:

> I hate going to the needle exchange: it's so seedy, and it's not safe. There are lots of drug addicts there. They are loud and violent. We [steroid users] are nothing like drug addicts. Heroin addicts rob people, and their drug use affects their families. I finance my own use. I'm careful. I'm not violent. Most serious athletes are careful, discreet and cautious about their use.

By contrasting her lifestyle favourably against her image of "drug addicts", this bodybuilder attributes danger and deviance to the way that other user communities manage their drug habits, while her drug use is by comparison described as safe, careful, and not impinging on anyone else. Contrasting steroid use to the experience of other recreational drugs and recreational drug users allows these illegal steroid users to assert that their steroid use is safe, superior, and not impacting wider society, even while they are making use of the harm reduction programs put in place to deal with the social effects of substance abuse.

The group that bodybuilders and strength athletes are most critical of is those outside of their communities using steroids, for non-performance reasons. Even non-competing steroid users within the strength and bodybuilding communities are hyper-critical of those outside of their communities using steroids. As those outside of these communities were not striving for similar goals, their use of steroids was described as pointless and unjustifiable. As one strength athlete explained, "Other people using just frustrates me; I'm using it for the real reason". When users discussed their own steroid use, they continually stressed how safe the drug was. Yet when they discussed people outside of their communities using steroids, they stressed the dangers and risks associated with the substances:

> If it's for sport, it's okay; it's okay to be the best. If you are just going to the gym and use steroids, then steroid use is pointless. You are potentially putting your body at risk, and that is just dangerous.

For these communities, steroid use is not a new phenomenon; it is a heavily entrenched practice. Consequently, many users did not associate the recent upsurge in steroid use with their communities, but suggested that increased rates of use were occurring outside their communities. A common group they identify as now using steroids are younger men supposedly using steroids as an easy means to enhance their bodies for music festivals. The strength athletes and bodybuilders believe that this group of users are the real target of the new law, and imply that they are a legitimate target of prohibition. One female bodybuilder explained that all illegal steroid users are

tainted by the same brush in the eyes of the law, but the activities of a few have really spoiled it for everyone. She was clear that the deviant steroid users were located outside her community. Given the strict diet and training regimens that most followed in these communities, and the avoidance of partying and recreational drugs, they predictably turn to a discourse of health to justify their right to use steroids:

> You shouldn't be using unless you are competing. We don't drink, we don't smoke, and we don't do drugs. We are healthy; our usage is different. I don't have time for gym rats that use that don't compete.

Turning to health allows these illegal users to assert physical and moral superiority over steroid users who had inferior motives.

Strength athletes and bodybuilders that habitually use steroids do not consider their behaviour deviant or morally wrong. Instead, they attribute deviance to other steroid users and to other recreational drug users. The *othering* of deviant steroid users means that they treat the new law as irrelevant to them; the new law is not applicable to how and why they use steroids. In the same way that legal TRT users consider all illegal users as abusers, the illegal users in this study portray other illegal steroid use as misuse and consider them to be the actual or legitimate target of this law.

Conclusion

The new law, the *Crimes and Other Legislation Amendment (Assault and Intoxication) Act 2014* (NSW), specifically associates steroid use with violence. Following Manderson's (1995:800) lead in discussing why drugs seem to matter so much, this chapter moves away from the discourse of reason and toward an analysis of the deeper symbolic meaning of drugs. Both public discussion and the law construct a certain image of the drug users and the drug itself. Used illegally, steroids are a symbol of a deviant and violent masculinity. Used legally, steroids are relabelled "testosterone" and signify a normative and healthy masculinity; if anything, they are discussed as a restoration of normality and vitality.

Given the increasing legal and illegal use, the severity of the punishment for illegal possession can only be explained by looking at the law as operating on the symbolic level. The belief implicit in this law is that steroids are capable of bypassing social conditioning and can transform the illegal steroid user; the substance is especially dangerous because the user will be possessed by the drug. Steroids, as they are imagined by the law, provoke a fear that men coming into contact with the drug will be powerless to prevent becoming uncontrollable, violent men. By fixating on the drug

as the cause of violence, the steroid user and his motives are completely ignored as are the other contextual causes of violence in young men.

In contrast, illegal steroid users that are members of strength and bodybuilding communities consider the law irrelevant as they do not recognise the image of the illegal steroid user as implied in the law: they simply do not recognise themselves as a likely or legitimate target. Instead, by contrasting their steroid use favourably against other recreational drug users and other illegal steroid users, these strength athletes and bodybuilders legitimate their right to use the drug, receiving support within their own subculture. In the same way that legal TRT users consider all illegal use to be abuse, the illegal users in this study describe other illegal steroid users as abusers and consider them to be the actual target of this law, pointing out that they do not live up to the subcultural principles that legitimate their own use of the drug.

In the last ten months of the Act's existence none of my illegal informants noticed changes in the ways other illegal users managed their steroid use. By focusing on the drug as a symbol of a deviant masculinity, the law fails to account for how particular illegal users justify steroid use. Consequently, the success of the law in modifying behaviour is potentially jeopardized as the law does not adequately reflect an understanding of why certain communities of steroid users choose to behave the way that they do.

Chapter 4
Steroids and Gender: Maintenance, Transformation, and Aberrance

> **EJ:** Do you ever see the transitioning process as complete? Do you ever go, now I've done it, I'm here?
>
> **Will:** No. No, I don't think so, because it's so psychological as well, I think there is a lot of healing that needs to be done. And there's a thing that says you can only be a man or a woman. And people say to you, well you're a bloke now. The first year I transitioned, I started to hear all these things I hadn't noticed before: "Men don't do that"; "Oh come on, don't be a baby, you're a man now"; "Man up mate". I'd be thinking: get fucked, what gives you the right to tell me how to be anybody. But suddenly you start to really listen to the way people speak to each other. You hear men talk to each other that way, and then you start to hear women talk to men in that way too: "What's that about? Stop crying. Man up."
>
> When transitioning, you realise that you've lived with all these expectations and all these feelings that come from being a female. And when you were female, you were always fighting back against these ideas. And then you get the opportunity to be who you feel you are, but what it involves is a loss of stuff. All of a sudden you can't cry. You have a sense of dullness about how you feel about things; it's all a bit of a loss.
>
> You know, I love kids. I'm fantastic with kids. You should see if I go near a child now. The mother will quickly grab her child away from me. It's always in the back of my mind when I see kids around. When I see children playing, I'll stop and look at them, and then I start to look around and people are looking at me. I'm a potential paedophile. And it's just shocking. It's bizarre. It's totally bizarre. Cis men just, I guess, get used to that. I guess they've never been much interested in children, or only their own kids, or they just get used to "get away from that child, old man".
>
> So the transitioning process, it is not only physical; it's all this emotional stuff about transitioning. And then on top of that you have all your own personal baggage.

Gender is socially constructed through an ongoing and conflict ridden process (Connell 1995; Wedgwood 2009). As a transgendered man, Will recognizes the dichotomous nature of gender and how becoming a man is about no longer being a woman (Klein 1993:17). In other words, the positive attributes of being a man are also equally negative attributes; Will can be stoic and brave, but he cannot cry and he cannot express emotions in the same way he once did. For Will, the journey to manhood entailed mourning aspects of his former female identity that he did not previously recognize as female.

Gender is a social project as much as a personal project. People battle between personal understandings of gender and also performing that gender in accord with social expectations. When a person accords to society's expectations, his gender appears to emanate "naturally" from his body; when his masculinity does not accord with expectations, then he is seen to have deviated, and his form of masculinity is not wholly socialized (Klein 1993:17). Men work with and against these gendered ideals when constructing their own masculinity. The dialectical nature of gender means that while an aspect of the gendered experience can feel stable and fixed at certain times, at other

times, it is fluid and open to change (Sweetman 1996: 437). People retain rigid and fixed notions of what it means to be masculine and what it means to be feminine, but over time these ideas evolve, and from person to person they change.

Gender is a work in progress. Steroid, as a pharmaceutical tool, provide a unique vehicle to explore the performance of gender. I argue that steroids are so intimately connected to maleness, that steroid users inevitably confront their understandings of sex and gender when using the drug. For transgendered males, steroids are an existential tool absolutely fundamental to the masculine reconstitution of their wrongly sexed bodies. In contrast, women that are cis-gendered (a term describing those whose gender identity matches their phenotypical sex) often use higher doses of steroids than transgender men, but deny the drug's ability to alter their gender. Lastly, cis-gendered men use steroids to maintain their idealised understandings of masculinity. As steroids physically alter the body, some steroid users consider biological maleness and femaleness changed by the drug. Steroids, as a pharmaceutical aid, only partially transform an individual's experience of gender: his expectations and hopes still shape his experience.

Transgender Transformations

There is probably no other group so profoundly impacted by the difference between "sex" and "gender" quite like transgendered people. For Butler (1993), "sex" is an ideal construct materialized through time. "Sex" is not a static description of what one is, but is a process of regulatory norms that are reiteratively performed to qualify "a body for life within the domain of cultural intelligibility" (Butler 1993:2). Failure to reiteratively perform these norms means that a body is culturally unintelligible. This lack of cultural intelligibility comes to the fore in the lives of children growing up transgendered who need to reconcile discordant personal views of their sex with everyone else's ideas about their sex. Will growing up confronted a constant cacophony of, "You don't look like a boy, are you sure?" Family, friends, and medical professionals continually tried to force him to submit to his biological sex:

> One bloody doctor said to me, 'Do you like velvet or calico?'
> I said, "What do you mean?"
> "What do you like the feeling of?"
> "Well, Velvet obviously."
> And he said, "See, a boy would like calico."
> Then of course I was sitting there thinking, maybe I'm wrong, maybe I'm not a boy. Eventually I realised that he had no idea what he was talking about.

Speaking of other children growing up transgendered, Will explained:

> One kid drove a pen into his leg, into his thigh. I asked, "Why'd you do that?" He said, "I wanted to see what was underneath, whether I was really under there." Another kid is absolutely covered in cuts; I've never seen so many cuts, every inch of his body. He is covered head to toe in cuts. You just can't

> make sense of it, and everybody just says no, no, no, it's just a phase... It needs to be much more open and easy for kids. It's always about you prove it; you prove to me that you are a boy, because I am looking at you, and you don't look like a boy.

The gravity of these stories reveals the severity of gender dysphoria for some children and the distress of being culturally unintelligible. Not all transgendered men have experienced such extreme dysphoria, but most have a sense that the word "transition" does not adequately capture the difficulty of the process of changing from one gender to another.

"Transition" implies movement, passage, change from one position to another, or even a brief modulation. The transition from one sex to another is not a simple passage or a brief modulation; it is a difficult, and often painful, existential transformation. The irony of this situation is that when asked, many transgendered men say that they would not change the process that they went through; the obstacles were necessary. The transitioning process is not pleasant, and it is not easy, but, according to them, the process should not be pleasant or easy.

For Tyson and Sam the transitioning process was continually interrupted with hurdles. When I met Tyson, he looked unmistakably male: cropped brown hair, loose hanging basketball shirt, lip piercing, scraggly facial hair, and tattoos. He is 27 and has been living as a transitioned male for around 6 months. Unlike other transgender men, Tyson was 18 before he started to identify as gender dysphoric, after meeting a transgender man and realising that he felt the same way. At 18, Tyson was not in the right headspace or in a financial position to allow him to pursue transitioning, so he did not commence the medical and legal processes required to transition until four years later. At 22, he started using male pronouns, a new name, and wearing a tight chest binder to contain and conceal breast tissue. Counselling also began, but the counsellor focused all his questions on Tyson's upbringing and family life. Coming from a broken, violent home and a difficult past, Tyson did not want to discuss these aspects of his life; he also did not understand the relevance of his family history to his desire to transition genders. Tyson points out that many counsellors tend to think that being transgendered results from coming from a broken home, and if they can talk through all your family issues, then the desire to change genders is just going to disappear. The counsellor persisted, and after a few months Tyson gave in and suspended transitioning plans. Months later, he re-commenced counselling through a different centre. Soon after this second attempt, he went to his physician requesting a referral to a psychiatrist versed in transgender issues. The psychiatrist sat with him just once and determined that he was ready for testosterone; given that Tyson was stable and could mentally cope with the transition, the psychiatrist felt no need to continue with the standard ongoing counselling sessions. Tyson's birth certificate is currently in the process of getting changed, since completing medical transition.

Stan's story is more complicated than Tyson's, as the same psychiatrist that had given Tyson approval for steroids, did not wholeheartedly endorse Stan's desire to transition. Consequently, Stan gave up on his desire to transition, feeling that the process was just too difficult. Six months later he re-started the process after realising that he really needed to affirm his male identity. This time Stan followed exactly what the psychiatrist said and went through the process dictated by the medical system; soon after, he was able to receive steroids. In total the process took around two years for Stan and around eight months for Tyson.

Given the time and relative difficulty it took them both to start receiving steroids, I was surprised that they would not want to change the process at all. Every obstacle to transitioning was reinscribed, in their minds, as a necessary evil. The obstacles overcome evidenced the difficulty of the journey and reinforced how far they had come. If the process was easy, then transitioning would not be such a big ordeal; this ease would imply that there was not much difference between their female and male selves. By ritually redefining the process as necessarily challenging and lengthy, Tyson and Sam are able to signal how far they have come and how transformed they are from their former female selves.

Further evidencing the need for some obstacles in the transitioning process as a way of signalling the magnitude of the transformation, one transgendered man delayed the transition process as none of his friends or family expressed any objections or reservations about him starting to change sex. Instead they offered unwavering support. Querying what their opposition could give him, he claimed that if he had to defend his position, then he might feel surer about transitioning. If he was forced to compose an argument about how he identifies as a male, he indicated that it would help him to convince himself that this choice is right for him. As his family and friends offered complete support for his transition, he felt that something was missing so he has put off engaging with the medical system to access hormones for now.

The obstacles and difficulties in achieving a transgender identity reinforce Connell's (1995) point that gender is constructed through a long and conflict ridden process. Steroids allow transgender men the ability to pass more easily as men. However, prior to receiving access to steroids, transgendered men are obligated to masquerade as men to prove to medical authorities that they understand what they are about to do to their bodies. This trial period entails name changes, pronoun changes, informing friends and family that the individual want to be male and to refer to them in this manner, wearing male clothes, donning a male haircut, and binding breasts. Beyond these steps, more subtle gestural and postural mannerisms also need to be learnt. While many elements are involved in affecting a male identity prior to accessing male hormones,

transgender men still maintain that steroids are absolutely essential to successfully emerge as their male selves. Without steroids, one man explains that he can sometimes pass as a man, but the moment he opens his mouth, his voice is a giveaway that he is female; steroids are crucial in order for the public to perceive him as male. Beyond the physical androgenic effects of steroids - which assist in male embodiment - steroids provide a sense of bodily confidence and psychological reassurance. If the transgendered male believes that he is more likely to pass as a man due to the hormones, then he is going to be more confident in affecting a male persona. Conversely, if he lacks confidence in his ability to pass as a man without hormones, then his performance of a male persona is less likely to be successful. This contrast is not implying that steroids are acting on the placebo level – there are very real effects from steroids – but steroids furnish transgender men with the biological proof of maleness, which assists in the gendered performance of masculinity.

The anxiety of not successfully passing as a cis-gendered male is petrifying for some transgendered men. As highlighted by Matza (2009:156), passing in the transgender context is not about passing as someone you are not, but is about passing yourself off as someone you are. To be able to gender pass as a cis-gendered man, transgendered men need to perform consistently and convincingly the gendered conventions of appropriate masculinity (155); that such conventions exist points to the rigid and fixed nature of gendered ideals. Will's success at gender passing means that he appears as an older man, and as such, he must yield to the discriminations levelled at older males, which when looking at young children play means that onlookers might brand him as weird and a potential paedophile. While this feels disconcerting to him, the reaction illustrates the shared and social nature of gender. Gender is interactional, meaning that it is through interaction that gender roles and gender presentation come into being, are endorsed or rejected (154). For most transgender men, steroids provide the crucial key to physically prove their maleness and to ensure that the public successfully accepts them as cis-gender men.

Aberrant femininities

Unlike other recreational drugs, which are often centred on more immediate and psychoactive experiences, steroids are a drug of the body and are a long-term project. The primary purpose behind illegal use for most women is to gain strength and reduce body fat. Unlike male illegal steroid use, which is common beyond serious athletes, female use of steroids outside of the sporting arena is rare. Even when women athletes do use steroids they are extremely private and cautious about their use. Zoe explains that female *lifters* (weightlifters) place a taboo on admitting to steroid use. According to Zoe, male *lifters* can openly joke about their steroid use to each other, but those conversations are not open to women. She says the fear that women will cross the line

between genders and become “she hulks,” closer to male than female, makes these conversations impossible. Zoe states she can tell when a woman is using by how rapidly she gains strength, but these women will not admit usage to her. Instead Zoe speaks with the partners of the female lifters; they often confidentially admit usage to her, but tell her not to discuss it with anyone, especially their girlfriends (who are using). Women’s steroid use is such a taboo in Zoe’s world that she has not met a woman with whom she can discuss steroid use. Instead she relies on information available online and second-hand advice from partners that have girlfriends that use steroids.

As Zoe is new to strength sports, she is planning on only doing a steroid cycle with a low daily dose of Anavar. Anavar, or oxandralone, is a relatively weak steroid known to have very low androgenic effects and mild anabolic effects. The mild masculinising effects combined with Anavar being orally ingested, rather than injected, makes Anavar an appealing choice for many female users. Consequently, to Zoe, Anavar is not a serious steroid. Zoe’s justifications illustrate how she prevents her steroid use from affecting her sense of her femininity: by opting for a mild steroid and by strictly monitoring her calorie intake and body weight, to prevent herself becoming a “she hulk.” Then, she suggests, her steroid use is unable to interfere with gender identity.

At the other end of the spectrum, Katrina and Lana are two elite level strength athletes. Katrina, a word-record holding power-lifter, and Lana, an international level strong-woman competitor, have been at the elite level of their sports for years now, and cycling steroids for most of that time. Catching up with Katrina at the gym one day, she mentioned that since being forced to reduce her training due to an injury, she had dropped seven kilograms. Before I could congratulate her, assuming that weight loss was desirable, she immediately bemoaned the potential muscle and strength loss that these kilograms represented. Sitting at around 90 kilograms, Katrina is heavier and larger than the average female. However, she sees her size as a display of her muscle-mass and strength. Her cropped hair is mousy brown, and she is nearly always wearing exercise gear. All her time is spent working, studying, or training; not much of her time is spent performing the gendered conventions usual for a 25-year-old woman. As an elite athlete, Katrina relates to her body in a very particular way: her body is a functional machine continually perfected to ensure that she reaches her strength goals. She is also intensely competitive and determined; once she qualified for her first world championships, she considered steroids necessary to guarantee her competitiveness. Her coach encouraged steroid use and explained what she needed to do. The potential side effects were inconsequential when compared to the potential strength gains. As the international competition required drug testing, the competition organiser explained that he would warn the female competitors when they were going to be tested, so they could make sure that there were no drugs in

their system at the time of testing. When Katrina was on a steroid cycle, she used around five to six times more testosterone than the standard dose for a transgender male, and she injected a combination of different steroids. These stronger steroids lead to virilising effects: deeper voice, acne, increased muscle mass, body hair, and facial hair. Talking about an international competition she was at, Katrina explained that she felt at home: all the women had deeper voices, facial hair, and acne.

Reading between the lines of her words, despite the androgenic effects from the steroids, she did not perceive that steroids had any impact on her gender or the gender of these women. The virilising effects are classified, by these women, as side-effects of steroids and not the primary effects; they are simply tolerated or ignored. These elite level female strength athletes refuse to allow steroids to shape their identity as women, even though a smaller dose of the same drug is able to transform existentially a transgendered man. For transgendered men the physical attributes that result from steroid use serve as biological proof of maleness that then accord with the transgendered man's identification as a man. For female steroid users, the virilising effects do not serve as proof of maleness, as they do not identify as men. Instead, these virilising effects are cast as steroid side-effects and are reworked in the production of an aberrant femininity.

Katrina and other elite level female athletes manufacture bodies that deviate dramatically from what Connel (1987) labels "emphasised femininity". "Emphasised femininity" refers to the public construction of femininity that is compliant, subordinate, and accommodating to the desires of men (Blaise 2005:58). The term acknowledges that there is no hegemonic femininity because in the order of genders, masculinity claims authority over femininity. As most elite female strength athletes embody aberrant female ideals, they sometimes fail to gender pass as women. Matza (2009:153) outlines that gender passing involves the intentional use of gendered markers to communicate gender. Gender passing exists in cultural systems with codified social rules outlining appropriate behaviour and presentation for members of distinct social identities (*ibid*). By not manufacturing bodies and presenting themselves according to pre-established gender norms, these elite female athletes have a harder time passing as their chosen gender. Occasionally children have mistaken Katrina for a man and have felt the need to tell her. Rather than be irritated or upset, Katrina intentionally subverts these children's judgements by reinterpreting them as proof that she must be stronger than the men that these children know. In this way the child's judgement is not embarrassing or shameful, but a source of pride. Working through a cultural resistance model, social scientists show how stigmatized individuals view their behaviour, and then in response to marginalization intentionally subvert the stigmas levelled at them, and instead bear them as

emblematic of status or resistance rather than shame (Fiske 1986; Hebdige 1979; Klein 1995:106). While not fitting into normative understandings of femininity, Katrina and women like her firmly adhere to their identification as women and proudly perform aberrant femininities.

Maintaining and Securing Masculinity

Male cis-gender use of steroids in Sydney, legally and illegally, bolsters a man's sense of masculinity. According to informants, steroids make men feel more like men. For Layne, steroids allow him to physically represent his masculinity, through his muscularity, but this normative masculine body sanctions his right to perform non-hegemonic masculinity. As a teenager, Layne was an average height and weight, but extremely intelligent. Fearing that his intelligence make him 'uncool' to his peers, Layne did everything he could to be "badass": getting drunk underage, experimenting with drugs, mucking around on the street, and getting in trouble with authorities. To further prove himself to others, he started training at the gym trying to get big. He soon started training other people and competing in bodybuilding. After winning some state titles and coming runner up in national competitions, he started to feel more confident in his expanding frame. All of a sudden night-club bouncers sized him up and down and asked him for advice, strangers complimented him, and men asked what they should eat to be like him. Layne felt like a minor celebrity due to his size. Attending his high school reunion he realized how far he had come from being the boy on the academic scholarship: he was now comfortable to be himself. He could be funny, he could be vulnerable, and nobody was going to judge or question him, because he was bigger than all of them. He was able to express more feminine qualities because his body was an unquestionable physical demonstration of his masculinity. Layne's use of his body reveals how the male body can be an illusion: a defensive construct with an intimidating exterior compensating for self-perceived weakness (Klein 1993:19).

Speaking with many men using steroids illegally, they clearly connect size and muscularity to masculinity; the smaller a man is, my subjects assumed, the more feminine. They seemed to feel that greater size correlated strongly with increased masculinity. For Connell (1990), multiple kinds of masculinities exist in relations of dominance and subordination to each other. "Hegemonic masculinity" is the "culturally idealized form of masculine character", where the most prized masculine traits are embodied (Connell 1990:83). Approaching masculinity from a psychoanalytic perspective, Horrowitz and Kauffman (1987:97) explain that:

> Because of its real-life distance from biological reality, masculinity is an elusive and unobtainable goal. From early childhood, every male has great doubt about his masculine credentials... the confirmation of masculinity can best be found in the trials of manhood (war, fighting, or more refined forms of

competition) and in relation to its mirror opposite, femininity.

Sport as a "refined form of competition" and a dominant institution is a prime avenue available to men to confirm their masculinity by achieving success. Through both sport and size James, an elite strongman, doggedly pursues his idolised masculinity. James has a muscular, hyper mesomorphic body and looks like the archetypal lumberjack: flannelette shirt, burnt orange hair, untamed beard, and an enormous hulk of a frame. Hovering around 150 kilograms, this kind of size takes a lot to maintain, not just in terms of daily food consumption, but also injury management and rehabilitation. Six years ago, James was just 85 kilograms, a relatively low weight for a man of his height. Since taking up the sport of strongman, size and strength became the only goals to strive for. James went from 85 kilograms to 120 kilograms through just eating and training: he would eat till he was full, throw up, and then eat some more. To get from 120 to 150 kilograms, James was assisted by steroids. While he gained a lot of mass, his perception of his size never changed, "I have tunnel vision; I'm one of the smaller guys in my eyes. I'm at the bottom of the food chain". James no longer comprehends the size of a normal male body; he looks to the top strongmen competing at 170 kilograms and considers them the physical ideal. James considers it impossible to get to where he wants without using steroids. For James muscularity equates to masculinity, and steroids provide the muscles that reify his masculinity. That James still feels small in his massive frame illustrates Klein's (1993:19) argument that those who uncritically subscribe to the ideals of hegemonic masculinity or "comic-book masculinity" are frequently doomed never to attain them. In Keane's (2005:192) discussion of steroids, she argues that the steroid user is increasingly conceived of as a feminized subject, "his muscular physique acting as ironic testimony to his vulnerability to media images and his lack of a healthy male identity". I would argue that even for men like James, who seem to exhibit some level of muscle dysmorphia, the attraction to steroids and a muscular physique is less about vulnerability to media images, and more about men's troubled sense of security in their gender.

Monaghan (2001) critiques Klein for claiming that bodybuilders are masculinities in crisis. Instead, Monaghan argues that bodybuilders, and strength athletes like James, participate in a distinct subculture and acquire a particular way of looking at bodies according to a "unique aesthetic code" (Keane 170). The muscular body becomes a signifier of dedication, diligence, and sacrifice. Discussing heavily muscled female bodybuilders, James explains, "I can respect those women, their body is attractive in terms of what they have achieved, even though I don't find them sexually attractive". With this particular way of looking at the muscular body – as emblematic of dedication and sacrifice – a man's hyper-muscular body signals more than just hegemonic masculinity. I argue that while James primarily uses steroids as a pharmaceutical tool to excel in his sport, he

nevertheless confronts his understandings of masculinity as a result of this drug choice. Due to his hyper-muscularity, muscularity equates to masculinity.

The use of steroids to sustain and embody hegemonic masculinity is not restricted to illegal usage; legal users similarly employ steroids for the same purpose, even more explicitly. Men on testosterone replacement therapy (TRT) are usually older males, so their natural testosterone levels are starting to decline. In fear that these declining testosterone levels indicate diminished masculinity, exogenous testosterone bolsters ailing masculinity. One TRT user online explains:

> That's it! turn the vial right side up, pull the needle out, inject, and enjoy feeling like a man again with normal levels of T. Acutally, [sic] it takes a day or two for you to really feel anything and then several weeks for it to build up in your system, but you know what I mean.

For these users testosterone itself is masculinity. In Keane's (2005:190-1) analysis of the steroid user, she claims:

> The status of testosterone as 'the male sex hormone', a kind of concentrated essence of masculinity, enhances the transformative power attributed to steroids. In contrast, 'female' sex hormones have been successfully domesticated, medicalized and commercialized and are not imbued with such dangerous capacities.

Buying into the transformative powers of steroids, one TRT user expected an immediate transformation:

> I'm really confused about the lack of effects though. Everyone talks about having high T and feeling all alpha, morning wood etc... I don't feel any different then when I was on the low end.

While this user did not feel the effects he expected, he still equates testosterone to feeling dominant ('alpha') and sexually virile ('morning wood'). Using testosterone as the concrete and biologically real essence of masculinity is a way for men to locate the "elusive and unobtainable goal" of masculinity (Horrowitz & Kauffman 1987:97).

Conclusion

Gender is a work in progress. Steroids are a drug so intimately connected to maleness, that steroid users inevitably confront their understandings of sex and gender when using the drug. For strength athletes and bodybuilders, a hyper-muscular male body signals more than hegemonic masculinity, it also represents dedication and sacrifice. Nevertheless, despite signalling these particular subcultural ideals, illegal male informants still reworked their muscular bodies as representations of their masculinity. For TRT users testosterone is masculinity, so increasing natural testosterone levels through steroids allows them to sustain their masculine credentials. Transgendered men, by using steroids to work on their biological sex, reinforce a belief that gender is fixed, while biological sex can be reworked. To reinforce the difference between their female and

male selves, transgendered informants ritually inscribe the transitioning process: the legal and medical obstacles to transitioning are used to signify how changed their male selves are, if the transition was easy, then it would not be a complete metamorphosis. Female steroid users use steroids purely for performance reasons, and classify all masculinising effects from steroids as "side-effects" to be mitigated or tolerated. While some elite female users are consuming 5-6 times the amount of testosterone as a transgendered user, they do not always successfully gender pass as women. These female informants intentionally subvert the stigmas levelled at them and recast the masculinising effects resulting from steroid use into the production of an aberrant femininity. These ethnographic accounts of steroids underscore that steroids only partially transform people's experiences of gender: their expectations and hopes still shape their experience.

Chapter 4

Conclusion

In Australia, steroids are increasingly used, licitly and illicitly, by a range of men and women. However, research into steroid users tends to nearly always focus on just one type of male user, ignoring all other populations using the drug. Media accounts and academic research similarly tends to spotlight either aging men using steroids for TRT, or illegal steroid "abusers". The specific aim of this research is to bring a range of steroid users into conversation with each other. This focus on multiple users shifts the perspective from looking at how just one group's steroid use is shaped by institutions to how institutions differentially shape the steroid experience depending upon who is using the drug and to what end. Moreover, this research unpacks how users speak back to these dominant institutions.

Biomedicine and physicians as biomedical agents are the focus of chapter one. This dominant institution shapes steroid use in Australia by willingly granting steroid access to TRT users, tolerating illegal usage, and making access to steroids difficult for transgender users. From these positions, steroid users take a number of directions: TRT users skirt biomedical authority to refashion their bodies according to their own dreams of masculinity; illegal users, as "expert patients", challenge biomedical knowledge by defending their own ethnopharmacological knowledge; and, transgender users submit to biomedical authority in order to gain access to steroids and have their male identities affirmed by a powerful institution.

The second chapter turns to the law as an institution producing a certain image of the illegal steroid user as violent. The law's construction of illegal users as violent supports the medical monopoly over drugs, and allows legal users claim a normative and ideal masculinity that is balanced and measured in relation to an imbalanced and violent illegal steroid user. Illegal informants of strength and bodybuilding communities subculturally normalise steroid use and do not understand their steroid use as deviant. Consequently, these illegal users continue to justify their rights to use steroids, and consider other illegal steroid users the actual target of this law.

The third institution this thesis centres on is gender. Martin (2004) encourages academics to study gender as a social institution, due to its persistence as an element structuring behaviour. Producing an ethnography of steroids that did not analyse gender would be lacking. Gender shapes how some steroid users perform their gender and, how other users embody their sex. In speaking back to gender as an institution female users rework the masculinising steroid effects into the production of an aberrant femininity, while male cis-gender users utilise steroids to bolster their masculinity.

This research opens up a new way to produce an ethnography of a drug. By holistically analysing multiple users the focus of the drug ethnography shifts from critiquing drug users to examining how institutions differentially treat people. The differences in treatment underscores that those with the most urgent need for the drug often experience the hardest time accessing and using steroids. A key limitation of this thesis is its size. The massive scope of this research deserves a much more detailed and robust analysis then these pages permits.

This thesis lays the groundwork for further research into specific populations of steroid users. Steroid users are often analysed as an undifferentiated mass, but subculturally the drug serves multiple purposes and is understood differently. For example, the analysis of female illegal users in bodybuilding and strength communities, in this thesis, underscores how their steroid use is distinct from male illegal use in the same community. Monaghan's (2001) work, in the same manner, systematically explores the particular subcultural meaning of steroid use in bodybuilding communities. I believe that more research is required into the subcultural understandings and uses of steroids, but multiple subcultures should be analysed in relation to each other.

Previous ethnographic research on steroids explores illegal steroid use from users' perspectives (Klein 1993; 1995; Monaghan 1999; 2001; 2002). To date, very little research analyses legal steroid users' perspectives in the same way. Feminist scholarship is increasingly concentrating on men and masculinity, but as Kimmel (2005 as cited in Matza 2009:175) asserts, "When we study men, we study them as political leaders, military heroes, scientists, writers, artists. Men, themselves, are invisible as men." Men legally using steroids for TRT are invisible as they are behaving in a legally and medically routine way; their behaviour does not set them apart from men, but helps to assimilate them further into the mainstream. Hence, future research ethnographically exploring their steroid use would further feminist scholarship by making men visible as men.

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Ethics Approval

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30 July 2014

Associate Professor Greg Downey
Department of Anthropology
Faculty of Arts
MACQUARIE UNIVERSITY
NSW 2109

Dear Associate Professor Downey

RE: *Testosterone versus Steroids: Treating a Deficiency, or Supplementing Performance and Beauty*

Thank you for submitting the above application for ethical and scientific review. Your application was first considered by the Macquarie University Human Research Ethics Committee (HREC (Human Sciences and Humanities)) at its meeting on 2 May 2014 at which a resubmission was requested. Your resubmitted application was considered at the HREC (Human Sciences and Humanities) meeting held on 30 May 2014 . Further information was requested to be reviewed by the HREC (Human Sciences and Humanities) Executive.

The requested information was received with correspondence on 27 July 2014.

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted at:

- Macquarie University

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007 – Updated March 2014) (the *National Statement*).

Details of this approval are as follows:

Reference No: 5201400448

Approval Date: 29 July 2014

The following documentation has been reviewed and approved by the HREC (Human Sciences and Humanities):

Documents reviewed	Version no.	Date
Macquarie University Ethics Application Form	2.3	July 2013
Correspondence from Ms Edwina James responding to the issues raised by the HREC (Human Sciences and Humanities) Executive		Received 27/07/2014
MQ Participant Information and Consent Form (PICF) (Legal Users) entitled *Steroids and Testosterone*	3	3/07/2014

MQ Participant Information and Consent Form (PICF) (Illegal Users) entitled *Steroids and Testosterone*
Interview Questions
Recruitment email (to be sent to the Gender Centre and Ausgender)

This letter constitutes ethical and scientific approval only.

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the *National Statement,* which is available at the following website:

http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC (Human Sciences and Humanities) Terms of Reference and Standard Operating Procedures are available from the Research Office website at:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics

The HREC (Human Sciences and Humanities) wishes you every success in your research.

Yours sincerely

Dr Karolyn White
Director, Research Ethics & Integrity,
Chair, Human Research Ethics Committee (Human Sciences and Humanities)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.