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APPEARANCE CONCERNS AND STEROID USE

**Physical appearance concerns are uniquely associated with the severity of steroid  
dependence and depression in anabolic-androgenic steroid users**

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### Abstract

**Introduction and Aims.** Emerging research suggests that the sub-population of anabolic-androgenic steroid (AAS) users who experience physical appearance concerns may suffer greater psychological dysfunction than other sub-populations, including users with athletic or occupational concerns. Thus, among current AAS users, we sought to determine whether, and to what extent, social physique anxiety – an established measure of appearance concern – was associated with psychological dysfunction. **Design and Methods.** Interviews were conducted with a sample of 74 male AAS users living in Australia. Users completed self-report instruments of the severity of AAS dependence, depression, hazardous and risky drinking, use of non-AAS illicit drugs, psychological side-effects due to AAS use, and abnormal test results due to AAS use. **Results.** Multivariate analyses revealed that greater social physique anxiety was uniquely associated with more severe symptoms of both AAS dependence and depression. Moreover, the effect size of these relationships was large. Social physique anxiety was not associated with hazardous or risky drinking, non-AAS illicit drug use, psychological side-effects or abnormal test results. **Discussion and Conclusion.** Limitations notwithstanding, the study is consistent with the notion that AAS users who experience appearance concerns are at heightened risk of co-morbid psychological dysfunction. Given trends indicating an increase in the prevalence of AAS use in Australia and elsewhere, the findings suggest that healthcare systems may need to consider prioritising the sub-population of AAS users who experience appearance concerns. Further investigation of the clinical syndrome of AAS dependence is required, including its relation to body image and eating disorders.

*Keywords:* anabolic steroids; body image; social physique anxiety; anabolic steroid dependence; depression

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## APPEARANCE CONCERNS AND STEROID USE

The non-medical use of anabolic androgenic steroids (AAS) is increasing in prevalence among people who inject drugs in Australia [1] and potentially elsewhere [2]. AAS users are a heterogeneous population with differing concerns underlying their AAS use, including, most notably, concerns about one's physical appearance, athletic performance and occupational performance [3-16]. An understanding of these differing concerns is critical to inform prevention, early intervention, treatment and harm reduction services for AAS. To this end, a small and growing body of literature suggests that AAS users who experience physical appearance concerns also experience elevated rates of co-morbid psychological dysfunction, and in particular, eating disorder and muscle dysmorphia symptomatology, than users who experience performance concerns [6]. Further, AAS users who experience appearance concerns may also be more impulsive, conferring a greater level of risk for the health consequences of AAS use. To this end, Underwood [17] conducted a qualitative study of bodybuilders motivated exclusively by appearance concerns and reported that those who used AAS tended to allow their appearance concerns to override the health complications of their AAS use. This is an important signal for quantitative research to further investigate.

To-date, scant research has directly examined whether there is a positive relationship between the degree of appearance concerns experienced by AAS users and psychological dysfunction related to AAS use. Given that appearance concerns are a major reason for AAS use [e.g. 4,6,9,16], and that appearance concerns among males are both widespread [18] and increasing [19], there is clear need for research examining this issue. The current study aimed to examine whether the degree of appearance concern among AAS users, as indicated by

social physique anxiety, is associated with higher levels of psychological dysfunction. Social physique anxiety refers to an individual's experience of anxiety about others' judgement of their physique in social settings [20-22]. It was primarily hypothesised that AAS users with greater social physique anxiety would experience higher levels of psychological dysfunction, including greater severity of AAS dependence, depression, hazardous and risky drinking, use of non-AAS illicit substances, more frequent psychological side-effects due to AAS use, and more frequent abnormal biological test results (e.g. tests of endocrine function).

## **Methods**

### **Recruitment**

AAS users were recruited using two methods, namely, purposive sampling and snowballing. The former method focused on a range of sources known to be accessed and/or frequented by AAS users, including needle and syringe program sites, gyms, supplement stores, online forums and social media channels. Geographically, recruitment was restricted to users living in the Sydney and Blue Mountains region of New South Wales, Australia.

### **Study procedures**

The wider study involved three modes of data collection: an in-depth interview, an online survey and a self-report survey. The current study focuses only on the sub-sample of participants who received an in-depth interview because the data of primary interest to the current study were only collected during these interviews. The interviews were conducted from December 2014 to August 2015 and lasted, on average, for 42 minutes (range = 30–60 minutes). Most interviews were conducted face-to-face using computer-based communication

software while a minority of interviews were conducted over the phone. Participants were reimbursed with \$60 AUD at the conclusion of the interview.

### **Participants**

Eligibility criteria included being male, aged 18 years or older, living in Sydney or the Blue Mountains for the last 6 months, and having used AAS and/or performance and image enhancing drugs within the last 6 months. In total, 74 men completed the in-depth interview.

### **Measures**

***Social physique anxiety.*** Individuals' self-reported anxiety about others' judgement of their physiques in social settings was measured using the 7-item version of the Social Physique Anxiety Scale (SPAS-7) [20], which is an adapted and improved version of the original 12-item Social Physique Anxiety Scale [21]. Example items include: "When I look in the mirror I feel good about my physique/figure" and "In the presence of others I feel apprehensive about my physique/figure". The response format on the SPAS-7 is a 5-point Likert-type scale with anchors at 1 (not at all characteristic of me) and 5 (extremely characteristic of me). Scores are summed to calculate an overall score that ranges from 7 – 35, with higher scores indicating greater social physique anxiety. The SPAS-7 demonstrates robust test-retest reliability ( $r = 0.94$ ) [22] and internal consistency [20]. Internal consistency in the current study was adequate ( $\pm = 0.85$ ).

***AAS dependence.*** Severity of AAS dependence was measured using the 5-item Severity of Dependence Scale (SDS) [23] adapted for AAS (SDS–AAS) [24]. Importantly, the SDS–AAS items are closely mapped to the tentative diagnostic criteria for steroid dependence proposed by Gen Kanayama [25]. For example, the item "How difficult did you

find it to stop or go without anabolic steroids” is closely mapped to the criterion of withdrawal (criterion 2), the item “Did you ever think your use of anabolic steroids was out of control” is closely mapped to the criterion of loss of control (criterion 3), and the item “Did you wish you could stop using anabolic steroids” is closely mapped to the criterion of desiring to control or cut down one’s steroid use (criterion 4). The response format of the SDS–AAS is a 4-point Likert-type scale with anchors at 0 (never/almost never) and 3 (always/nearly always). The fifth and final item, “How difficult did you find it to stop or go without anabolic steroids?” uses different response labels: 0= not difficult, 4 = impossible. Scores are summed to calculate an overall score that ranges from 0 – 15, with higher scores indicating greater severity of AAS dependence. The psychometric properties of the SDS–AAS are less clear than for other illicit drugs because the scholarly literature on AAS is considerably smaller [24]. Nevertheless, the SDS–AAS items appear to have strong content validity for AAS, and internal consistency in the current study was adequate ( $\pm = 0.75$ ).

***Depression symptoms.*** Symptoms of depression were measured by the depression module of the Patient Health Questionnaire [26]. Respondents are asked to indicate the frequency with which they have been bothered by various problems linked to depression during the past two weeks. Examples include “Feeling tired or having little energy” and “Little interest or pleasure in doing things”. The response format is a 4-point Likert-type scale with anchors at 0 (not at all) and 3 (nearly every day). Scores are summed to calculate an overall score that ranges from 0 – 27, with higher scores indicating more severe depression symptoms. Scores higher than 10 are strongly predictive of an individual suffering

from major depression [26]. Internal consistency in the current study was adequate ( $\pm=0.74$ ).

***Hazardous and risky drinking.*** Hazardous and risky drinking was measured using the 3-item Alcohol Use Disorders Identification Test – Consumption (AUDIT-C), which is a modified short-form of the 10-item Alcohol Use Disorders Identification Test [27]. Respondents are asked how often they consume drinks containing alcohol, how many standard drinks they consume during a typical day, and how often they consume six or more drinks in a single occasion. The response format is a Likert-type scale with anchors at 0 and 4 (response labels differ for each item). Scores are summed to calculate an overall score that ranges from 0 – 12, with higher scores indicating riskier and more hazardous drinking.

***Use of non-AAS illicit substances.*** Participants were asked about their recent (12 months) use of non-AAS illicit substances, including cannabis, methamphetamine, crystal methamphetamine, cocaine, ecstasy, LSD and heroin. Endorsements were summed to create a variable representing the number of non-AAS illicit substances used recently by participants.

***Side-effects of AAS use.*** Participants were asked about the occurrence of psychological side effects of their AAS use. Psychological side-effects examined in the survey included impulsivity, sleeplessness, irritability, aggressiveness, relationship difficulties, fatigue/tiredness and paranoia. Occurrences were summed to create a variable representing the number of psychological side-effects experienced by participants.

***Abnormal test results.*** Participants were asked to indicate if they had ever received an abnormal test of liver or renal function, abnormal cholesterol levels, or abnormal testosterone

and oestrogen levels. Occurrences were summed to create a variable representing the overall number of abnormal test results.

### **Statistical analyses**

Very little missing data were present, with the exception of data on the AUDIT-C. Missing data on the AUDIT-C were confined to 10 participants for whom no item-level AUDIT-C data were recorded at all. Participants for whom AUDIT-C data were missing did not differ in any significant way from participants who reported these data. Because hazardous and risky drinking was a primary variable of interest in the current study, it was decided to retain the variable in subsequent multivariate analyses, despite the consequent loss of power caused by its inclusion as a predictor in the multiple regression. In the interest of thoroughness, we subsequently conducted a regression with the AUDIT-C excluded as a predictor, and the results were unchanged, suggesting that this decision had little, if any, influence on the results.

Data distributions for several variables were positively skewed, including social physique anxiety, depression symptoms, AAS dependence symptoms, hazardous and risky drinking, and number of abnormal test results. Spearman rank-order bivariate correlations were conducted in order to accommodate the preponderance of non-normality in the dataset.

Next, a simultaneous multivariate regression was conducted with social physique anxiety as the dependent variable and the following entered as predictor variables: depression symptoms, AAS dependence symptoms, hazardous and risky drinking, number of non-AAS illicit drugs used, number of psychological side-effects, and number of abnormal test results. All predictors were mean-centred prior to entry. Each test assumption of multivariate

regression was met, including normally distributed residuals, no evidence of non-linear relationships between the predictors and dependent variable, no evidence of multicollinearity, and no evidence of heteroscedasticity. An *a-priori* power analysis conducted using G\*Power version 3.1 indicated that the multiple regression was adequately powered to detect medium-to-large relationships between the predictor variables and the dependent variable using a conventional level of power ( $\rho^2 = 0.80$ ) and significance ( $\alpha = 0.05$ ).

Importantly, one case was identified as a significant multivariate outlier (Mahalanobis' distance  $\chi^2 = 24.67$ ,  $df = 6$ ,  $P < 0.001$ ) and this case was disproportionately influential on the results of the multivariate regression analysis (Cook's distance = 1.05; values  $> 1.00$  are indicative of disproportionate or undue influence) [18]. Therefore, the multivariate regression was conducted with the outlier removed and the summary statistics presented in Table 2 reflect this. In terms of significance testing, the relationship between social physique anxiety and AAS dependence severity was significant with the outlier excluded, but not when the outlier was included. The decision to exclude the outlier response was justified on the basis that the outlier was a clear and unequivocal outlier that exhibited a demonstrably disproportionate influence on the results of the regression. Further, we note that the relationship of AAS dependence with social physique anxiety became convincingly significant ( $P = 0.001$ ) after the outlier was removed, as opposed to becoming only marginally significant.

Finally, in order to control the family-wise error rate at  $\alpha = 0.05$ , a Bonferroni-corrected  $\alpha$  of 0.008 was used as the significance threshold for each individual predictor in the multiple regression analyses.

## Results

### Sample characteristics

The median age of participants was 29 years (interquartile range = 23–33 years). Approximately one-fifth of participants reported speaking a language other than English (20%), cultural background other than Anglo-Australian (22%), or country of birth other than Australia (16%). More than half of participants were full-time employed (59%), however almost one-third (30%) had a weekly income less than \$600AUD.

### Descriptive statistics

Descriptive statistics are shown in Table 1. Psychological side-effects reported by AAS users included impulsivity (56.7%), sleeplessness (54.1%), irritability (46.6%), aggressiveness (45.3%), relationship difficulties (38.4%), fatigue/tiredness (23.3%), and paranoia (16.3%).

### Bivariate correlations

As shown in Table 1, AAS users who reported greater social physique anxiety also tended to report more severe symptoms of both depression and AAS dependence. In turn, depression and AAS dependence were positively correlated. Social physique anxiety was not correlated with hazardous and risky drinking, the number of non-AAS illicit substances used, the number of psychological side-effects due to AAS use, or the number of abnormal test results. AAS dependence was positively correlated with the frequency of abnormal test results.

### Multivariate regression

The regression model accounted for 46.0% of the variance in social physique anxiety scores, which was significant,  $F(6, 53) = 7.53, P < 0.001$ . As shown in Table 2, greater social physique anxiety among AAS users was uniquely associated with more severe symptoms of both depression and AAS dependence. The size of these associations, indexed by partial eta squared ( $\eta_p^2$ ), was large. Social physique anxiety was not associated with hazardous and risky drinking, the number of non-AAS illicit substances used, the number of psychological side-effects due to AAS use, or the number of abnormal test results.

### Discussion

This study aimed to determine whether, and to what extent, social physique anxiety was associated with indicators of psychological dysfunction among AAS users. The results from the multivariate regression analysis provided partial support for the hypothesis of the study, namely, that AAS users who experience greater social physique anxiety would report greater severity of AAS dependence and depression, more hazardous and risky drinking, more frequent use of non-AAS illicit substances, more frequent psychological side effects due to AAS use, and more frequent abnormal test results due to AAS use. The results showed that greater social physique anxiety among AAS users was uniquely associated with more severe symptoms of both depression and AAS dependence, but not with hazardous and risky drinking, non-AAS illicit substance use, psychological side-effects due to AAS use, or abnormal test results.

The finding that greater social physique anxiety is associated with more severe symptoms of AAS dependence is compelling and consistent with previous research. Two studies are instructive. First, research conducted by Cole and colleagues [24] found that

symptoms of AAS dependence were highly correlated ( $r = 0.58$ ) with eating disorder symptoms among AAS users, and second, research conducted by Murray and colleagues [6] found that AAS users who reported an appearance motivation for their AAS use exhibited markedly more severe eating disorder psychopathology than users who reported either a performance motivation or a blended motivation of both appearance and performance. Consistent with the hypothesis that AAS users motivated by appearance are at greater risk for harm than users motivated by other factors, we speculate that appearance users are more susceptible to a core nexus of psychopathology that involves body image, dieting, and exercise, and which may facilitate the development and/or maintenance of a syndrome of AAS dependence [25,28-30]. In line with this notion of a core nexus of psychopathology, we note the strong relationship of social physique anxiety with AAS dependence that emerged in the current study ( $\eta^2_p = 0.18$ ).

In addition, the core nexus of psychopathology associated with AAS users motivated by appearance concerns may also include mood disturbance, and in particular, depression. Indeed, the relationship observed in the current study between social physique anxiety and depression symptoms ( $\eta^2_p = 0.26$ ) was stronger than the relationship observed between the former and AAS dependence symptoms. Several studies of AAS users have reported elevated rates of depression, and or dysphoric mood more generally, among this population [e.g. 31]. In addition, studies of men with muscle dysmorphia – a subtype of body dysmorphic disorder akin to (and formerly named) “reverse anorexia” – report elevated rates of co-morbid mood disorders. In two studies by Cafri and colleagues [32] and Olivardia and colleagues [33], the prevalence of a lifetime history of either depression or bipolar disorder was some 58–74%

among individuals with muscle dysmorphia, and just 3–7% among healthy gym-attending controls. These studies of muscle dysmorphia are made relevant because some 40–54% of individuals with muscle dysmorphia report using AAS [32-34], and nearly one in four (21%) exhibit AAS abuse or dependence [35].

Limitations of the study are noted. First and foremost, the measure of AAS dependence, the SDS-AAS, has not been validated to the same extent as for other substances, warranting caution in the interpretation of these data. Additional psychometric testing of the SDS-AAS and of complementary measures of steroid dependence [e.g. 36] is a critical direction for future research. Second, high levels of social physique anxiety do not necessarily indicate an appearance-linked motivation for AAS use. Third, the study design was cross-sectional, precluding statements regarding the direction of causality. Fourth, socially desirable responding may have suppressed true reporting of social physique anxiety and psychopathology more generally because traditional notions of masculinity are incompatible with emotional weakness and expressions of this nature [37] – a limitation made more salient by research indicating that AAS users are stronger adherents to traditional male gender roles than non-users [38]. Fifth, it would have been useful to collect descriptive data about our participants' past and present engagement in athletic and bodybuilding competitions, including whether they used AAS in these competitions. Further, it would have been useful to collect data about participants' past and present employment, including, in particular, those occupations that have been linked with AAS use [e.g. 13].

In conclusion, the current study aimed to determine whether or not AAS users who are motivated by appearance concerns are at greater risk for psychological dysfunction. The

results indicate this appears to be the case. Specifically, AAS users who are motivated by appearance concerns may also be at higher risk of both AAS dependence and depression – an important finding that warrants additional research.

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Variable	Observed	<i>M</i>	<i>SD</i>	1.	2.	3.	4.	5.	6.	7.
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*Table 1.* Descriptive statistics and Spearman rank-order bivariate correlations for the dependent and predictor variables included in the multivariate regression analysis.

	range									
1. Social physique anxiety	7 – 32	14.85	6.15	-	0.49***	0.31**	-0.00	0.12	0.11	0.01
2. Depression symptoms	0 – 16	3.89	3.57		-	0.28*	-0.19	0.08	0.25*	0.04
3. Severity of AAS dependence	0 – 14	2.14	2.54			-	-0.09	0.05	0.37**	0.41***
4. Hazardous and risky drinking	1 – 10	3.89	2.35				-	0.30*	0.03	-0.16
5. Number of non-AAS illicit substances used	0 – 5	1.31	1.39					-	0.25*	-0.01
6. Number of psychological side-effects	0 – 7	2.81	1.71						-	0.27*
7. Number of abnormal test results	0 – 6	0.61	1.29							-

\* =  $P < 0.05$ ; \*\* =  $P < 0.01$ ; \*\*\* =  $P < 0.001$ . AAS, anabolic androgen steroids.

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Variable	<i>b</i>	SE <i>b</i>	$r^2$	95% CI	<i>t</i> (53)	<i>P</i>	$r_p^{2**}$	<i>Table 2. Summary</i>
Depression symptoms	0.82	0.19	0.48	0.44, 1.19	4.36	<0.001*	0.26	statistics from the
Severity of AAS dependence	1.19	0.35	0.40	0.50, 1.88	3.46	0.001*	0.18	simultaneous
Hazardous and risky drinking	0.17	0.31	0.06	-0.45, 0.80	0.55	0.583	<0.01	multivariate
Number of non-AAS illicit substances used	-0.21	0.51	-0.05	-1.23, 0.82	-0.40	0.690	<0.01	regression
Number of psychological side effects	-0.19	0.42	-0.05	-1.04, 0.66	-0.44	0.662	<0.01	predicting social
Number of abnormal test results	0.55	0.51	0.12	-0.47, 1.57	1.08	0.284	0.02	physique anxiety

among AAS users

AAS, anabolic androgen steroids; CI, confidence interval.

\* statistically significant when compared against a Bonferroni corrected  $\alpha$  of 0.008. \*\* the effect size given here is partial eta squared ( $\eta^2_p$ ) (small = 0.01, medium = 0.06, large = 0.14).