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Addressing Stigma and Bias in Healthcare for Individuals Dependent on Steroids: Clinical and Ethical Approaches to Treatment

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ABSTRACT

Steroid dependence, particularly involving non-medical anabolic-androgenic steroid use, presents significant clinical, psychological, and ethical challenges. Affected individuals may experience cardiovascular, endocrine, reproductive, hepatic, renal, and psychiatric complications, yet many delay or avoid healthcare because of anticipated judgment, dismissal, punishment, or breaches of confidentiality. This review examines how stigma and professional bias undermine disclosure, diagnostic accuracy, continuity of care, and treatment outcomes. It argues that ethical management should integrate person-first language, nonjudgmental communication, confidential and comprehensive assessment, harm reduction, shared decision-making, psychological support, and multidisciplinary referral. Clinicians must balance autonomy, beneficence, non-maleficence, justice, and professional integrity while recognizing the social, identity-related, and body-image factors that sustain steroid use. Refusing unsafe prescribing should not result in abandonment or denial of appropriate care. Healthcare institutions should strengthen professional education, establish coordinated evidence-informed pathways, protect patient privacy, and involve people with lived experience in service design to promote equitable, trustworthy, and overall effective treatment.

Keywords: anabolic-androgenic steroids, steroid dependence, stigma, healthcare bias, harm reduction, medical ethics, substance use disorder

INTRODUCTION

Steroids are a broad class of substances with different therapeutic and non-therapeutic applications. Corticosteroids, such as prednisone, are prescribed for inflammatory, allergic, autoimmune, and other medical conditions. Anabolic-androgenic steroids are testosterone and related compounds that may be prescribed for selected clinical indications but are also used without medical supervision to increase muscle mass, physical strength, athletic performance, or perceived attractiveness [1]. These categories should not be treated as interchangeable. Physiological dependence on prescribed corticosteroids, including suppression of the hypothalamic–pituitary–adrenal axis, differs clinically and ethically from a substance-use disorder involving supraphysiological anabolic-androgenic steroid exposure [2]. This review focuses primarily on anabolic-androgenic steroid dependence because non-medical use is particularly affected by moral judgment, criminalization, sporting narratives, and stereotypes about appearance and masculinity. Anabolic-androgenic steroids do not usually produce the rapid euphoria associated with many psychoactive drugs. Nevertheless, some individuals develop a substance-use disorder characterized by persistent use despite adverse consequences, difficulty stopping, withdrawal symptoms, and repeated use to prevent loss of muscularity or relieve physical and psychological distress [3]. Their use may cause serious and sometimes irreversible cardiovascular, endocrine, hepatic, renal, reproductive, and psychiatric harm. Despite these risks, steroid dependence remains poorly integrated into mainstream substance-use and primary-care services. The limited evidence base for withdrawal management, combined with inadequate professional training, can produce uncertainty among clinicians. When uncertainty is accompanied by stigma, patients may be blamed for their condition, denied appropriate investigations, or told simply to stop using steroids without receiving support for withdrawal, hormonal

dysfunction, body-image concerns, or co-occurring mental-health problems. The result is an avoidable treatment gap.

Understanding Steroid Dependence

Anabolic-androgenic steroid dependence differs from dependence on intoxicating substances because steroid use is often tied to long-term goals such as muscularity, work performance, confidence, identity, social recognition, and protection from physical vulnerability. Users may continue because they value increased strength, muscle growth, self-esteem, and belonging within training communities [4]. Dependence can also be sustained by hormonal suppression, since prolonged exposure to high androgen levels reduces natural testosterone production. Stopping may cause fatigue, low libido, sexual dysfunction, depression, anxiety, reduced strength, muscle loss, and other symptoms of hypogonadism. Because no universally accepted withdrawal treatment exists, clinical care varies, and some users turn to unregulated post-cycle therapies [5]. Psychological and social factors are equally significant, including muscle dysmorphia, body dissatisfaction, perfectionism, trauma, low self-esteem, comparison with others, and occupational pressures. Effective treatment must therefore address not only drug use but also identity, training habits, social environment, and fears of losing physical size. Steroid users are diverse and include athletes, bodybuilders, security workers, manual laborers, and people seeking appearance changes. Women and sexual- and gender-minority users may face additional barriers because stereotypes often portray steroid use as exclusively male, causing healthcare services to overlook their needs [6].

Sources of Stigma in Healthcare

Non-medical anabolic-androgenic steroid use is often moralized as cheating, vanity, irresponsibility, aggression, or weak character, which can lead clinicians to view related harm as self-inflicted and patients as less deserving of empathy or care. Such judgments may also encourage stereotyping, with users assumed to be aggressive, dishonest, appearance-obsessed, or resistant to advice. These assumptions can cause diagnostic overshadowing, where symptoms are automatically blamed on steroids, or the opposite problem, where steroid-related complications are overlooked [7]. Fatigue, depression, sexual dysfunction, chest pain, hypertension, infertility, and abnormal test results still require a full history, examination, and differential diagnosis. Limited professional knowledge about steroid use, withdrawal, endocrine recovery, and harm reduction can further damage trust, especially when clinicians dismiss patient experiences, exaggerate uncertain risks, or avoid discussion [8]. Fear of legal consequences, employer or sports disclosure, insurance problems, or permanent labeling may discourage honest reporting, reducing the accuracy of clinical assessment. Injectable steroid use may also be wrongly equated with opioid use or chaotic behavior. Clinicians should instead assess actual injection practices, infection risks, equipment sharing, and blood-borne virus exposure. Overall, steroid dependence should be understood through biological, psychological, behavioral, and social factors rather than as a failure of willpower, within respectful, confidential clinical care [9].

Effects of Stigma on Medical Care

Stigma surrounding anabolic-androgenic steroid use can significantly undermine medical care by delaying treatment, limiting honest disclosure, fragmenting services, worsening psychological distress, and increasing health inequalities. Fear of judgment may cause individuals to avoid seeking help until serious complications, such as cardiovascular disease, hormonal dysfunction, infertility, depression, or withdrawal-related suicidality, become severe [10]. Rather than preventing steroid use, stigma may drive it underground and increase reliance on unreliable informal advice. Patients who expect condemnation may conceal doses, injection practices, additional substances, or sexual and psychiatric symptoms, making accurate diagnosis and safe prescribing more difficult. Respectful, non-judgmental communication is therefore essential for obtaining complete medical histories and preventing missed interactions or misleading test results [11]. Care may also become fragmented across emergency departments, private clinics, specialists, online providers, and harm-reduction services, with some patients excluded because steroid dependence does not fit traditional addiction models. Repeated judgment can create shame, secrecy, social isolation, low self-worth, and reluctance to seek support, particularly during withdrawal. These harms are not experienced equally: women, sexual-minority men, racialized groups, and people facing socioeconomic, occupational, or legal disadvantages may encounter overlapping barriers. Effective care should therefore be coordinated, confidential, person-centred, equitable, and informed by lived experience [12].

Ethical Analysis

Ethical care for people using non-medical anabolic steroids should balance autonomy, beneficence, non-maleficence, justice, and professional integrity. Respect for autonomy requires clinicians to provide accurate information, protect confidentiality, avoid coercion, and involve patients in setting realistic goals, whether cessation, gradual withdrawal, fertility recovery, mental-health support, risk reduction, safer injection, or monitoring. Beneficence means promoting overall welfare through cardiovascular, metabolic, endocrine, reproductive, liver, kidney, and mental-health assessment, while also understanding the perceived benefits steroids provide, such as confidence, identity, safety, status, or occupational effectiveness [13]. Non-maleficence requires warning patients about serious harms while avoiding additional damage caused by abrupt unsupported

discontinuation, untreated depression, breaches of privacy, careless prescribing, or refusal of care. Harm reduction does not endorse steroid use; it reduces foreseeable risks when patients are not ready or able to stop. Because evidence for drug treatment of steroid withdrawal is limited, hormonal interventions should be individualized and preferably specialist-led. Justice demands respectful, equitable healthcare regardless of stigma or personal responsibility, while institutions should address gaps in training, referral pathways, and research [14]. Professional integrity allows clinicians to refuse unsafe or unjustified prescriptions without abandoning patients, who should still receive monitoring, treatment, support, referral, and evidence-based advice.

A Patient-Centred Clinical Approach

A patient-centred clinical approach to anabolic-androgenic steroid use begins with respectful, precise language that avoids stigmatizing labels and clearly distinguishes prescribed testosterone, non-medical androgen use, corticosteroid treatment, withdrawal, and misuse. Clinicians should create psychological safety by explaining that questions about hormones, supplements, and performance-enhancing drugs are intended to protect health, not judge behavior. Assessment should be neutral and comprehensive, covering substances used, dosage, duration, reasons for use, attempts to stop, withdrawal symptoms, physical and mental health effects, injection practices, other substances, body image, exercise patterns, fertility goals, suicide risk, priorities, and readiness for change [15]. Investigations should be individualized according to symptoms and risk, with attention to cardiovascular, hepatic, endocrine, reproductive, and metabolic complications. Shared decision-making should establish realistic goals, whether supporting cessation, managing withdrawal, monitoring recovery, addressing mental health and fertility, or reducing harm for patients who continue use. Clinicians should communicate known risks honestly while acknowledging uncertainty. Care may require collaboration across primary care, addiction medicine, endocrinology, cardiology, mental health, reproductive medicine, sexual health, dietetics, and harm-reduction services [16]. Psychological support should address body image, perfectionism, social pressure, and identity. Relapse or disagreement should prompt reassessment, not abandonment, because sustained therapeutic engagement often offers the greatest protection for long-term health.

Institutional and Policy Recommendations

Institutional action is essential because individual professionalism alone cannot eliminate stigma toward people who use anabolic-androgenic steroids. Healthcare education at undergraduate and postgraduate levels should cover steroid use, dependence, withdrawal, endocrine effects, body-image disorders, and harm reduction, while challenging stereotypes through realistic clinical cases. Organizations should establish clear, flexible referral pathways linking primary care, endocrinology, addiction medicine, and mental-health services [17]. Anti-stigma programs should meaningfully involve people with lived experience, reflecting WHO principles of leadership, social contact, and inclusive partnership. Services must protect privacy, explain confidentiality clearly, and ensure electronic health records use neutral, clinically relevant language rather than speculative or derogatory labels. Research should better represent women, sexual- and gender-minority groups, non-athletes, and culturally and economically diverse populations. More evidence is needed on withdrawal treatment, endocrine recovery, cardiovascular screening, psychological care, and long-term outcomes [18]. Public-health messages should reject fear-based portrayals of users as vain, violent, or immoral. Credible communication should recognize motivations, acknowledge uncertainty, explain risks honestly, and guide people toward accessible, confidential, nonjudgmental care. These coordinated reforms can improve trust, encourage earlier help-seeking, and promote safer, more equitable healthcare.

Discussion

Stigma toward people dependent on steroids extends beyond personal prejudice and can directly shape healthcare outcomes. It may discourage disclosure, delay treatment seeking, influence how clinicians interpret symptoms, limit treatment options, and reduce continued engagement with care. Although condemnation is often intended to deter steroid use, it can instead increase secrecy and undermine harm-reduction efforts. Ethical care should clearly communicate the serious risks of prolonged supraphysiological androgen exposure without resorting to humiliation, dismissiveness, or making abstinence a condition for basic treatment [19]. Because the evidence base is still limited and often draws on observational studies, qualitative research, expert opinion, and related clinical practice, uncertainty should strengthen the case for shared decision-making. Patients need transparent explanations of what is known, what remains uncertain, and why monitoring or treatment is advised. Importantly, maintaining a therapeutic relationship does not mean endorsing steroid use. Clinicians can oppose unsafe non-medical use while preserving dignity, reducing immediate harm, supporting informed choices, and encouraging gradual, safe long-term change.

CONCLUSION

Steroid dependence should be recognized as a complex health condition shaped by biological, psychological, social, and cultural factors, rather than as evidence of moral failure. Stigma and bias within healthcare can delay help-seeking, restrict disclosure, distort clinical judgment, and worsen preventable physical and mental health outcomes. Ethical and effective practice therefore requires respect for autonomy, confidentiality, beneficence, non-

maleficence, and justice. Clinicians should use person-first language, conduct comprehensive and individualized assessments, communicate risks honestly, and provide harm reduction, shared decision-making, psychological support, and appropriate specialist referral. Maintaining therapeutic engagement does not endorse non-medical steroid use; instead, it creates opportunities for safer choices, earlier diagnosis, and sustained recovery. Healthcare institutions must strengthen professional education, develop coordinated care pathways, protect privacy, and include people with lived experience in service design. Reducing stigma is therefore not an optional expression of compassion, but a clinical and ethical requirement for delivering equitable, trustworthy, and effective care.

REFERENCES

1. Singh, R., Bansal, R.: Revisiting the role of steroidal therapeutics in the 21st century: an update on FDA approved steroidal drugs (2000–2024). *RSC Med. Chem.* 16, 2902–2918. <https://doi.org/10.1039/d5md00027k>
2. Gavin T, Madeline S, Andrea L H, Jessica A W, Jessica K, Max A, et al (2021). Shotgun sequencing of the faecal microbiome to predict response to steroids in patients with lower gastrointestinal acute graft-versus-host disease: An exploratory analysis. *British journal of haematology*, 192, 3. Dio 10.1111/bjh.17238
3. Ayubi, N., Kusnanik, N.W., Herawati, L., Komaini, A., Mutohir, T.C., Callixte, C., et al: Abuse of Anabolic-Androgenic Steroids and Adverse Effects on Human Organ Health: A Review. *Biointerface Res. Appl. Chem.* 13, (2023). <https://doi.org/10.33263/BRIAC133.281>
4. Scarth, M., Havnes, I.A., Bjørnebekk, A.: Anabolic-androgenic steroid use disorder: case for recognition as a substance use disorder with specific diagnostic criteria. *Br. J. Psychiatry.* 228, 68–72. <https://doi.org/10.1192/bjp.2025.73>
5. Rojas-Zambrano, J.G., Rojas-Zambrano, A., Rojas-Zambrano, A.F.: Impact of Testosterone on Male Health: A Systematic Review. *Cureus.* 17, e82917. <https://doi.org/10.7759/cureus.82917>
6. Margaret L M, Shernan G H, Armin R, Todd E D, Claudio G B, John E W, et al (2018). Validation of minnesota acute GVHD risk score and identification of new factors associated with initial response to steroids: not all GVHD is created equal. *Blood*, 132, 67, <https://doi.org/10.1182/blood-2018-99-113085>
7. Piacentino, D., Kotzalidis, G.D., del Casale, A., Aromatario, M.R., Pomara, C., Girardi, P., Sani, G.: Anabolic-androgenic Steroid use and Psychopathology in Athletes. A Systematic Review. *Curr. Neuropharmacol.* 13, 101–121 (2015). <https://doi.org/10.2174/1570159X13666141210222725>
8. Malhotra, J., Devi, M.G., Patil, M.: Best Practice Recommendations for Infertility Management. *J. Hum. Reprod. Sci.* 17, S1–S240 (2024). https://doi.org/10.4103/jhrs.JHRS_ISAR_IFS
9. Garrett, R., Young, S.D.: The role of misinformation and stigma in opioid treatment uptake. *Subst. Use Misuse.* 57, 1332–1336 (2022). <https://doi.org/10.1080/10826084.2022.2079133>
10. Margaret L M, Shernan G H, Armin R, Todd E D, Bruce B, Daniel J W (2017). Pediatric Acute GVHD Grade, Risk Prediction and Response to Upfront Steroids in 370 Children Treated at the University of Minnesota. *Blood*, 130, 4486. https://doi.org/10.1182/blood.V130.Suppl_1.4486.4486
11. El Hayek, S., Foad, W., de Filippis, R., Ghosh, A., Koukach, N., Mahgoub Mohammed Khier, A., et al: Stigma toward substance use disorders: a multinational perspective and call for action. *Front. Psychiatry.* 15, 1295818 (2024). <https://doi.org/10.3389/fpsy.2024.1295818>
12. Chang, J.E., Lindenfeld, Z., Hagan, H.: Integrating Harm Reduction into Medical Care: Lessons from Three Models. *J. Am. Board Fam. Med. JABFM.* 36, 449–461 (2023). <https://doi.org/10.3122/jabfm.2022.220303R3>
13. Varkey, B.: Principles of Clinical Ethics and Their Application to Practice. *Med. Princ. Pract.* 30, 17–28 (2021). <https://doi.org/10.1159/000509119>
14. Hamid A.A, Kaushal T., Ashraf R., Singh A, Gupta A. C, Prakash O. M, et al (2017). (22β, 25R)-3β-Hydroxy-spirost-5-en-7-iminoxy-heptanoic acid exhibits anti-prostate cancer activity through caspase pathway. *Steroids* 119, 43–52. <https://doi.org/10.1016/j.steroids.2017.01.001>
15. Piatkowski, T., Ayurzana, L., King, M., Hattingh, L., McMillan, S.: Community pharmacy's role in dispensing androgens and supporting harm reduction amid current policy dilemmas. *Subst. Abuse Treat. Prev. Policy.* 20, 2 (2025). <https://doi.org/10.1186/s13011-025-00636-y>
16. Marques, M. do C., Pires, R., Perdigão, M., Sousa, L., Fonseca, C., Pinho, L.G., Lopes, M.: Patient-Centered Care for Patients with Cardiometabolic Diseases: An Integrative Review. *J. Pers. Med.* 11, 1289 (2021). <https://doi.org/10.3390/jpm11121289>
17. Hamid A A, Mohammad H, Arjun S, Balakishan B, Prema G V, Jayanta S, et al (2014). Synthesis of novel anticancer agents through opening of spiroacetal ring of diosgenin. *Steroids*, 87, 108–118. <https://doi.org/10.1016/j.steroids.2014.05.025>

18. Shahwan, S., Goh, C.M.J., Tan, G.T.H., Ong, W.J., Chong, S.A., Subramaniam, M.: Strategies to Reduce Mental Illness Stigma: Perspectives of People with Lived Experience and Caregivers. *Int. J. Environ. Res. Public. Health*. 19, 1632 (2022). <https://doi.org/10.3390/ijerph19031632>
19. Luderer, M., Stockreiter, D., Binder, A., Müller, L., Burger, F., Stüben, N., Reif, A.: Stigma from healthcare professionals and care-limiting behaviors in individuals with substance use disorders: a mixed-methods study. *Lancet Reg. Health - Eur.* 63, 101587 (2026). <https://doi.org/10.1016/j.lanepe.2025.101587>

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