MENTAL HEALTH

of men who have sex with men

in the Arab world

Mcoalition
mena region

mcoalition
mena region

Promoting right to health

Promouvoir le droit à la santé

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INDEX

Note to reader: The intended audience of this report is composed of Gay men, bisexual and other men who have sex with men in the Arab world, and the community of activists, organizations and their constituencies working with and for the needs of this population in the MENA region.

The results were presented descriptively, with the goal of showing mental health inequities suffered by MSM, in order to jointly concept and implement relevant interventions.

ABSTRACT

Available data on the global level suggest that gay, bisexual and other men who have sex with men (MSM) live with a higher burden of health disparities including mental health. This fact can be clearly observed in the MENA region due to high levels of stigma and discrimination. Despite the great diversity, we explored the socio-demographics among a sample of MSM from the 5 regional countries (Lebanon, Morocco, Algeria, Tunisia and Sudan), and assessed different facets of their mental.

A 40 questionnaire was used to recruit 250 participants. Simple layout of our data was used to describe socio-demographic information, mental health and sexual abuse. The sample's mean age was 27 years and 62.8% self-identified as gay with 40% who are currently in a relationship. 1/4 did not complete grade school and almost half are currently working. 2/3 is comfortable with their sexual orientation yet some still expressed a high level of internalized homophobia. Half of the participants reported experiencing different types of discrimination with 52% being treated with coldness, to 33% who were physically assaulted and 28% not hired or lost their job because someone thought or knew they were having sex with men.

Half of our men expressed religious associated guilt. Anxiety and self esteem level were average while coping mechanisms and general well-being were on the negative side, adding 26% who scored positive for partner violence. Clinical depression was highly alarming at 16% with 9.6% of suicidal attempts. Another alarming fact was around the high level of sexual abuse (43%) and low level or relevant counseling (16%).

Healthcare and prevention efforts for MSM in the MENA region are yet to be effective, and they need to account for the influence of all socio-demographic determinants of health disparities, more specifically sexual abuse and mental health issues. It is an issue that has been neglected for a long time among key populations, knowing its direct link to greater health syndemics including HIV vulnerability.

INTRODUCTION

Although gay, bisexual and other men who have sex with men (MSM) are as diverse as the general population in their experiences of mental health and well-being, they face higher risks for some mental health issues due to the effects of discrimination and the social determinants of health.

These individuals suffer serious mental health disparities relative to their heterosexual peers, and researchers have linked these disparities to difficult social experiences (e.g., antigay victimization) and internalized biases (e.g., internalized homophobia) that arouse stress. Even if these men are not visible or not open about the nature of their sexual behavior, the general societal attitudes and messaging (within households, education, neighborhoods and media), to which these members are exposed to, are bound to induce the negative effect described above and by that, have its toll on mental health without proper – and much needed – support systems.

Living in a region where same sex behaviors are punishable by law (in some instances with a death penalty), and with the rising of religious and social extremism, we can only assume that gay, bisexual and other men who have sex with men suffer even greatly than their global peers, yet not enough data is available to understand the national or regional trends in the Middle East and North Africa.

Stigma and discrimination have been reported to exist in all countries within the Arab region, and are one of the main reasons why key populations and people living with HIV have hindered access to health services, or in more simple words, losing the will and skill to take care of themselves.

Our goal within this study is to shed the light, on the psycho-social experiences of gay, bisexual and other men who have sex with men, their potential coping mechanisms and the relation between existing mental health issues and health vulnerabilities. Also we aim to come up with tangible recommendations for future research tracks and interventions for the MENA region.

METHODOLOGY

Sample

Over the period of 3 months, peer educators interviewed 250 individuals from 5 designated regional countries (Lebanon, Sudan, Morocco, Algeria and Tunisia), who were asked to fill out a 40 minute questionnaire. Participant eligibility criteria consisted of being biologically male and male-identified, age 18 years or older, having had oral or anal sex with a man in the past 12 months, of Arabic origins and residing in the above mentioned countries. The interview was administered at one of several collaborating community organizations or a neutral location preferred by the respondent. Participants were given 10 USD for completing the interview

Measures

Sociodemographics and sexual orientation

The study inquired about age, education, education level, income, relationship status, country of origin, country of residence, sexual orientation, sexual attraction, as well as comfort about sexual orientation. Regarding sexual orientation, participants were asked to indicate whether the identify as: (1) gay; (2) bisexual; (3) Transsexual; (4) Other; and (5) Don't Know/ Uncertain. Items pertaining to Sexual attraction ranged between 1 (Men Only) and 7 (Women Only), while comfort about sexual orientation ranged from 1 (Very comfortable) and 5 (Very Uncomfortable).

Anxiety

The 21-item Beck Anxiety Inventory was used to assess symptoms of anxiety (BAI) which requests participants to identify the extent of which they have had particular symptoms in the past month. The 4-point Likert-type inventory ranged from 0 (not at all) to 3 (severely). The total score can be obtained by summing the items which would result in a value between 0 and 63, with higher score indicating greater likelihood of anxiety.

Depression

An adaptation of the Patient Health Questionnaire (PHQ-9) was used to evaluate the presence of a depressive disorder. The 9 items inventory is rated on a 4-point Scale, ranging from 0 (not at all) to 3 (nearly every day). A skip pattern was also employed: if neither of the first two items had a score of 2 and above, questions 3 to 9 are skipped and responses are resumed at question 10. Two additional items were added: the first item (Q10) assesses for suicidal attempts and employs the same rating scale as the PHQ-9 while the second assesses the acquisition of counseling, therapy, or any kind of mental health service. For the later, participants are requested to simply answer yes/no.

Self-harm

The Self-Harm Inventory (SHI) was used to screen for the prevalence of self-harm behaviors. The inventory requires respondents to select whether they have intentionally or purposefully engaged in any of the 22 items. The responses are dichotomous (yes/no) and the sum of the "yes" scores yields the total score. The cut-off score employed is five (or more) endorsements which is potentially indicative of mild forms of self-harm yet may not indicative of psychopathology in a non-clinical population.

General wellbeing

Kessler Psychological Distress Scale (K10) is a self-report measure of global distress that provides information about the respondent's current condition. The scale requires participants to rate the occurrence of the 10 items within the past 30 days. The 5-point items, ranging from 1 (None of the time) to 5 (All of the time), are summed to produce the total score.

Social support

Social support from family and friends was evaluated with the Multidimensional Scale of Perceived Social Support Assessment. This is a 12-item self-report questionnaire with a 7-point Likert-type scale answers ranging from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree). The total score is the sum of all items with higher scores indicating higher acuity.

Partner violence

HITS (Hurt-Insult-Threaten-Scream) is a short screening tool for domestic violence. The scale include 4 items that are rated on a scale of 1 (Never) to 5 (Frequently). The inventory scores range from 4 to 20, with scores greater than 10 indicating the occurrence of domestic violence.

Self-esteem

The 10-item self-report Rosenberg Self-Esteem Scale (SES) was used to measure both positive and negative feelings about the self. The items are scored on a 4-point Likert-Type scale: For Items 1, 3, 4, 7, and 10, the items range from 1 (Strongly Disagree) to 4 (Strongly Agree), while items 2, 5, 6, 8, and 9 are reverse coded. The scores are then summed and higher scores indicate higher self-esteem.

Coping strategies

Coping strategies were assessed using the 22-item "Tactics for Coping with Stress" questionnaire. The participants are asked to mark the items that they typically or often use. The even-numbered items represent constructive coping methods while odd-numbered items are more likely to be less productive and practical.

Discrimination

Experienced gay-related discrimination was measured with the subscale of the Multiple Discriminations Scale, which asks the respondent to indicate whether or not they experienced any of five types of discriminatory events (e.g., insulted or made fun of; denied or lost a job; physically assaulted) in the past year as a result of others thinking the respondent was gay or bisexual; the sum of types of discrimination experienced was used in analyses.

Internalized homonegativity

Internalized homophobia was assessed using the Sexual Identity Distress Scale, which consists of 7 items (e.g., "I have a positive attitude about being G/L/B") and response options ranging from 1 'strongly agree' to 5 'strongly disagree'; mean scores were calculated for each of the seven questions.

Religiosity

We developed three items to assess harmony between religiosity and sexual identity, which were intended to represent the extent to which the respondent is able to integrate their religious beliefs with their sexual identity versus these two aspects of their life creating an internal psychological conflict. Respondents were asked to rate their level of agreement with "My religious beliefs make me feel bad about having sex with other men" and "It is possible to be comfortable with being gay or bisexual and still have strong religious beliefs" on a scale from 1 'strongly agree' to 5 'strongly disagree'; mean item score was calculated and higher scores represent greater harmony between one's religious beliefs and sexual identity.

Sexual abuse

Three items of the Childhood Experiences Questionnaire (CEQ) (Lyons-Ruth, K. & Botein, J., 1984) were adapted to assess for sexual abuse. A fourth item was added to assess whether individuals sought counseling or any form of treatment for the abuse. A skip pattern was also employed whereby if participants were not subjected to any sexual abuse, the remaining three questions would no longer be applicable.

Data Analysis

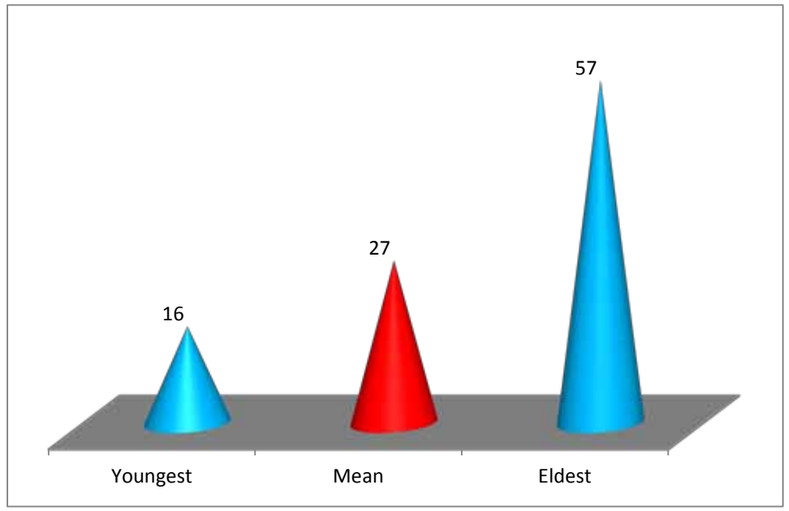
The purpose of this study is to provide an understanding of prevalence rates of mental health subjects within an MSM population. As such, the scope of the analysis was restricted to conducting a frequency and descriptive analysis using IBM SPSS statistics 22.

An MVA was also conducted to insure that the amount of missing variables does not impact the credibility of the results. Worship Attendance had 2% missing data, while Orientation Counseling had .4% and Conversion Therapy had 1.2% missing data. Marijuana Use, Drug Use, and Coping even scores had low missing data (.8%, 1.6%, and .4%, respectively). As for the depression variable, q10 only had 1.20% missing values. The MVA revealed a total of 8% missing values which warranted the little MCAR's test. Given that the EM Means was not significant, the MCAR can be inferred and the data is not problematic.

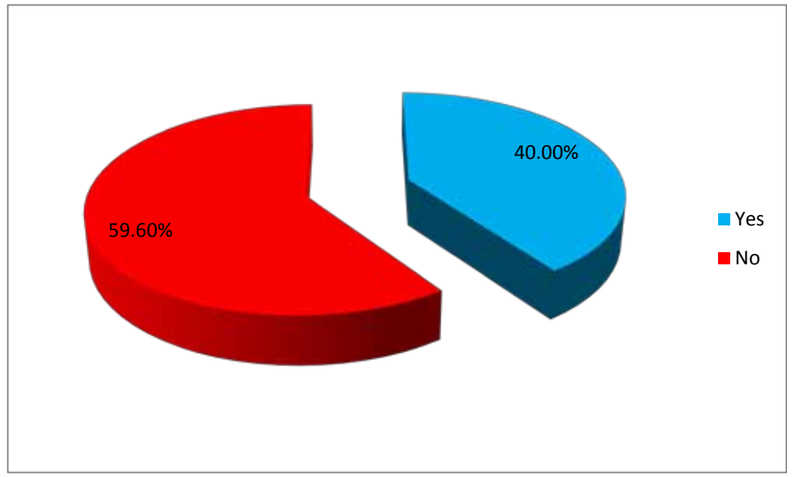
RESULTS

DEMOGRAPHICS

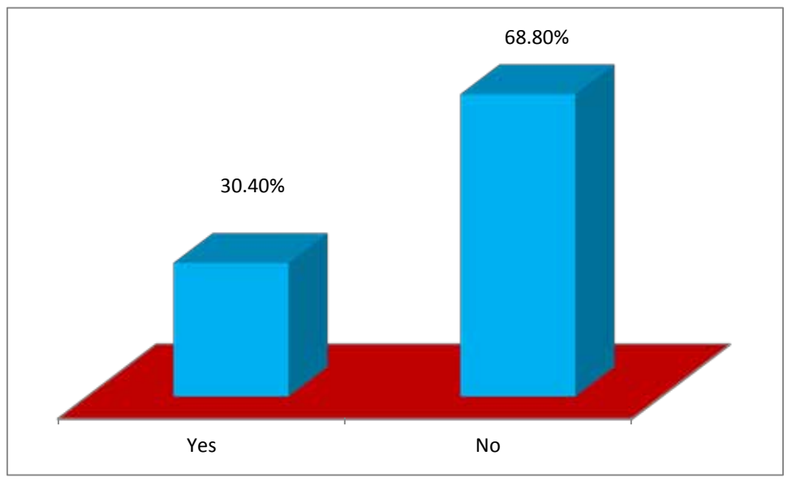
Age of participants



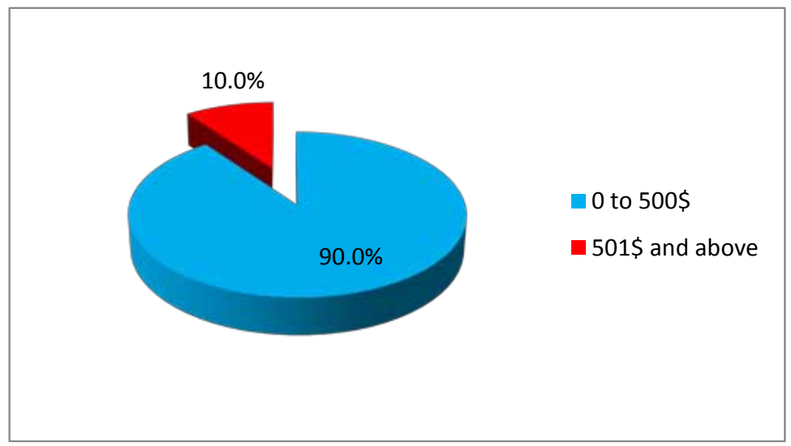
Relationship



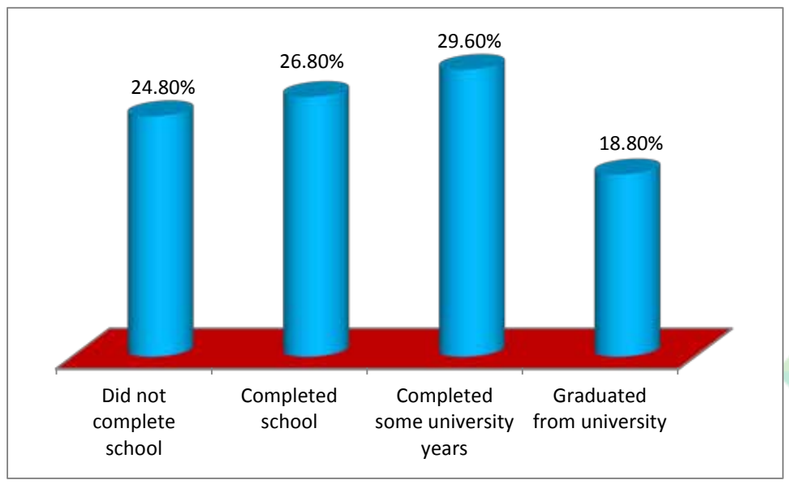
Education



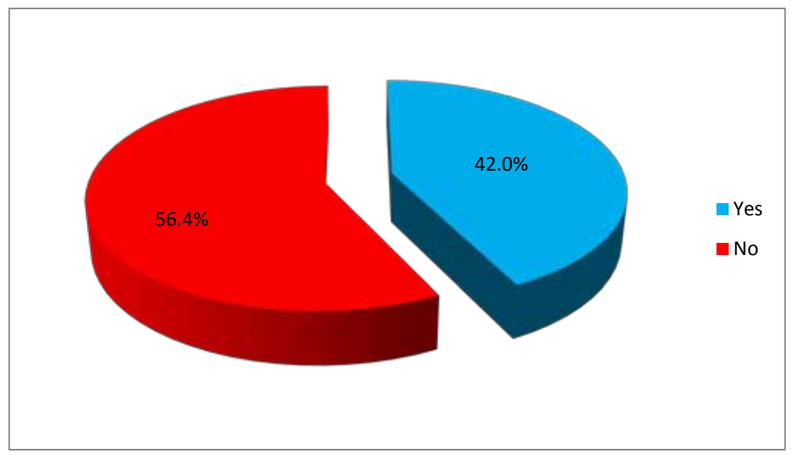
Income



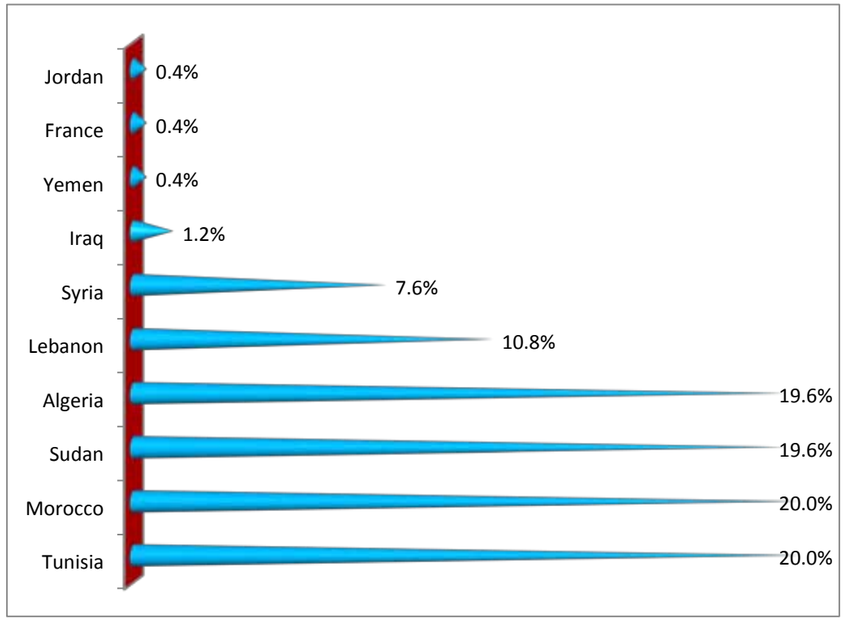
Education level



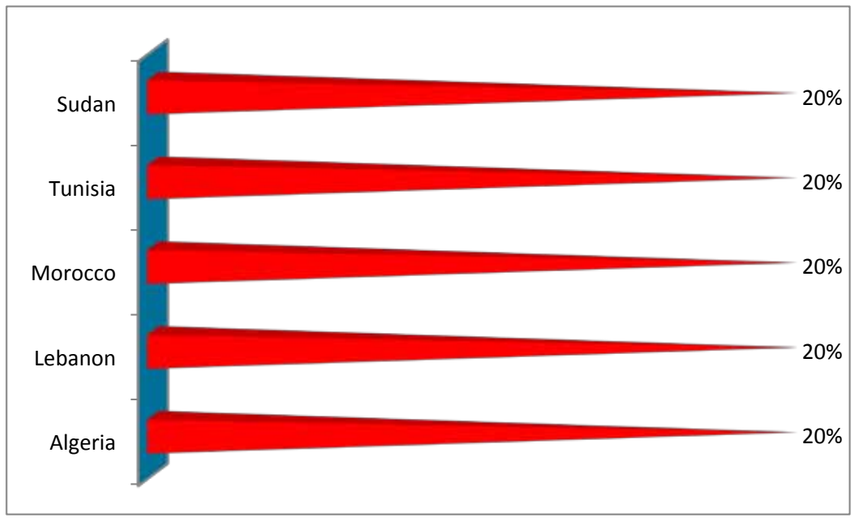
Work or Source of Income



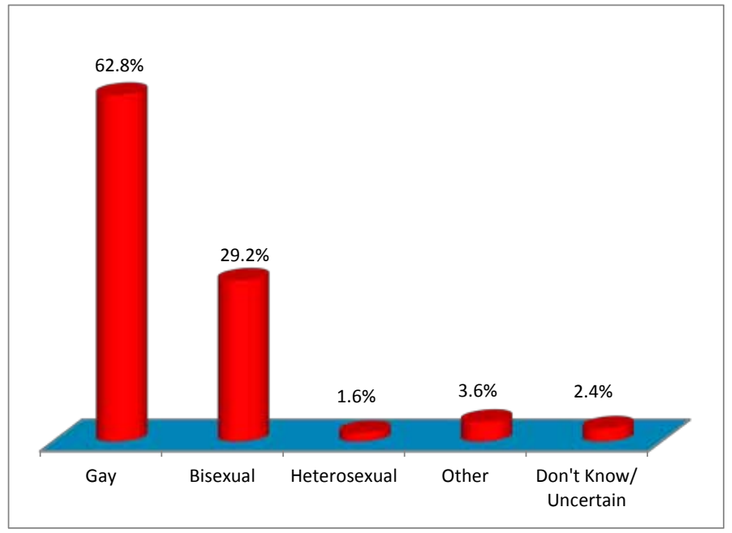
Country of Origin



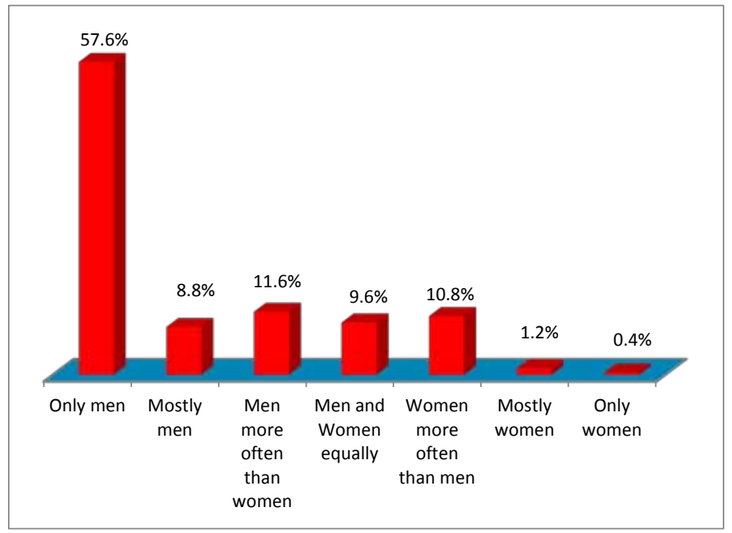
Country of Residence



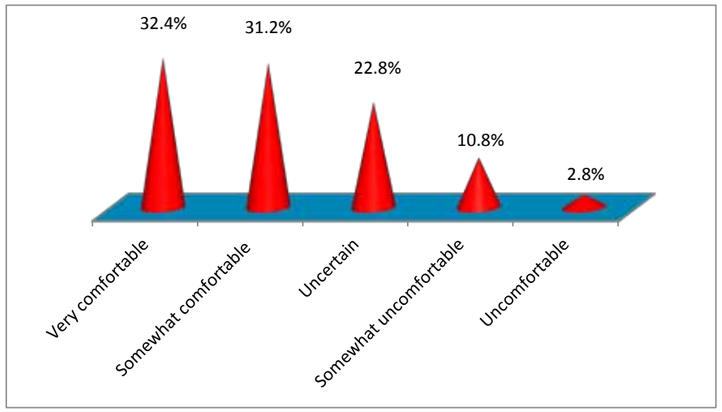
Sexual Orientation



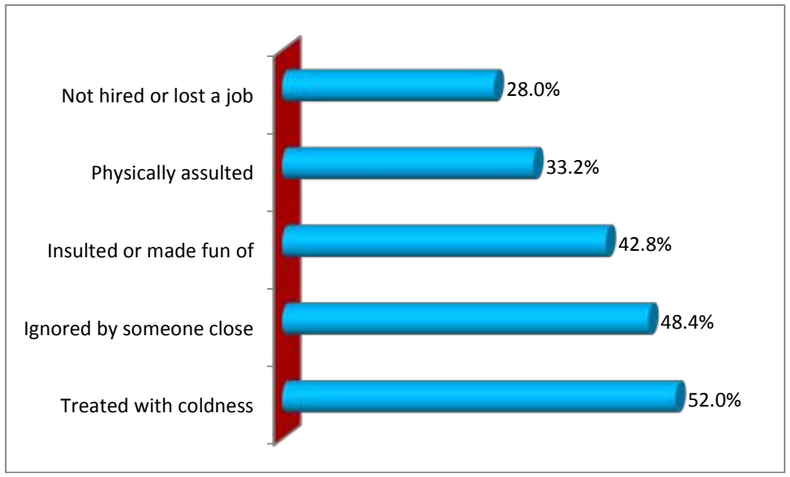
Sexual Attraction



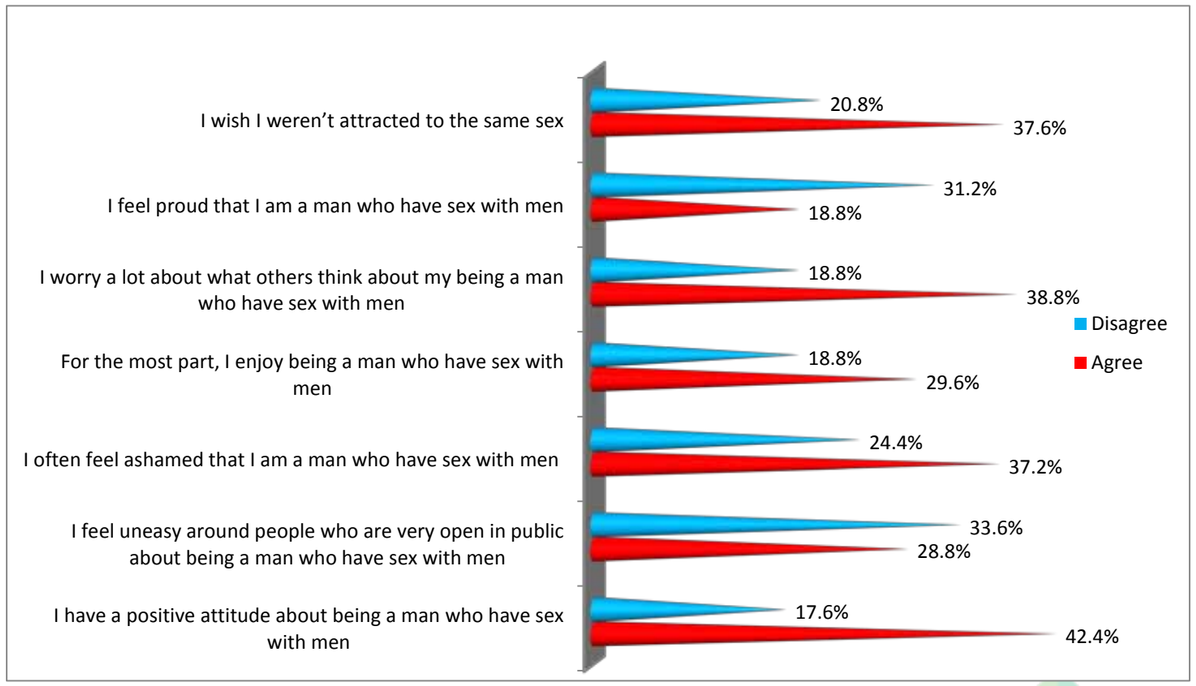
Comfort with sexual orientation



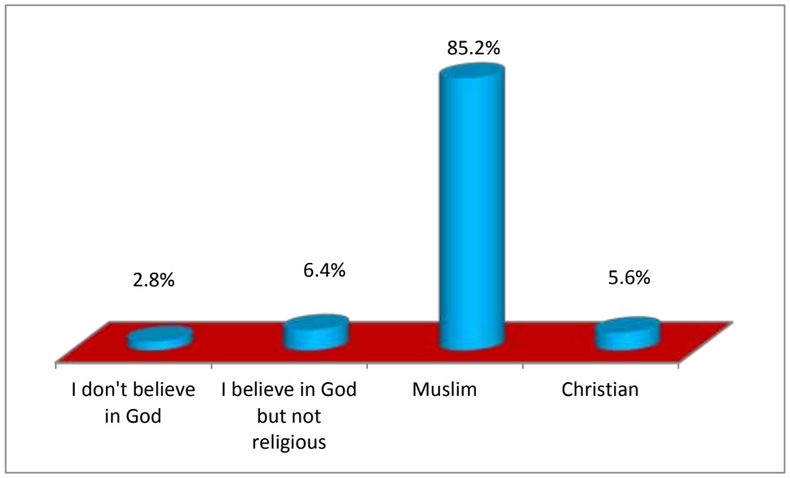
Because people knew/thought they had sex with men, they were …



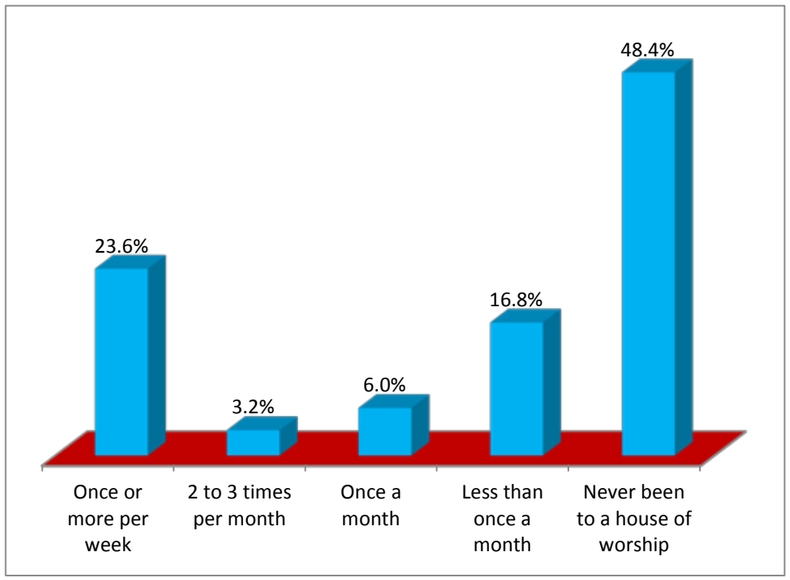
Internalized homo-negativity



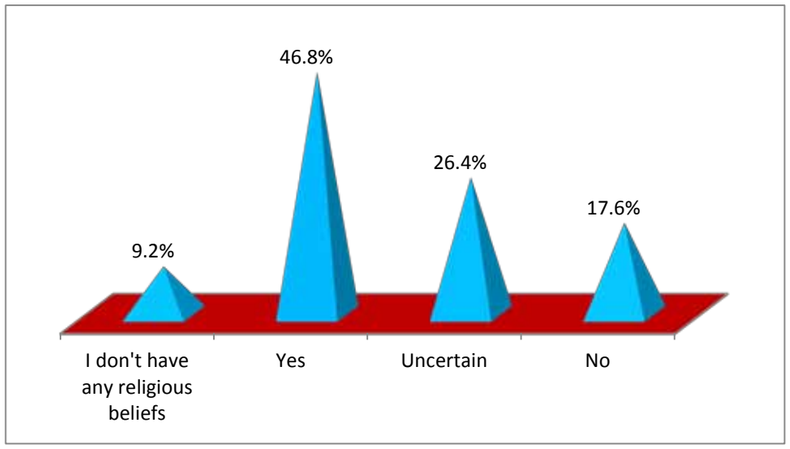
Religion



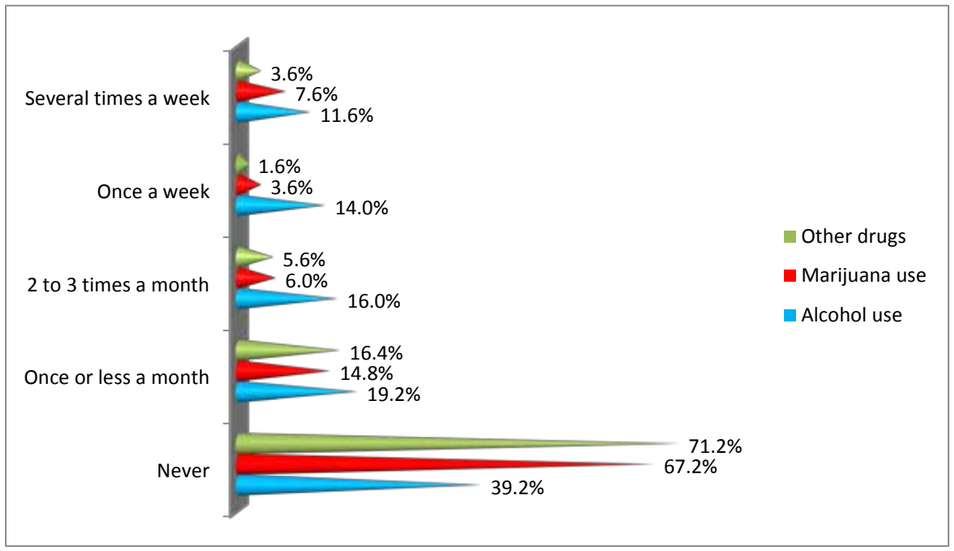
Worship Attendance



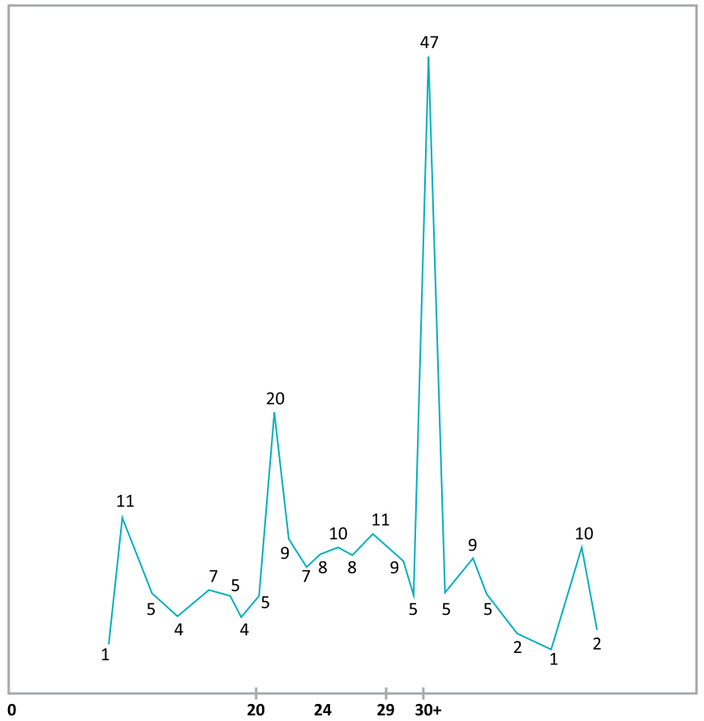
Religious associated guilt



Drug use



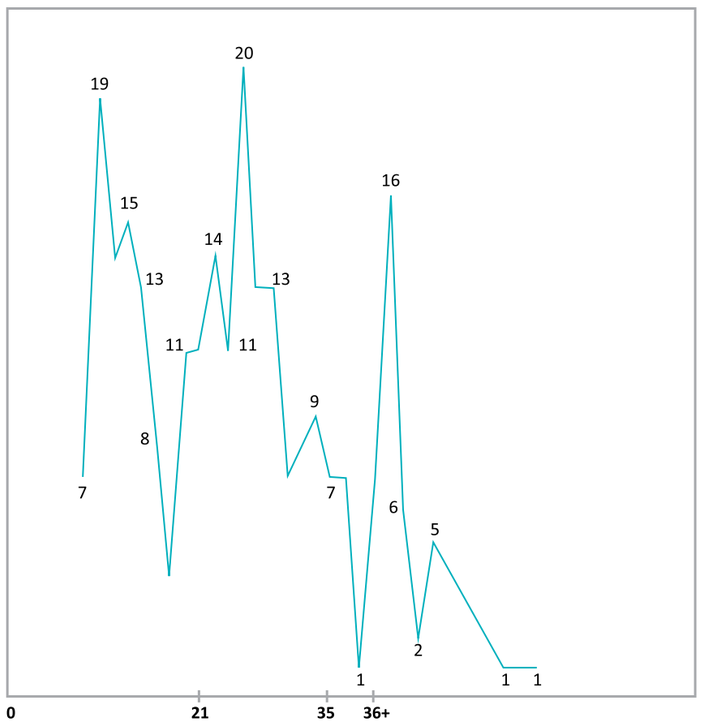
Wellbeing Score



Mean = 24.5

0 - 20: Likely to be well
20 - 24: Likely to have a mild mental disorder
24 - 29: Likely to have a moderate mental disorder
30+: Likely to have a severe mental disorder

Anxiety Score

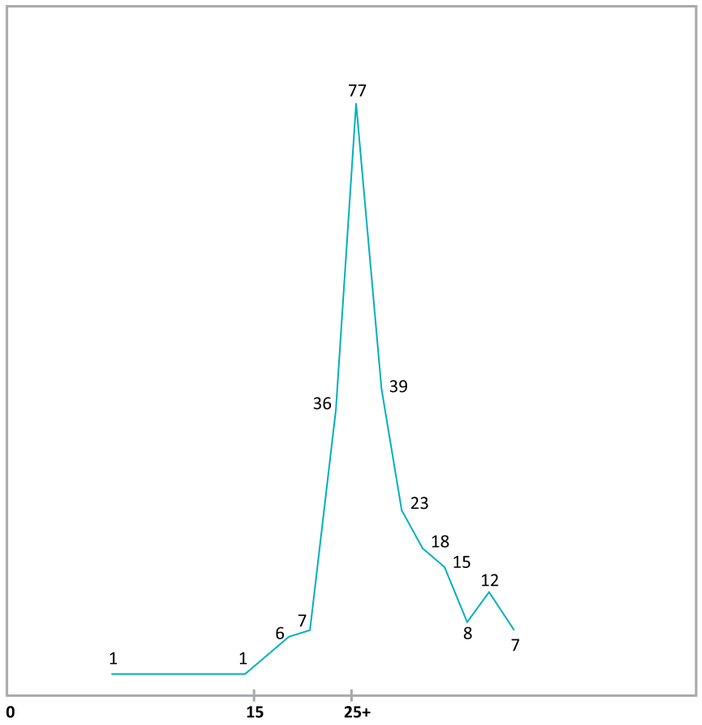


Mean = 20.43

0 - 21: Very low anxiety
21 - 35: Moderate anxiety
36+: High anxiety

These figures demonstrate the frequency of response

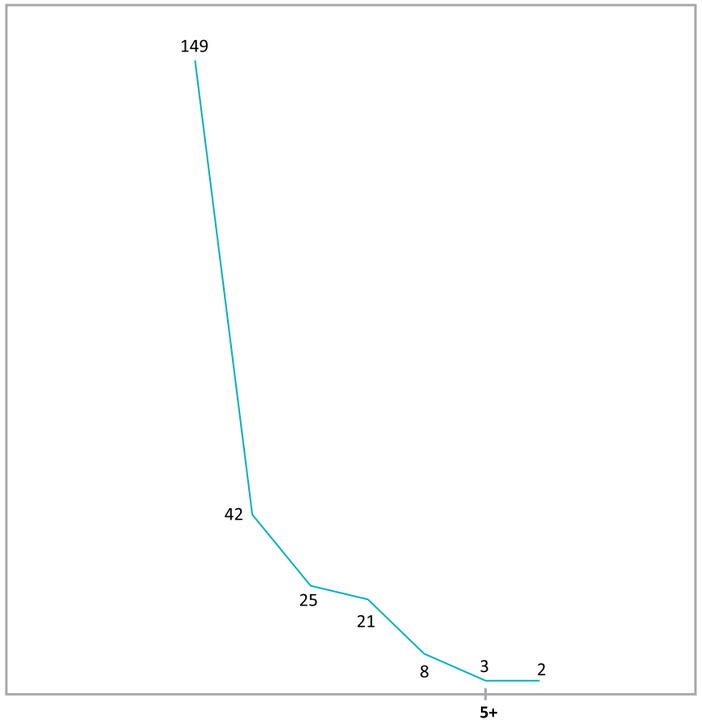
Self-esteem score



Mean = 27.66

0 - 15: Low self-esteem
15 - 25: Average self-esteem
25+: High self-esteem

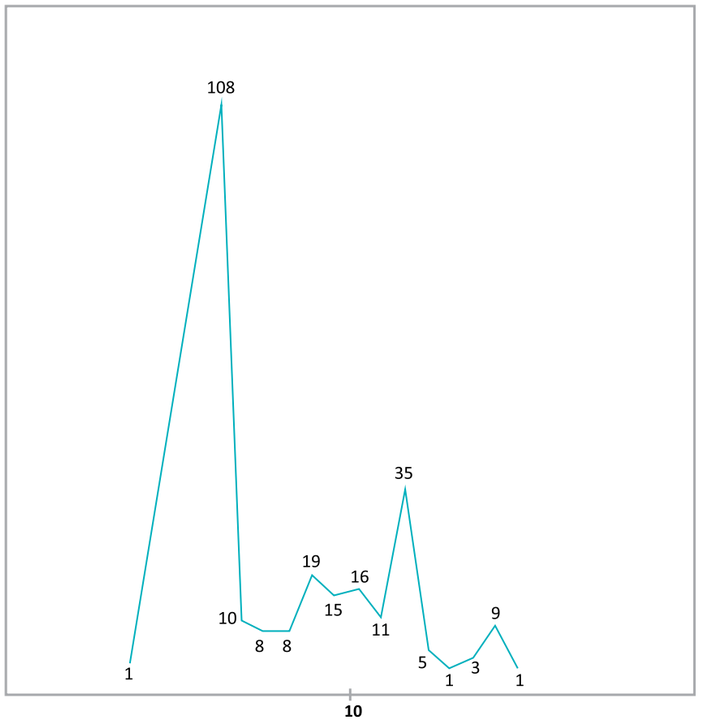
Self harm score



Mean = 0.86

5+: Indicative of mild forms of self-harm

Partner violence score



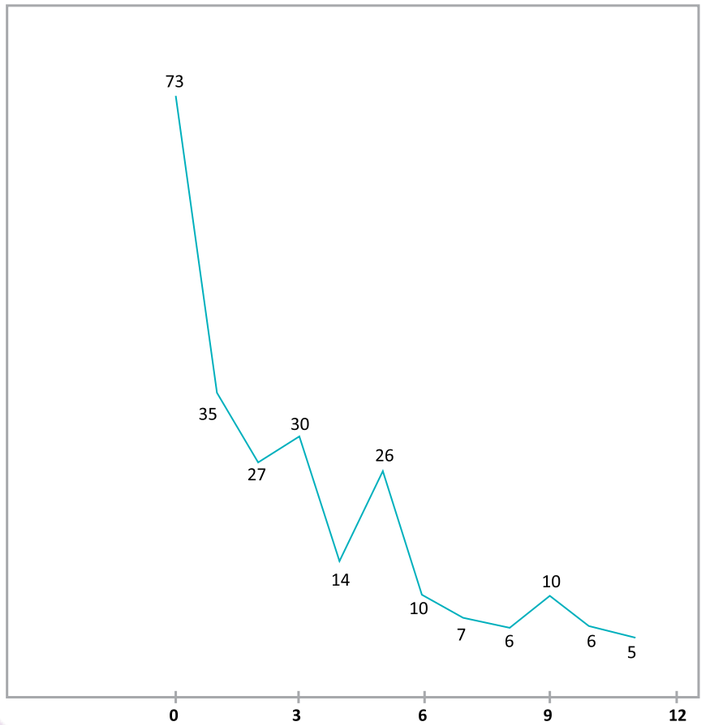
Mean = 7.44

< 10: Negative
> 10: Positive

These figures demonstrate the frequency of response

Coping even score

"Number of constructive coping methods"

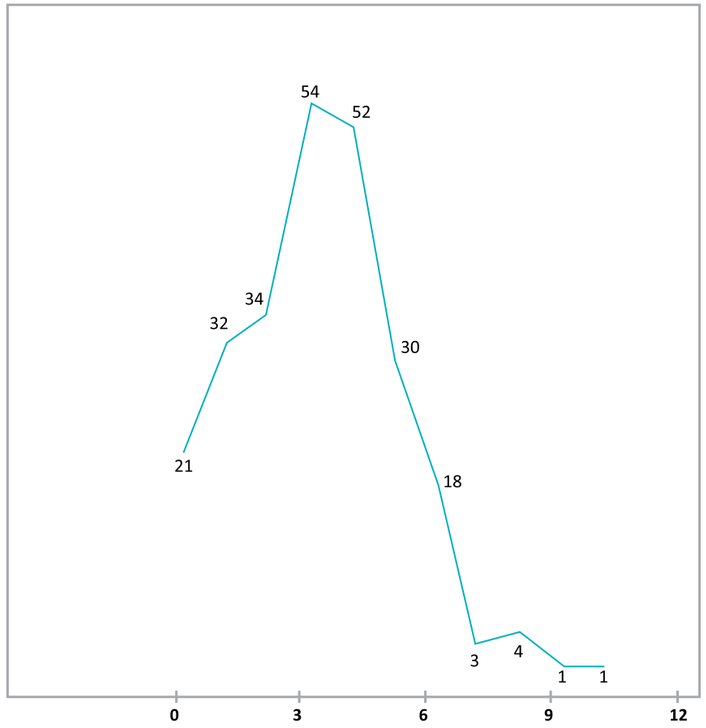


Mean = 2.92

These figures demonstrate the frequency of response

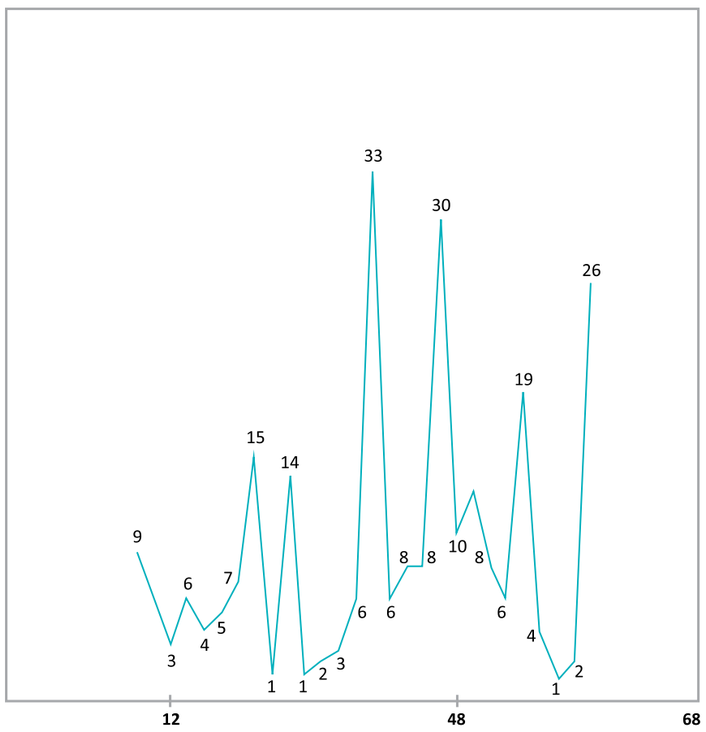
Coping odd score

"Number of less constructive coping methods"



Mean = 3.2

Social Support

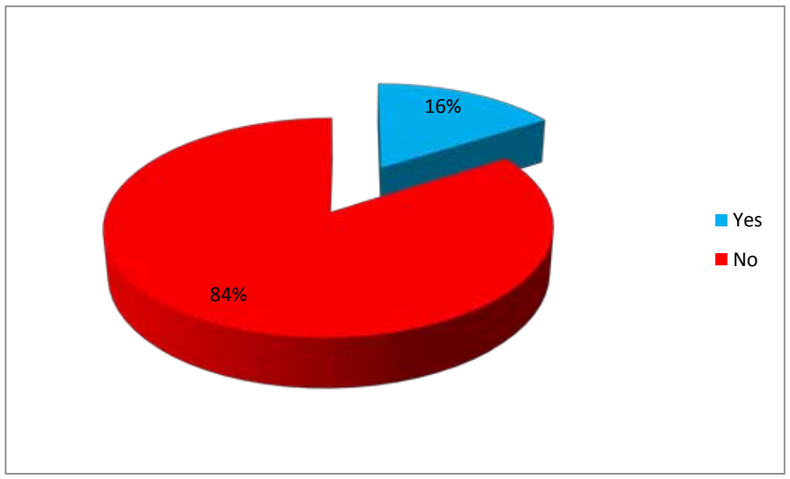


Mean = 39.86

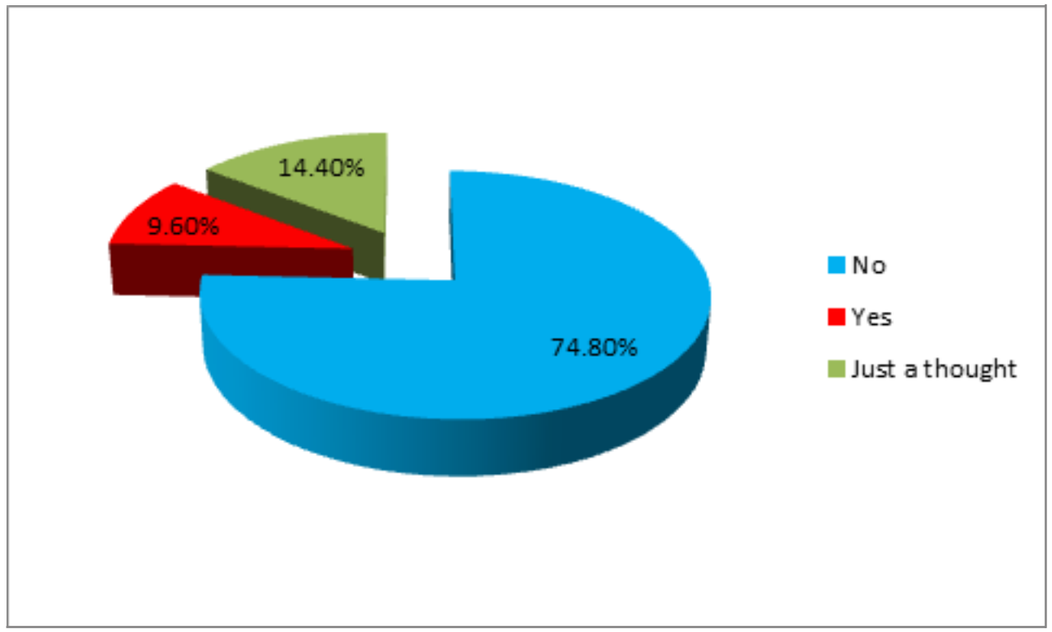
12 - 48: Low Acuity
48 - 68: Moderate Acuity

These figures demonstrate the frequency of response

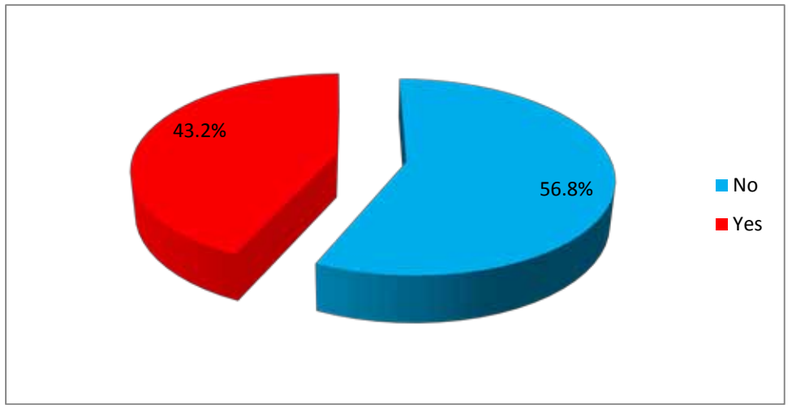
Clinical Depression (PHQ-9)



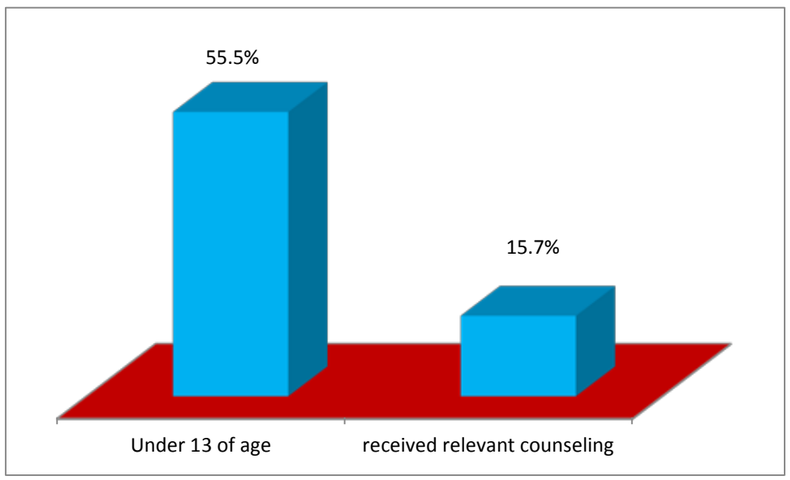
Have you ever attempted suicide?



Sex Abuse



Among those who experienced sexual abuse



DISCUSSION

Sexual health of gay, bisexual and men who have sex with men (MSM) has historically been an understudied subject in the MENA region. Yet even when studied, it's almost solely focused on HIV, STIs and sexual risk, with major neglect of other predictors of HIV vulnerability and other health syndemics, more specifically mental health.

Consistent with what has been reported elsewhere on the global level, the MSM community holds a higher burden of mental health issues. Due to minority stress and a group of social and emotional experiences in a hostile environment, we generally found that men in our sample reported a high level of emotional and psychological distress, associated with negative experiences of social aggression and internalized homophobia.

With 2/3 of our sample self identifying as gay, it is interesting to see if this is a reflection of a new generation of men who are more affirmative with their sexual identity, or a simple limitation in reaching more hidden individuals, knowing that 63.4% have expressed their comfort with their sexual orientation.

Overall we found a significant amount of social discrimination, which is not surprising in settings were homosexuality is still criminalized; And where social and religious laws and regulations still police the human body. Close to half of our sample where insulted or made fun of because someone thought or knew they were gay, and 33.2% were physically assaulted due to the same reason and most of these violations go unreported; On the one hand, there are no protective laws or policies, furthermore, individuals might find themselves detained upon arrival to police stations, on the other hand, not all of these countries have community organizations that would be able to protect, collect testimonies and report for future advocacy efforts.

Although over 90% of our participants self affiliate with a religion (Islam or Christianity), only half of them go to worshiping venues (mosque or a church), while only 26.8% did not experience any religious associated guilt. This fact is not surprising in countries where religion and politics are interlinked, not only through official laws and regulations but also in everyday life among families and social institutions, even as part of education.

Concerning the multiple facets of internalized homophobia, the scale analysis has shown that our sample do suffer from personal homo-negativity. This phenomenon can be easily explained by how individuals are exposed to negative messages about homosexuality, from the minute they start getting integrated in their families and societies. From households, to neighborhood to schools, and from media to social conversations to professional life; all messaging in mostly homophobic and it's bound to get internalized without proper support systems. In major studies around the world, Internalized homophobia has been found associated with self hate/harm, auto-destructive behaviors and as a predictor to other health syndemics. Creating support systems and enabling the social environment for a healthy identity development, is crucial for these men and it should be on the top list of intervention efforts.
Most of our participants did not portray high anxiety symptoms, and self esteem was generally above average, yet 26% scored positive for partner violence, with less constructive coping mechanisms (mean value = 3.2) and with what has been discussed previously around internalized homophobia, it's not surprising that 1/3 of our sample is on the verge of a severe mental disorder.

Almost half of our sample reported experiencing sexual abuse (43.2%), and half of these individuals experienced it, while they were under 13 years of age and only 16% have ever received any relevant psychological counseling. Once again, another subject that is very rarely tackled or even talked about in intervention or community based projects. These men prevent themselves from talking about it, either in fear of judgment, or mostly for the lack of safe spaces; and all the negative outcomes of being though such experience, are suppressed and not dealt with, fueling the emotional distress around sexual identity development and negatively affecting the psychological wellbeing.

According to a fact sheet of depression prepared by the World Health Organization (WHO) in 2013 around the Middle East, the rates were up to 7%. Our sample has scored a stagnating 16% which is more than double the rate among the general population. This fact is alarming and once again highlights the level of social and emotional distress suffered by this community, who also reported another alarming fact around suicide where 9.6% of our sample, has previously attempted to end their life. Any intervention with gay, bisexual and other men who have sex with men in the Arab world, cannot be expected to have high success rates, even if only for HIV health outcomes, unless it takes into consideration, the mental health of their target community.

LIMITATIONS AND FUTURE RECOMMENDATIONS

One main concern pertaining to this study is the limited number of participants given the covered region. Future research could focus on micro-analyses of each region of residence targeted in the study or opt to increase the number of participants if a general analysis is desired. Interestingly, 90% of the participants had 500$ or below worth of income. Given that the socioeconomic class can potentially influence people's responses, it would be important to cover the scope of socioeconomic classes that is representative of the general population. Another concern in this study pertains to the interview format of data collection. In fact, individuals might be less likely to disclose sensitive information about themselves if they perceive anonymity to be questionable. As such, it would be interesting to conduct a mental health examination by using more private means of participation (e.g. pen-and-pencil self-report questionnaires, online survey websites...etc.), and cross examining these results with the ones found in this study in order to evaluate levels of disparity.

The scope of this research mainly focused on understanding the prevalence of mental disorder. Future work should opt to understand the relation between the prevalence rates and other psychosocial factors. It would be central to construct an understanding of the impact of societal stressors on people's mental wellbeing and identity developments. The benefit of the current study and future work that would expand these subjects rests on the decomposition of commonly accepted biases and the potential development of mental health programs, gender and sexuality institutes that enable enhanced mental health.

This study has shown us that gay, bisexual and other men who have sex with men in the Arab world are in dire need of mental health support, having to deal with minority stress. Issues of legal, social and even personal homophobia should be tackled in all future interventions targeting this community, to enable the environment for a healthy sexual identity development and as a basic human right. Some of the needed programs would be:

- Safe spaces for community members
- Mental health support programs and mental health providers training
- Legal advocacy efforts (decriminalizing homosexuality…)
- Anti-discrimination initiatives (targeting service providers and the general population)
- Community activities and workshops tackling:
    - Sexual abuse
    - Body image and self esteem
    - Stress management
    - Coping skills

ABOUT THE AUTHORS

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Clinical Psychology graduate, been an activist for LGBT rights since 2006. Started working in community research in 2012 on an NIH funded study among gay men in Lebanon. Two years later, he got a scholarship to study behavioral research among LGBT at University of Pittsburgh through the amfAR scholars program, which resulted in conducting a bio-behavioral study among gay refugees residing in Beirut, Lebanon. He is currently the director of M-Coalition, co-chair of the Youth Reference Group at the Global Forum for MSM and HIV (MSMGF), and part of a team working on the adaptation of the HIV M-powerment intervention program among young gay men in Lebanon.

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Ghina has a three year experience as a practicing therapist and has worked on several gender and sexuality research studies. She has been involved with M-Coalition over the current study and in another study focusing on general health among gay, bisexual and other men who have sex with men in the Arab world. She is interested in pursuing a PhD with a specialization in gender and sexuality studies.

Data collection in target countries was achieved in collaboration with our local partners:

Algeria: a team of peer educators / HIV activists
Lebanon: Mosaic organization: www.mosaicmena.org
Morocco: Association de la Lutte Contre le Sida (ALCS) / Marrakesh: www.alcs.ma
Sudan: Sudan Fertility Care Association (SFCA)
Tunisia: Damj organization: https://ar-ar.facebook.com/damj.tunisie

M-Coalition is officially hosted, and fiscally sponsored by the Arab Foundation for Freedoms and Equality (AFE)

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AFE is a registered non-governmental organization based in Beirut, Lebanon, with a mission to encourage and support sexuality, gender and bodily rights' movements in the Middle East and North Africa through capacity building, knowledge production, exchange, and security and emergency response.

This document has been funded by Hivos people unlimited