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Sexual Violence in Childhood and Post-Childhood: The Experiences of Young Men Who Have Sex With Men in Beirut

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Abstract

Sexual violence has been found to have psychosocial and sexual ramifications for men who have sex with men (MSM) but has not been studied in the Middle East. We assessed the prevalence and correlates of experiences of child and post-child sexual violence among young MSM residing in Beirut, Lebanon. In total, 226 MSM, aged 18 to 29, were recruited with long-chain peer referrals and administered a survey that included questions on history of being pressured to have sex, as well as specific forms of sexual harassment and abuse, in addition to measures of psychosocial functioning and sexual behavior. Logistic regression analysis was used to examine correlates of child sex abuse and experiences of sexual violence post-childhood; 17.3% experienced sexual abuse as a child (below age 13), while 63.3% experienced any form of sexual violence post-childhood—furthermore, 48.7% had experienced being forced or pressured to have sex during their lifetime, including 32.3% prior to age 18. Participants who experienced child sex abuse were more likely to experience abusive relationships in adulthood, as well as at least one type of sexual harassment/abuse post-childhood. Experience of any sexual violence post-childhood was correlated with greater recent sexuality-related discrimination and more recent male sex partners. These findings reveal a high prevalence of sexual violence among MSM in Beirut, both in childhood and post-childhood. More research within the Middle East is needed

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to better understand the drivers of sexual violence in this population, and how to best provide prevention and coping services.

Keywords

sexual abuse; child abuse; sexual assault; LGBT; mental health; violence

Introduction

Sexual violence is any form of non-consensual vaginal, anal, and/or oral sex, including any form of non-consensual and/or forced unsolicited touch and/or other forms of unwelcomed sexual advances (Rebeiz & Harb, 2010). Sexual violence can take on different forms, including rape, sexual assault, and sexual harassment. Sexual violence is a global health issue that transcends borders and is rampant in different societies and across cultures (Khadr et al., 2018; World Health Organization [WHO], 2014). Although sexual violence is widely believed to be underreported, the WHO (2014) estimates that one in six adults have experienced one form of non-consensual sexual experience in their lifetime, and that being a victim/survivor of sexual violence accounts for the loss of 5% to 16% of one's life expectancy. This can be attributed to short- and long-term consequences of having survived such a traumatic event; mood and anxiety disorders, high-risk sexual behavior, substance abuse, and poorer interpersonal relationships are among the health sequelae that could alter a survivor's life expectancy (Banyard, Williams, & Siegel, 2001; Myers, 1989).

Sexual violence in adulthood is a topic that typically focuses on women as the victims, as they are disproportionately affected by such violence (Uggen & Blackstone, 2004). Yet men also experience sexual violence, as children, adolescents, and adults (McLean, 2013), and perhaps even more so among men who have sex with men (MSM; Schafer, Gupta, & Dillingham, 2013). In fact, a systematic review of studies of MSM in the United States found rates of intimate partner violence that were similar to those reported by women, with one quarter to a third of MSM experiencing such violence (Finneran & Stephenson, 2013). Yet little is known about the prevalence of sexual violence among MSM in diverse parts of the world, including the Middle East, nor the psychosocial and sexual sequelae of such violence (WHO, 2014). There is a paucity of studies of men as victims of sexual violence in part because of the underreporting of sexual violence experienced by men (WHO, 2014), which may be due to social desirability biases and insecurities related to masculinity and sexuality (e.g., fear of being perceived to be a victim or a homosexual; Alaggia, 2005).

Studies that have examined sexual violence among MSM have often focused on histories of child sex abuse and their relationship to sexual risk behavior and sexual relations in adulthood (McLean, 2013). A meta-analysis of child sex abuse among MSM in the United States found an overall rate of 27% (Lloyd & Operario, 2012). A similar rate of male child sex abuse (22%–26%) was found in another meta-analysis of studies conducted across 19 countries (none of which were in the Middle East or Arabic countries), but this analysis did not delineate the sexual orientation of men in the studies (Finkelhor, 1994). Within the Middle East, a study of Egyptian male college students revealed that 21% had experienced

child sex abuse (Aboul-Hagag & Hamed, 2012). Like studies of their non-homosexual counterparts, childhood sex abuse among MSM has been associated with greater number of sex partners, difficulties establishing long-term relationships, greater substance use, mental health problems, and greater condomless anal sex and HIV infection (Lloyd & Operario, 2012; Schafer et al., 2013). Studies of the psychosocial and sexual sequelae of intimate partner violence among MSM have found similar correlates as those of sexual abuse in childhood. A meta-analysis of intimate partner violence among adult MSM found that men who are victims of such violence are more likely to engage in substance use, suffer from depressive symptoms, be living with HIV, and engage in condomless anal sex (Buller, Devries, Howard, & Bacchus, 2014).

This research described above has been conducted mostly in North America and Western Europe, and we are not aware of any research on adult sexual violence and abuse or history of child sex abuse among MSM in the Middle East. The absence of research in the Middle East on sexual violence among MSM is undoubtedly influenced by factors such as stigma (both internal and external) and discrimination related to their sexuality (as well as stigma related to being a victim of sexual violence), which may impede disclosure and discussion of sexual victimization, as well as willingness to participate in research that is specific to this population. In Lebanon, homosexuality remains highly stigmatized and also criminalized (Nasr & Zeidan, 2015), despite it being relatively diverse politically and socially for the region and its perception of being progressive for the Middle East. The gay community in Beirut has experienced significant development over the past two decades, and Beirut has a growing presence of community-based organizations and activism that fight for the rights and needs of sexual and gender minorities (Nasr & Zeidan, 2015). With this context, Beirut is likely one of the few cities in the Middle East where research examining sexual violence among MSM is feasible.

We conducted a secondary analysis of data collected from a sample of 226 young MSM in greater Beirut, Lebanon, as part of a larger sexual health intervention study. We examined the prevalence of childhood and post-childhood experiences of sexual violence, and how they are correlated with each other as well as with measures of mental health, substance use, sexual behavior, and sexuality-related discrimination.

Method

Study Design and Participant Recruitment

The survey data used for this article's analysis are drawn from a cohort of men enrolled in an open trial of a community-based HIV prevention, sexual health promotion intervention. Recruitment of the cohort took place between July 2016 and March 2017 using long-chain peer referral methods (Salganik & Heckathorn, 2004; Yan et al., 2012) primarily (73% of the sample was recruited by this method), though other methods such as recruitment flyers, postings on social media, and word of mouth were added near the end of recruitment to enable the study to reach its target sample. Eligibility criteria consisted of being biologically male and/or male-identified, aged 18 to 29 years, fluent in English or Arabic, residing in greater Beirut, and having had oral or anal sex with a man in the past 12 months.

For the long-chain peer referral methods, recruitment began with a small number of eligible persons designated as “seeds” who were identified through recommendations from community organizations working with MSM and our community advisory board, and were purposively selected to be well connected to other MSM in the community and to represent the diversity in the community. All participants, including seeds and those recruited through flyers, postings, and word of mouth, received three recruitment coupons to recruit members of their social network, resulting in multiple waves of participants. Participants were instructed to give a coupon to eligible peers who were interested in participating and to inform the recruit to call the study coordinator for coupon verification, eligibility screening, verbal consent procedures, and scheduling of an interview. The survey interview was administered at the project office, by either a young MSM or a queer woman interviewer, depending on the preference of the participant. Participants were compensated US$40 for completing the interview, as well as for each recruit (US$10; up to three) who enrolled in the study.

Measures

The survey was administered in English or Arabic, depending on the preference of the participant, with computer-assisted interview software. The survey was developed in English and translated into Arabic using standard translation and back-translation methods. Participants were given the option of completing the survey on their own or having the interviewer administer the survey; study interviewers reported that it was very rare (less than 5%) for a participant to choose to self-administer the survey.

Socio-demographic characteristics.—These consisted of age, education level, employment, monthly income, religious affiliation, country of birth, legal status as a resident of Lebanon, sexual orientation, and relationship status. For analysis, response categories were combined to create binary indicators for measures of education (at least some university education), monthly income (<US$1,000; note that U.S. dollars is a regular currency in Lebanon), and sexual orientation (self-identify as gay).

History of sexual violence.—Sexual violence, which encompasses sexual assault, harassment, and rape, was assessed by asking respondents whether “anyone ever forced or pressured you to touch or be touched in a sexual way, have oral sex, or have vaginal or anal intercourse” and the age that such an event first took place. We did not ask about the age, sex, nor gender identity of the perpetrator. Age responses were recorded by the interviewer as being in one of three age categories: below 13 years, 13 to 17 years, and 18 years or older. Respondents who reported that such an event first took place when below 13 years of age were classified as having experienced child sex abuse. Participants who reported ever having been forced or pressured to have sex were also asked whether such an event has occurred as an adult, being at age 18 years or older.

Other forms of sexual violence were assessed with items from the Community Attitudes on Sexual Assault (CASA) Survey developed by Massachusetts Institute of Technology (MIT; 2014); respondents were asked whether they had ever been taken advantage of sexually in these four types of situations: was too drunk or high to stop what was happening; was

threatened that information about their sexual orientation would be spread—"blackmail"; received threatening messages after refusing sex; and was slipped a rape drug. Although we did not ask the respondents to specify their age when these experiences occurred, each type of experience is one that occurs most likely in an adolescent or adult context, rather than in childhood (below age 13). Variables representing whether or not any of these four types of harassment/abuse had been experienced, and the sum of these four types that had been experienced, were computed. Finally, respondents were asked whether or not they had ever "been in a relationship that was sexually, emotionally, verbally, or physically abusive?" If they had been in such a relationship, they were then asked whether they had discussed this experience with someone.

Sexual behavior and condom use.—Respondents were asked to report their sexual activities, the HIV status of their partners, and the number of male sex partners they had in the past 3 months. For receptive and insertive anal intercourse, respondents were asked "how many times they engaged in the act over the past 3 months," "how many of those acts involved the use of a condom," and the "HIV status of the partners with whom they had condomless anal sex." Respondents indicated how many of these partners "told you he was HIV negative and you had no reason to doubt it," "you knew this man was HIV-positive," and "you were not completely sure of this man's HIV status." A dichotomous variable was created to indicate whether or not any condomless anal sex took place with a male partner who was known to be HIV-infected or whose HIV status was unknown to the respondent, in the past 3 months. This variable indicates engagement in sexual behavior that poses a risk for HIV transmission; however, it should be noted that we did not assess perception of viral load status among HIV-positive partners. Individuals in Lebanon are required to pay for their viral load status laboratory tests, which are quite expensive, so most individuals are unaware of their current viral loads. Therefore it is plausible that some reports of condomless sex with HIV-positive partners did not involve HIV risk if the partner had an undetectable viral load.

Substance use.—Non-prescription substance use was measured using items developed by the study team in which participants were asked how often they used the following substances in the past 3 months: alcohol, marijuana/hashish, ecstasy/methyl enedioxy methamphetamine (MDMA), crystal methamphetamine, ketamine, gamma-hydroxybutyrate (GHB), hallucinogens/LSD lysergic acid diethylamide (LSD)/mushrooms, poppers, crack, cocaine, heroin, Viagra/Cialis/Levitra, and any other pharmaceutical drugs not prescribed by a physician. Response options included the following: never, once a month or less, 2 to 3 times a month, about once a week, and several times a week.

Depression.—Depression was assessed using the nine-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). Each item of the PHQ-9 corresponds to the nine symptoms assessed in the depression module of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The total score ranges from 0 to 27, as each item is scored on a 0 = "never" to 3 = "every day" scale of symptom frequency over the past 2 weeks. The first two items (depressed mood; loss of interest in activities that are normally enjoyable; two-item Patient Health

Questionnaire [PHQ-2]) were asked of all participants, and PHQ-2 scores >2 represent potential depression. Participants who scored at least a 2 = “more than half the days” on one of these two items were then administered the full nine-item scale. A PHQ-9 total score >9 signifies clinical depression (Kroenke et al., 2001).

Suicidal history.—Participants were also asked whether they had ever thought of or attempted suicide. Response options consisted of 0 = “Never,” 1 = “It was just a brief passing thought,” 2 = “I have had a plan at least once to kill myself but did not try to do it,” 3 = “I have had a plan at least once to kill myself and really wanted to die,” 4 = “I have attempted to kill myself but did not want to die,” and 5 = “I have attempted to kill myself and really hoped to die.”

Sexuality-based discrimination.—Discrimination was measured with the sub-scale of the Multiple Discrimination Scale (Bogart et al., 2011) that asks the respondents to indicate whether or not they experienced any of the 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 the analyses.

Data Analysis

Bivariate tests (chi-square tests; two-tailed, independent *t* tests) were used to examine the correlates of the two main dependent variables of interest, having experienced child sex abuse and having experienced any form of sexual violence post-childhood (in adolescence or adulthood). Any experience of post-child sexual violence represented an indication of having experienced any of the four types of sexual violence situations or being pressured or forced to have sexual contact at an age of 13 years or older. When analyzing substance use as a correlate, we examined only substances in which at least 5% of the sample reported using the substance in the past 3 months; also, use of ecstasy, crystal methamphetamine, ketamine, cocaine, and GHB were combined into a category named “club drugs.”

Separate multiple logistic regression models were then conducted for each of these two dependent variables, with variables that were at least marginally correlated ($p < .10$) in bivariate analysis being included as independent variables. The regression models included a cluster adjustment to account for dependence among persons recruited by the same individual (via long-chain referral recruitment). We used the Taylor series (linearization) method for computing cluster-adjusted variances (Lohr, 2010). The cluster-adjusted regression analyses were conducted using SAS survey analysis procedures (SAS Institute, 2013).

Results

Sample Characteristics

A sample of 226 young MSM enrolled in the study. Table 1 lists the socio-demographic and background characteristics of the sample, as well as characteristics related to mental health, substance use, and violent sexual experiences in both childhood and post-childhood.

Two thirds (60.2%) were below age 25, nearly half (45.6%) were attending university, and a quarter (24.6%) were in a committed relationship; 74.8% were born in Lebanon and held Lebanese citizenship.

Prevalence of Sexual Violence as a Child and as an Adult

Nearly half (n = 110, 48.7%) reported having experienced being "forced or pressured to have sex" during their lifetime. A stratification based on age (in years) of the respondent when they first experienced such an event revealed that of these 110, 39 (17.3% of the whole sample) were younger than age 13 and thus had experienced sexual abuse as a child; 34 were between ages 13 and 17, and 37 were age 18 or older, resulting in 71 (31.4% of the whole sample) who had first experienced this specific form of sexual violence post-childhood (in adolescence or adulthood). Among the 73 (32.3% of the whole sample) who had first experienced this form of sexual violence prior to age 18, 22 said they had also been forced or pressured to have sex as an adult (aged 18 or older); therefore, 59 (26.1% of the whole sample) had experienced this type of sexual violence as an adult.

When asked about experiences with four specific types of sexual harassment/abuse, 18.3% (n = 41; missing data from two respondents) reported being taken sexual advantage of when too drunk/high to stop it, 18.6% (n = 42) reported being taken sexual advantage of when a person threatened to spread information regarding their sexuality, 7.6% (n = 17; missing data from two respondents) reported that someone used a rape drug to take advantage of them, and 34.2% (n = 77; missing data from one respondent) reported that someone sent them violent or threatening messages after they refused sex. Just over half (n = 115; 50.9%) reported at least one of the four above described events of sexual harassment/abuse (M = 0.77, SD = 0.88, median = 1), and a total of 143 (63.3%) participants reported any type of sexual violence (including sexual harassment/abuse or being forced/pressured to have sex) event post-childhood. Participants who reported being sexually abused as a child were more likely to report any of the four types of sexual harassment/abuse post-childhood (67.6% vs. 48.6%; p = .036), and more types of sexual harassment/abuse (1.24 vs. 0.68; p = .004), but did not differ significantly in terms of experiencing any particular type of post-childhood sexual violence (any of the types of harassment/abuse or being forced/pressured to have sex; 74.4% vs. 61.3%; p = .123), compared with those who experienced no child sex abuse.

Furthermore, one third (n = 82, 36.4%; missing data from one respondent) of the sample reported having been in a relationship that was sexually, emotionally, verbally, or physically abusive. The majority of this subgroup (n = 63; 76.8%) reported telling someone about this abuse. Those who had been in an abusive relationship were more likely to have been sexually abused as a child (29.3% vs. 10.5%; p < .001), and to have experienced any post-childhood sexual violence (74.4% vs. 57.3%; p = .011), including any of the four post-childhood types of sexual harassment/abuse (62.0% vs. 46.2%; p = .023), compared with those who reported never being in an abusive relationship.

Correlates of Childhood Sexual Abuse

Table 2 lists the bivariate correlates of experiencing childhood sexual abuse. Participants who reported being sexually abused as a child experienced more types of sexuality-related

discrimination in the past year, and were more likely to have ever been in an abusive relationship, compared with their peers who did not report being sexually abused as a child; they were also marginally more likely to report at least weekly use of club drugs. Multiple regression analysis was performed to further examine the correlates of having experienced child sex abuse. As shown in Table 3, history of ever being in an abusive relationship post-childhood was associated with nearly triple the odds (adjusted odds ratio, OR [95% confidence interval, CI] = 2.77 [1.31, 5.88]) of having experienced child sex abuse, and experiencing a greater number of types of sexuality-related discrimination was also an independent correlate (adjusted OR [95% CI] = 1.25 [1.01, 1.55]), after controlling for the other independent variables.

Correlates of Sexual Violence Post-Childhood

Table 2 lists the bivariate correlates of experiencing any sexual violence post-childhood. Participants who reported any of the four types of sexual harassment/abuse or who had been forced/pressured to have sex in adolescence or adulthood were more likely to report at least weekly use of marijuana and a greater number of substances used in the past 3 months compared with those who experienced no post-childhood sexual violence; they were also marginally more likely to use club drugs at least once a week. Having experienced sexual violence post-childhood was significantly associated with reporting a greater number of types of sexuality-related discrimination in the past year, having been in an abusive relationship, and reporting a greater number of male sex partners in the past 3 months, in comparison with those who did not experience post-childhood sexual violence; it was also marginally associated with being more likely to have engaged in any condomless anal sex with partners whose HIV status was positive or unknown in the past 3 months (among participants who did not report being HIV positive).

In multiple regression analysis, greater number of types of sexuality-related discrimination events experienced in the past year (adjusted OR [95% CI] = 1.48 [1.19, 1.84]) and number of sex partners in the past 3 months (adjusted OR [95% CI] = 1.07 [1.00, 1.15]) were both independently associated with higher odds of having experienced any sexual violence post-childhood (see Table 3). Although several substance use variables were associated with sexual violence in the bivariate analysis, we chose to include only one substance use variable in the model to avoid issues related to multicollinearity; we present the model with the inclusion of number of substances used in the past 3 months, but we also repeated the model with marijuana use and club drug use as replacements, and similar results were obtained (data not shown).

Discussion

This study with young MSM residing in Lebanon brought to light the high rates of lifetime experiences of sexual violence. Nearly one fifth of the sample reported having experienced sexual abuse as a child, defined in the study by having been pressured or forced to have sex prior to the age of 13 years, and nearly two thirds reported experiences of sexual violence in adolescence or adulthood. Also, being sexually abused as a child was associated with experiencing sexual harassment or abuse as an adult and having been in an abusive

relationship, suggesting the pervasive nature that sex abuse can have in one's life and relationships for MSM who are survivors of child sex abuse. Our findings also shed light on the psychosocial and sexual correlates of being a survivor of sexual violence in this population, specifically with regard to substance use, sexuality-related discrimination, and sexual behavior.

The high rates of sexual violence in both childhood and post-childhood as experienced by the men in our study are consistent with other studies of MSM conducted outside of the Middle East (Finneran & Stephenson, 2013; Lloyd & Operario, 2012). We are unaware of any other study of such experiences among MSM in the Middle East, but our findings related to child sex abuse are consistent with rates of male child sex abuse in Egypt (Aboul-Hagag & Hamed, 2012).

Survivors of child sex abuse in this study were more likely to experience sexual violence post-childhood, which is consistent with research that has examined the aftermath of traumatic experiences (De Venter, Demyttenaere, & Bruffaerts, 2013; Schilling, Aseltine, & Gore, 2007), especially traumatic experiences of a sexual nature. Researchers have referred to this as "revictimization"—when the sexual violation reoccurs in adulthood (Messman & Long, 2003). Furthermore, aligned with research examining the long-term impact of child sex abuse on interpersonal relationships in adulthood, our results showed that adult men who have experienced a form of sexual violence as young boys were more likely to be engaged in abusive relationships as adults (Putnam, 2003). Researchers have attributed this to unresolved trauma where individuals are unable to identify "safety" which in turn leads to the creation of a pattern of abuse, especially in relationships. This in turn makes survivors unable to discern "healthy" relationships from those that will perpetuate and replicate harm that they had experienced (Levine, 1997). Participants who were survivors of sexual violence were thus more likely to engage in riskier relational choices, particularly being in emotionally, physically, and sexually abusive relationships. Therefore, the young men in our study might be unable to discern and maintain healthy personal boundaries, especially in intimate settings, as maintaining healthy personal boundaries is impaired by a history of trauma (Van der Kolk, 2014).

In their theory of "sexual traumatization," Finkelhor and Browne (1985) speculate that childhood sexual violence acts as a precursor to unhealthy sexual activities and sexualized behaviors. Individuals who have been sexually violated as children are more likely to sexualize their relationships (Alaggia & Mishna, 2014), that is, to approach and engage in relationships from a sexual perspective. This often leads survivors of sexual trauma to have a greater number of sexual partners (Lalor & McElvaney, 2010; Lloyd & Operario, 2012), which is consistent with our data showing that men who had experienced sexual violence post-childhood had twice as many recent male sex partners. However, further research is needed to explore whether these implications of childhood sexual abuse and trauma exist for the sexuality and adult sexual relationships of young MSM in Lebanon.

While research that has studied the experiences of MSM in the context of HIV risk has found that this population may be more likely to engage in riskier sexual activity when they had been sexually violated as children (Banducci, Hoffman, Lejuez, & Koenen,

2014; Tomori et al., 2016), or had experienced sexual violence as an adult (Stephenson & Finneran, 2017), we did not find strong evidence for such associations in Beirut. Condomless anal sex with male partners whose HIV status was positive or unknown was only marginally associated with any history of post-childhood sexual violence and not related at all to childhood sexual abuse, among the men in our sample who did not report to be HIV positive.

Consistent with trauma research that suggests that survivors of sexual violence are more likely to abuse substances (Brems, Johnson, Neel, & Freemon, 2004; Rosenberg, 2011), we observed bivariate correlations between various measures of recent and frequent substance use and exposure to sexual violence in childhood and post-childhood. While our research did not inquire into the reasons why participants frequently use substances, we speculate that these may constitute attempts at self-soothing and self-regulating for survivors of generalized and sexual trauma (Gallop, 2002). More research is needed to understand the substance-seeking behaviors of MSM who are survivors of sexual violence in the Middle East and North Africa (MENA) region.

Activist accounts and literature on the lived experiences of young lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth highlight the different forms of violence and discrimination that this marginalized group faces. Study participants who reported greater recent sexuality-related discrimination were more likely to experience sexual violence as a child and in post-childhood. These findings are consistent with research documenting the effects of verbal and physical harassment and discrimination in this population (Collier, Van Beusekom, Bos, & Sandfort, 2013). More research is needed to understand how these discriminatory violent acts intersect with gender expression and sexual orientation and the overall well-being of this marginalized group.

Limitations

One limitation to this study is potential for recall bias when responding to questions about past sexual violence. Many survivors of sexual violence do not recall their experiences due to the traumatic nature of these violations. Social desirability may also bias the findings through underreporting of sexual violence and a desire not to acknowledge an event that is usually associated with shame and guilt. Other measurement limitations relate to how childhood and post-childhood sexual violence were defined. Child sex abuse was defined as having been forced or pressured to have sex prior to the age of 13 years, which is a younger cutoff age than what is typically used, but which was necessitated by the nature of the measure we used; similar events of sexual violence that occurred between the ages of 13 and 17 should likely have been designated as child sex abuse (e.g., those that occurred prior to age 15). The measure of four specific types of sexual harassment/abuse asked about events that were presumed to occur post-childhood, that being in adolescence or adulthood, but it is possible that such events could have occurred below age 13, albeit rare. Also, the sample of participants that we recruited is between the ages of 18 and 29, residing in Beirut, highly educated, and mostly self-identified as gay; therefore, it is not representative of MSM who are less educated and do not identify as gay. The generalizability of the data is likely further hampered by selection bias, especially in a setting that highly stigmatizes sexual minorities,

as men who are more comfortable with their sexual identity may have been more likely to be comfortable participating in this study. These limitations not withstanding, we believe our measurement of these constructs is sufficiently valid to provide meaningful findings, particularly in the absence of other such research in the Middle East with MSM.

Conclusion

The prevalence of sexual violence along with its correlation with various forms of sexuality-related discrimination among this sample of young MSM living in Beirut is alarming. The research community and public health practitioners need to acknowledge that sexual violence among MSM is a serious sexual health issue that requires more holistic research to better understand the lived experiences of MSM with sexual violence. While most preventive efforts have focused on reducing HIV risk among MSM, more efforts are needed in providing post-violence care for survivors and in the prevention of sexual violence, on a local, regional, and global level. As researchers and activists work to reduce the stigma from HIV, similar work needs to be applied to sexual violence so that more young men can speak up about their trauma without shame.

On a clinical level, health care providers need to address the issue of sexual violence among men. Early and sensitive screening for a history of sexual violence needs to be added while taking the sexual health history of MSM. Broader and more integrated knowledge of sexual violence needs to be addressed in curricula of nursing and medical schools. Similar efforts need to be tailored for mental health providers who need to screen their patients and clients for a history of sexual violence when looking at other problems such as substance abuse or compulsive sexual behavior, which may be associated with experiences of sexual violence. This is not to say that experiences of sexual violence result in or cause these other psychosocial problems, for these associations may be bidirectional (e.g., substance abuse and multiple sex partners may heighten the risk for sexual violence), but rather it argues for a holistic approach to the health of MSM.

Groups and activists working on ending sexual violence need to include male survivors in their campaigns. More efforts are needed to encourage male survivors to discuss their experiences, and to not feel shame for such events, so that more men are empowered to speak up about such experiences. On a legal level, the Lebanese penal code needs to reconsider its legal definition of sexual harassment and rape so that it is more inclusive of male survivors. Also, abolishing Article 534 from the Lebanese penal code, which criminalizes homosexuality, would help to reinforce the holistic health of MSM who do not disclose sexual violence out of fear of being persecuted and/or arrested for their sexual identities and/or orientations. The fight against sexual violence goes hand in hand with ending all forms of oppression and discrimination.

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Table 1.

Sample Characteristics.

	M (SD)/%
Socio-demographics	
Age between 18 and 24 years	60.2%
Education	
Did not complete high school	4.9%
Completed high school	9.7%
Attended some university	50.0%
University degree	35.4%
Currently attending university	45.6%
Religious affiliation	
Christian	24.0%
Muslim	38.0%
Other	28.1%
Atheist	10.0%
Monthly income <US$1,000	70.3%
In a committed relationship	24.6%
Legal residency status in Lebanon	86.3%
Self-identify as gay	81.9%
Experiences of sexual violence	
Experienced child sex abuse	17.3%
Ever had any of the following experiences of sexual harassment/abuse	
Taken sexual advantage of when too drunk/high to stop it	18.3%
Taken sexual advantage of by someone threatening to spread information about your sexual orientation	18.6%
Someone used any kind of rape drug to take sexual advantage of you	7.6%
Were sent violent/threatening messages after you refused to have sex	34.2%
Any experience of sexual harassment or abuse	51.8%
Number of types of sexual harassment/abuse ever experienced	0.77 (0.88)
Any history of sexual violence post-childhood	143 (63.3%)
Been in abusive relationship (sexually, emotionally, verbally, or physically)	36.4%

Table 2.

Bivariate Correlates of Having Any Experience of Sex Abuse as a Child and Any Sexual Violence Post-Childhood.

	Any Child Sex Abuse?			Any Adult Sexual Violence?		
	No (*n* = 187)	Yes (*n* = 39)	*p*	No (*n* = 83)	Yes (*n* = 143)	*p*
Age between 18 and 24 years	59.1%	66.7%	.382	56.6%	62.2%	.406
Any university education	83.9%	92.3%	.176	84.3%	86.0%	.731
Employed	58.1%	61.5%	.689	59.0%	58.0%	.884
Monthly income <US$1,000	70.9%	66.7%	.602	67.9%	71.6%	.558
In a committed relationship	26.6%	15.4%	.139	28.9%	22.0%	.245
Legal residency status	87.1%	84.6%	.679	88.0%	85.3%	.579
Self-identifies as gay	82.1%	86.8%	.693	84.0%	82.4%	.713
Clinically depressed (PHQ-9 > 9)	25.8%	25.6%	.983	24.1%	27.3%	.600
Suicidality						
Any history of suicidal ideation	32.3%	38.5%	.455	29.3%	35.7%	.327
Any history of having suicidal plan	14.0%	17.9%	.524	13.4%	15.4%	.688
Number of types of sexuality-related discrimination experienced in the past year	1.54	2.36	.005	1.14	2.01	.000
At least weekly use of the following substances in the past 3 months						
Alcohol	53.2%	61.5%	.343	50.6%	57.3%	.326
Marijuana	11.4%	15.4%	.482	6.1%	15.4%	.039
Club drugs	3.2%	10.3%	.074	1.2%	6.3%	.066
Number of substances used	2.03	2.31	.391	1.66	2.31	.004
Ever been in an abusive relationship	31.2%	61.5%	.000	25.6%	42.7%	.011
Number of male sex partners in the past 3 months	4.6	5.9	.461	2.7	6.0	.002
Any condomless anal sex in the past 3 months, with partner whose HIV status was positive or unknown[a]	15.0%	8.1%	.203	8.5%	16.9%	.082

Note. PHQ-9 = nine-item Patient Health Questionnaire.

[a]Among those who did not report to be HIV positive (*n* = 218).

Table 3.

Logistic Regression Analysis of Correlates of Experiencing Child Sex Abuse and Sexual Violence Post-Childhood.

	Experienced Child Sex Abuse OR (95% CI)	Experienced Sexual Violence as an Adult OR (95% CI)
Had been in a relationship that was abusive (emotional, physical, or sexual)	**2.84 [1.47, 5.40]**	1.48 [0.74, 2.97]
Number of types of sexuality-related discrimination experienced in the past year	**1.26 [1.02, 1.54]**	**1.44 [1.13, 1.85]**
Any condomless anal sex with HIV+/ unknown status male partner in the past 3 months	—	1.32 [0.45, 3.89]
Number of sex partners in the past 3 months	—	**1.07 [1.01, 1.14]**
Number of recreational substances used in the past 3 months	—	1.22 [0.98, 1.51]
At least weekly use of club drugs	2.75 [0.82, 9.20]	—

Note. OR = odds ratio; CI = confidence interval.

Odds ratios in bold type are statistically significant (p<.05).