

Depression and Quality of Life in Older Gay and Bisexual Men in Spain and Portugal

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Abstract

The purpose of this study was to assess levels of depressive symptoms and quality of life in older gay and bisexual older Spanish and Portuguese men and explore associations between these two samples and these variables. Using online surveys, 191 older gay and bisexual men from Spain and Portugal (mean age = 70 years) completed the Spanish and Portuguese versions of the Center for Epidemiologic Studies—Depression Scale and World Health Organization Instrument to Assess Quality of Life. Overall, moderate levels of depression and quality of life were found. Gay men and Spanish men report higher levels of depressive symptoms than bisexual and Portuguese men. Gay men score higher on physical health dimensions; bisexual men score higher on the social relationships dimension. Lower levels of physical health, psychological symptoms, and social relationships were significant predictors of depressive symptoms. These exploratory findings offer both similarities and differences between the samples from the two countries—and with U.S. data—and further evidence of the pervasive experience of depression in the lives of sexual minority older men with a renewed awareness of myriad contexts within which individuals age.

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Introduction

The aging Lesbian, Gay, Bisexual and Transgender (LGBT) communities are growing in visibility throughout the western world. Estimates of the numbers of LGBT persons are hampered by the absence of census or generalizable data (Choi & Meyer, 2016); still, in the United States, estimates of the numbers of LGBT persons aged 50 years and older range from 2.4 million to 4 million persons (Administration on Aging, 2014; Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015). Framed in another way, recent estimates suggest that 4.5% of LGBT adults identify as LGBT—increasing a full percentage point since 2012 (Gallup, 2018). The numbers of LGBT persons in other western nations are not as readily available, though a Dalia (2016) poll found that 5.6% of Europeans identify as LGBTQ. (It is interesting to note that, in an earlier Dalia pool, the percentage of European respondents who identified as *not only heterosexual* was twice as high as those who identified as LGBTQ; perhaps this difference comprises bisexuality, but some of this difference might also be language, customs, culture, and politics.)

Somewhat more thoroughly studied has been the psychosocial experiences of LGBT adults, although the understanding of transgender experiences is uneven and lags behind (Choi & Meyer, 2016). Overall LGB older persons, relative to heterosexual older adults, report poorer mental health and greater mental distress (e.g., Wallace, Cochran, Murazo, & Ford, 2011). For older LGB adults, there is an estimated 29% likelihood of presenting clinically significant depressive symptomatology (Fredriksen-Goldsen et al., 2013). Among these groups, gay men, especially, tend to experience even higher rates of depression (Cochran, Sullivan, & Mays, 2003).

Depression, particularly untreated, has a negative impact on quality of life (Chapman, Perry, & Strine, 2005; Fiske, Wetherell, & Gatz, 2009); several studies show that social support and interpersonal interactions are protective factors that decrease levels of depression and increase overall levels of quality of life (Wight, LeBlanc, de Vries & Detels, 2012). Findings add further evidence of the importance of friends, neighbors, and relatives in providing social support to LGB older adults (de Vries & Megathlin, 2009), particularly when predicting higher levels of mental health (lower levels of depression and anxiety) and quality of life (Masini & Barrett, 2008).

Symptoms of depression can compromise health in many ways among LGB older adults, including health-care engagement. Knowing this information may be helpful to provide screening for potential depressive symptomatology within both primary care and community aging-related service settings, as well as to

develop and offer necessary interventions that aim to promote both mental health well-being and health-care engagement among this vulnerable and growing population (Shiu, Kim, & Fredriksen-Goldsen, 2017).

Little research has focused on the study, the experience of depression, and quality of life among Southern European gay and bisexual men, such as Spain and Portugal. Both countries have transitioned, much like the United States, from repressive and exclusive environments for LGBT persons to more accepting and inclusive ones. Currently, both Spain and Portugal have marriage equality, gender identity transition recognition, nondiscrimination statutes protecting sexual orientation in employment circumstances; such characteristics depict an accepting environment.

Mesquida, Quiroga, and Boixados (2015) presented a summary of the needs and experiences of LGBT persons at least 50 years of age in Barcelona. Their results similarly have an increasingly familiar sound (e.g., de Vries, 2013) describing the higher rates of depression and anxiety (than those of the general population) of these older adults having survived the traumas of violence, exclusion and repression of their early life into later years of ongoing marginalization and vulnerability. There is a greater reliance on public and social services (Mesquida et al., 2015) often owing to alienation from biological kin, similar to U.S. findings (MetLife, 2010).

European data suggest, however, that differences exist between these two countries in the current environment for LGBT persons. For example, a European Commission study (2015) examined discrimination in the European Union across multiple dimensions, including sexual orientation and gender identity. Results revealed that 90% of respondents in Spain agreed with the statement, "gay, lesbian and bisexual people should have the same rights as heterosexual people"; 71% of Portuguese respondents replied affirmatively. Similarly, 87% of Spanish respondents agreed with the statement, "There is nothing wrong in a sexual relationship between two persons of the same sex"; the corresponding percentage of Portuguese respondents was 59%.

These social environments may well affect the psychosocial lives of LGBT persons living therein. Therefore, the purpose of this study was to assess levels of depressive symptoms and quality of life, comparing these two countries and exploring further associations between these two variables. This information is necessary to support the development of interventions to effectively promote health-care engagement among gay and bisexual older men, which is an important step toward developing strategies to reduce health disparities in this population.

Methods

Participants

A convenience sample of a total of 191 self-identified older gay and bisexual men participated in the study in comparable numbers: 98 participants were from

Spain and 93 were from Portugal. These men had an average age of 70.04 years ($SD = 5.60$), ranging from 65 to 82 years. No significant differences in age were found between participants from Portugal (average age = 68.94) and Spain (average age = 71.14). Nearly two thirds (60%) of participants identified as gay and 40% as bisexual, again in comparable proportions in both countries.

In Table 1, we describe in greater detail sociodemographic information of all participants in the study. It was a minority of both samples who reported being in some form of romantic relationship (33% for Portugal, about 40% for Spain). The majority of both samples lived in large urban centers; the Spanish samples were somewhat more highly educated. Surprisingly, almost 60% of both samples reported having children; the vast majority were retired; monthly income was reportedly sufficient, though almost 40% of the Portuguese men reported that it was not, compared with about 25% of the Spanish men. Similarly, more Spanish men owned their own homes/apartments than did the men from Portugal. The equality of variances for all variables was calculated for the two groups of Spanish and Portuguese participants with Levene's homogeneity test. The resulting p value ($>.05$) showed that the obtained differences in sample variances were homogeneous.

Measures

The survey included three categories of questions/measures: demographic information, depression symptoms, and quality of life.

Demographic information. Items included those summarized earlier: age, sexual orientation, marital status, place of residence, education, having children, current professional situation, sufficiency of monthly income, and the type of residence in which participants were living.

Depression. Participants' perceived levels of depression were measured using the Center for Epidemiologic Studies—Depression Scale (CES-D) (Radloff, 1977). The CES-D is a 20-item scale that has the objective of measuring depression symptoms in community populations. It is useful to screen for symptoms but not for confirming diagnosis. Participants answer questions based on the week preceding the evaluation using a 4-point scale ranging from 0 (*rarely*) to 3 (*most of the time*). The total score is calculated using a simple sum that varies from 0 to 60, with higher scores indicating more depressive symptoms. The Portuguese version (Gonçalves & Fagulha, 2014) and the Spanish version (Vázquez, Blanco, & López, 2007) of the CES-D were used. Since factor solutions are different for each country, we chose to use only the total score to calculate levels of depression, using the cutoff point of 16. Cronbach's α s for each country revealed excellent scores ($\alpha = .90$ for Portugal; $\alpha = .89$ for Spain).

Table 1. Sociodemographic Characteristics of the Participants ($N = 191$; Mean Age = 70.04 Years).

	Portugal ($N = 93$)		Spain ($N = 98$)	
	<i>n</i>	%	<i>n</i>	%
Sexual orientation				
Gay	55	59.1	59	60.2
Bisexual	38	40.9	39	39.8
Marital status				
Single	37	39.8	38	38.8
Married	16	17.2	18	18.4
Divorced/separated	22	23.7	16	16.3
Widower	2	2.2	5	5.1
De facto union	5	5.3	5	5.1
Emotional commitment	11	11.8	16	16.3
Place of residence				
Big urban place	61	65.6	58	59.2
Small urban place	23	24.7	31	31.6
Big rural place	5	5.3	5	5.1
Small rural place	4	4.4	4	4.1
Education				
Up to 4 years of school	8	8.6	3	3.1
Up to 9 years of school	25	26.9	16	16.3
Secondary education completed	42	45.1	38	38.8
University degree	18	19.4	41	41.8
Children				
Yes	52	55.9	56	57.1
No	40	44.1	42	42.9
Current professional situation				
Retired	65	69.9	70	71.4
Employed	28	30.1	28	28.6
Monthly income sufficient				
Yes	54	58.1	73	74.5
No	39	41.9	25	25.5
Residence type				
Owned house/apartment	48	51.6	68	69.4
Rented house/apartment	45	48.4	30	30.6

Quality of life. We used the brief version of the World Health Organization Instrument to Assess Quality of Life (WHOQOL-BREF) (Skevington, Lotfy, & O'Connell, 2004). This is a 24-item abbreviated version of the WHOQOL-100. The brief version covers four domains as well as the overall perception of QOL. The four domains are as follows: physical health (seven items); psychological relationship (six items); social relationship (three items); and environment

(eight items). The Portuguese version (Vaz Serra et al., 2006) and the Spanish version (Lucas-Carrasco, 1998) were used. The WHOQOL-BREF is a sound and a cross-culturally valid assessment of quality of life (Lucas-Carrasco, Laidlaw, & Power, 2011). Cronbach's α 's for each country revealed excellent scores ($\alpha = .92$ for Portugal; $\alpha = .90$ for Spain).

Procedures

The survey was conducted between January 2018 and March 2018. Recruitment targeted specifically older gay and bisexual men and involved Internet notifications (emails and electronic messages) and advertisements sent to LGB organizations (such as FELGTB—National Federation of Lesbians, Gays, Transsexuals and Bisexuals of Spain, ILGA—Portugal and Opus Gay—Portugal), social networks such as Facebook, and mailing lists. Participants responded to this outreach online by way of two websites created for this purpose, one in Portuguese and another one in Spanish. All advertisements referred participants directly to the online survey according to the respective nationality, where they were informed that their responses would be anonymous and confidential, according to the Helsinki Declaration of Ethical Principles for research with human subjects. Also, this study was approved by the Ethical Committee of the University of Beira Interior (Portugal). The first page of the questionnaire explained the objectives of the study and informed participants about how to complete the survey, their freedom to withdraw from the study, and how to contact the authors for further information, if needed. Confidentiality was assured by using codes on data documents, by encrypting identifiable data, by assigning security codes to computerized records, and by limiting access to identifiable information (IP address).

Results

Depression

Overall results for depressive symptoms indicate moderate levels of depression (mean score = 18, $SD = 6.70$, median = 16, mode = 14, ranging from 5 to 39), which is higher than the cutoff point of a mean score of 16. When comparing levels of depressive symptoms between sexual orientations (gay vs. bisexual men) and Spanish and Portuguese participants, significant differences were found: Self-identified gay older men and Spanish older men present higher levels of depressive symptoms than bisexual older men and Portuguese older men (see Table 2 for these results).

Table 2. Results for Depressive Symptoms by Sexual Orientation and Nationality.

	<i>n</i>	<i>M (SD)</i>	<i>T (df)</i>	<i>p</i>
Depressive symptoms				
Gay men	114	18.17 (7.05)	2.445 (160)	.016*
Bisexual men	77	15.90 (5.31)		
Portuguese	93	16.97 (6.49)	−2.049 (160)	.042*
Spanish	98	19.13 (6.89)		

* $p < .05$.

Quality of Life

To assess levels of QOL for all dimensions, cutoff points were determined for each dimension and the observed mean was then compared with the respective cutoff, adhering to the criteria established for the critical value of 60% as the optimal cutoff point for assessing perceived quality of life in older people (Silva, Soares, Santos, & Silva, 2014). For the overall perception of QOL, a mean of 7.19 ($SD = 1.45$) was obtained, ranging from 3 to 10, indicating that participants perceived moderate levels of QOL since the cutoff point would be 7. No significant differences were found between gay and bisexual, and Spanish and Portuguese participants. Regarding the domain of physical health, a mean of 28.15 ($SD = 4.59$) was obtained, ranging from 12 to 35, indicating that perception of physical health was moderately positive, since the cutoff point for this dimension was 24. Self-identified gay men scored higher than bisexual men for this dimension ($p = .049$). No differences were found between Spanish and Portuguese participants for this dimension. For the psychological dimension, a mean of 23.15 ($SD = 4.08$), ranging from 10 to 30, was obtained, indicating moderate levels of QOL for this dimension, since the cutoff point was 20.5. No significant differences were found when comparing our participants by sexual orientation and nationality. Regarding the social relationships dimension, a mean of 10.59 ($SD = 2.54$) was found, ranging from 3 to 15, indicating moderate levels of QOL for this dimension, since the cutoff point was 10. Statistically significant differences were found indicating that bisexual men display higher levels of social functioning than gay men ($p = .023$). No differences were found for nationality. Finally, for the environmental dimension, a mean of 30.68 ($SD = 4.59$) was found which indicates moderately high levels of QOL of this dimension, since the cutoff point was 28.5 (with a range of 18 to 40). No significant differences were found when comparing sexual orientation and nationality for this dimension. All the results for QOL by sexual orientation and nationality are presented in Table 3.

As shown in Table 4, a correlation analysis was conducted to determine levels of association between depressive symptoms and QOL. Correlation coefficients

Table 3. Results for Quality of Life by Sexual Orientation and Nationality.

	<i>n</i>	<i>M (SD)</i>	<i>t (df)</i>	<i>p</i>
Overall quality of life				
Gay men	114	7.26 (1.52)	−.306 (159)	.760
Bisexual men	77	7.34 (1.25)		
Portuguese	93	7.25 (1.47)	−.392 (159)	.696
Spanish	98	7.34 (1.43)		
Physical health				
Gay men	114	74.23 (16.87)	−1.825 (153)	.049*
Bisexual men	77	79.28 (13.70)		
Portuguese	93	77.21 (17.06)	−1.305 (153)	.229
Spanish	98	73.60 (14.71)		
Psychological				
Gay men	114	70.00 (17.94)	−.898 (156)	.194
Bisexual men	77	73.87 (14.40)		
Portuguese	93	72.23 (17.31)	.567 (156)	.371
Spanish	98	69.59 (16.64)		
Social relationships				
Gay men	114	60.67 (21.67)	−2.302 (158)	.023*
Bisexual men	77	68.85 (19.18)		
Portuguese	93	65.33 (20.69)	1.581 (158)	.116
Spanish	98	59.89 (21.74)		
Environment				
Gay men	114	72.57 (14.83)	−.009 (156)	.993
Bisexual men	77	72.37 (12.77)		
Portuguese	93	72.40 (14.97)	−.241 (156)	.810
Spanish	98	72.68 (13.24)		

* $p < .05$.**Table 4.** Results for the Correlation Matrix Between Depressive Symptoms and Quality of Life.

	1	2	3	4	5	6
1—Depressive symptoms	—					
2—Overall quality of life	−.325**	—				
3—Physical health	−.557**	.449**	—			
4—Psychological	−.610**	.510**	.488**	—		
5—Social relationships	−.527**	.446**	.430**	.661**	—	
6—Environment	−.399**	.636**	.503**	.600**	.536**	—

** $p < .001$.

Table 5. Hierarchical Multiple Regression Analysis Predicting Depressive Symptoms.

Variable	Model 1			Model 2		
	B	SE B	β	B	SE B	β
Age	.024	.082	.029	.039	.066	.048
Country of origin	1.907	1.395	.139	.515	1.125	.038
Sexual orientation	-2.792	1.577	.182	-1.493	1.264	-.097
Overall QOL				.691	.573	.141
Physical health				-.107	.050	-.254*
Psychological				-.141	.053	-.344*
Social relationships				-.073	.034	-.237*
Environment				.018	.178	.012
R^2	.065			.451		
F for change in R^2	2.287			9.652**		

Note. QOL = quality of life.

* $p < .05$. ** $p < .001$.

were all strong or very strong and statistically significant ($p < .001$), indicating that depressive symptoms are negatively associated with all dimensions of QOL.

Finally, a hierarchical multiple regression analysis was performed to assess the effects of overall perception of QOL on depressive symptoms. The possible confounding variables “age,” “sexual orientation,” and “country of origin” were added in the first block. All dimensions of QOL were added in the second block. The first block of the analysis explained 6.5% of the overall variance, while the second block—QOL—explained 45%. Therefore, as shown in Table 5, lower levels of physical health, psychological symptoms, and social relationships were significant predictors of depressive symptoms in the second step.

Discussion

The results of this research showed overall moderate levels of both depression and of perceived quality of life. Older gay men and older Spanish men reported higher levels of depressive symptoms than older bisexual and older Portuguese men. Gay men scored higher on physical health dimensions, but bisexual older men scored higher on the social relationships dimension. Lower levels of physical health, psychological symptoms, and social relationships were significant predictors of depressive symptoms not influenced by country or sexual orientation. All differences were statistically significant ($p < .05$). Thus, this study offers an exploratory, preliminary, and unique cross-national contribution to the literature on aging and psychological well-being among older gay and bisexual men. Findings reveal many similarities both between the two samples from

Spain and Portugal and with existing (primarily North American) research, some nuances, and offer evocative questions for subsequent research.

Demographics Circumstances

Demographically, these men share many similarities. The majority of the gay and bisexual men in these two samples (almost two-thirds across samples) are currently single (including those who are divorced, separated, and widowed). Such rates are dissimilar to those of comparably aged heterosexual men, yet consistent with U.S. research on the relational status of older gay and bisexual men (de Vries, 2013; Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emlet, 2017). Singlehood introduces potential vulnerabilities in later life in many domains, not the least of which includes the reduced potential for the provision of care.

Unlike much research in the United States, over half of these gay and bisexual men in this study report having children; in the United States, up to 75% of LGBT samples report not having children (e.g., Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010). The extent to which these children are either physically or emotionally available is not known; in U.S. research in San Francisco, it was found that 60% of older LGBT persons with children felt that their children were not available to time (Fredriksen-Goldsen et al., 2013). Still, relative to U.S. research, there exists greater potential support from children among these gay and bisexual Spanish and Portuguese men—an area that offers interesting prospects for subsequent research.

One demographic difference between the two samples lies in the perceived sufficiency of income; here, a greater proportion of Portuguese sample felt that their income was not sufficient as compared with the men in the Spanish sample. Such financial stressors, added to the stressors of aging in general, may well have an effect on quality of life and potentially increase vulnerabilities. Lee, Oliffe, Kelly, and Ferllatte (2017) have found, for example, that lower socioeconomic status is a predictor of depression and lower quality of life.

Affective Experiences

In the context of quality of life dimensions, gay men scored significantly higher than bisexual men on physical health (e.g., mobility, activities, pain, energy) and lower on social functioning (i.e., personal relationships, social support, sex). These differences offer a portrait of gay men as perhaps more physically active, though less socially engaged than bisexual men. Much North American research notes the relative isolation of older gay men in particular—perhaps at least superficially comparable to the reduced social engagement reported herein as observed by the lower levels of QOL obtained in the “social relationships” dimensions; such findings are typically associated with *poorer* physical health (Fredriksen-Goldsen et al., 2013). The extent to which this

alternative finding is based in/on culture, sample (e.g., internet based), or some interaction of these with sexual orientation remains to be seen and merits further research.

Concomitantly, the gay men of this sample exhibited higher symptoms of depression than bisexual men, consistent with previous research (Cochran et al., 2003; Warner et al., 2004). The higher rate of depressive symptoms may well derive, at least in part, from its association with lower social functioning (the two of which were significantly, negatively associated in overall correlations). Similar research has found that reduced support (Mustanski & Lui, 2012) and membership in a minority or socially disadvantaged groups (Lee et al., 2017) were related to depression and lower quality of life.

Interestingly, the Spanish sample of gay and bisexual men also presented higher levels of depressive symptoms than did the Portuguese sample. There is some previous supporting this finding and implicating health. Marti-Pastor et al. (2018), for example, examined health-related quality of life among a random sample of Barcelona residents finding that gay and bisexual men (as well as lesbians and bisexual women) reported significantly worse health-related quality of life; these authors propose that chronic conditions and health-related behaviors may account for a wide swath of differences by sexual orientation due to internalized stigma and anticipation of discrimination. Similar data on the poor health of older gay and bisexual men in Barcelona have been reported as well (Perez, Marti-Pastor et al., 2015).

Neither nationality nor sexual orientation contributed significantly to the regression analysis predicting depression; lower levels of physical health, psychological symptoms, and social engagement were significant predictors. These are the general predictors of some of the more specific associations cited earlier drawing from a building body of research on the sequel of poorer physical and mental health (Fredriksen-Goldsen et al., 2017) and fewer social and financial resources (Lee et al., 2017). These data offer international support for such associations.

Limitations and Future Directions

Several limitations ultimately restrict the generalizability of the findings of this exploratory research. The samples were disproportionately urban, well-educated men with Internet and technology access, recruited through social organizational and social network settings; the extent to which these gay and bisexual men are similar to men from other regions of the countries remains to be studied. However, the intention of this study was not to generalize the findings to all older gay and bisexual men but to provide a contribution from Spanish and Portuguese realities to better understand the obstacles that older gay and bisexual men experience. Finally, some of the measures included were more

presumptive than derivative (e.g., physical health); additional measures would have assisted in filling out the details and associations (e.g., social support).

Further comparative research would enhance this field—across European countries and beyond. For example, it would be of interest to explore the diurnal lives of older Spanish and Portuguese gay and bisexual men (and lesbian and bisexual women), both cisgender and transgender, given the varying social conditions of the countries of residence. In particular, the family ties and social connections are of interest. Much is studied, recently, in these domains in the United States and such comparisons would be intriguing. A better understanding of the experiences of sexual and gender minorities in such international contexts would contribute to the field of gerontology in general and to the better appreciation of, and service provision to, all older adults in particular—with a renewed awareness of myriad contexts within which individuals age.

National/International Relevance and Implications

Both Spain and Portugal, in a little over one generation, have gone from being among the most repressive to the most egalitarian societies for LGB people in the world. Under the fascist dictatorships of Franco in Spain and Salazar in Portugal, homosexuality was forbidden and LGB people were reportedly imprisoned in large numbers. But soon after both regimes collapsed in the mid-1970s, the new democracies embarked on a legal overhaul. Today, Spain and Portugal are among a handful of countries in the world that have enshrined in their constitutions the prohibition of discrimination on the grounds of sexual orientation. The two countries have presented legislation that is inclusive and protective of LGB people, such as the 2005 (Spain) and the 2010 (Portugal) laws allowing same-sex couples to marry, or the 2005 (Spain) and the 2016 (Portugal) laws allowing same-sex couples to adopt and joint-adopt children. Today, LGB identities share a great deal of visibility, especially in big cities across the Iberian Peninsula.

Nonetheless, discrimination can still be encountered in small villages and among some parts of society, and differences can be observed when comparing the two countries as well. For example, according to the European Union LGBT Survey (European Union Agency for Fundamental Rights, 2014), 38% of Spanish respondents felt discriminated against or harassed on the grounds of sexual orientation in the last 12 months, whereas for Portuguese respondents, the figure was 51%. Thus, it seems that Portuguese society is more restricted by negative societal attitudes toward LGB people than the Spanish one. Unfortunately, the European Survey is completely omissive of any reference to LGB *older* people.

Our results are consistent with accumulating data indicating that depression and quality of life can be diminished due to exposure to social discrimination, and policy makers need to be particularly aware of older gay and bisexual

people's needs in their social inclusion decisions—currently scarce in both countries. To begin addressing this omission, this study documented the depressive symptoms and quality of life among Gay and Bisexual older men, but more research is needed, namely, the inclusion of heterosexual older persons to address health disparities among these groups. In addition, qualitative research is needed to address the needs of LGB older persons that could translate into more inclusive policy measures, namely, innovation when implementing local and global actions to protect LGB older adults from the risk of depression and facilitating the improvement of their overall levels of quality of life.

Still, these data add to the international discourse on aging among sexual minority persons and contribute further to the evidence of depression experienced by gay and bisexual men. Furthermore, our results allowed the identification of several predictors of depression that may be influenced by cultural meanings of what it is like to be vulnerable to depression as an older gay or bisexual male in Spanish and Portuguese cultures, facilitating dialogue, questioning sources of oppression, and promoting of values which are committed to social change for this group of people, ensuring the implementation of prejudiced-free practice guidelines in these two countries and others.


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