Attitudes and Stigma Toward Seeking Psychological Help Among Saudi Adults

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Research Article

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Abstract

Background

In the Kingdom of Saudi Arabia (KSA), public attitudes and stigma toward mental health illness seem to prevent people from seeking psychological help, which results in having a negative impact on an individual's life. The primary objective of this study was to investigate people's attitude toward seeking psychological help and identify the extent to which the associated stigma is responsible for preventing them from seeking psychological help.

Methods

Two hundred and eighteen adults recruited from the community living in the Eastern Province of KSA completed the questionnaires, customized to create the Arabic version of Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF-A), the Arabic version of Stigma Scale for Receiving Psychological Help (SSRPH-A), and the Arabic version of Hopkins Symptom Checklist-25 (HSCL-25-A).

Results

Both stigma and psychological distress significantly affected attitudes toward seeking professional help. Further, it indicated that attitudes were negatively correlated with stigma while positively correlated with psychological distress. No significant difference in attitudes toward psychological help-seeking was identified between male and female participants. However, males displayed higher levels of stigma, while females showed greater psychological distress. Furthermore, the groups who received psychological treatment demonstrated more favorable attitudes toward seeking psychological help.

Conclusion

Stigma and psychological stress influence the attitudes toward treatment-seeking behavior for mental illness, making them two major predictors responsible for the underutilization of mental health services. More research is needed to assess specific sociodemographic disparities across more data sources and the factors that further contribute to the stigma and psychological distress.

Background

The World Health Organization has reported that about 25% of the World's population suffers from some form of mental illness, depression and anxiety being the almost common conditions [1]. At primary healthcare centers (PHC), the prevalence rate of psychiatric disorders is estimated to be 30–46%, with depression accounting for 20% of the total in KSA [2]. Saudi women and the elderly with any form of disability recorded a higher prevalence rate [3, 4, 5].

Mental illness (henceforth, MI) can cause severe distress and disability that impair the quality of life of the individual [6]. Though a treatable condition if diagnosed at an early stage, the stigma and negative attitudes toward MI inhibit the patients from seeking psychological help and impede their recovery from mental disorders [7].

There is no clear consensus on the definition of the stigma that can be universally applicable. However, it was first explored by Durkheim [8] as a social phenomenon and more recently as a negative social identity that often results in a person being disqualified from full social acceptance [9, 10, 11]. Later, it was further categorized as either public stigma or self-stigma that may work together to form a barrier to seeking psychological help [12, 13].

From a more help-seeking perspective, public stigma is defined as the prevalence of negative beliefs held by the general public toward persons with MI as undesirable or socially unacceptable [9]. Corrigan and Watson [14] have classified it as a composite of three distinct components: stereotypes, prejudice and discrimination; together, they tend to prevent persons with MI and their families from utilizing mental health services. For example, the person with MI is often perceived as insane, dangerous or incurable (stereotypes), feared by others (prejudice), or avoidant and incapable of making use of available resources (discrimination) [12]. On the other hand, self-stigma occurs when stigmatized persons with MI endorse and internalize these negative beliefs against themselves, which, in turn, evoke negative emotional and behavioral reactions [15]. In other words, the stigmatized persons might feel responsible for their own MI, and therefore, may bear greater feelings of shame and hesitation toward seeking psychological help [16]. Researchers have noted that attitudes toward seeking help are a powerful indicator of the intention to seek treatment, as they affect the individual's decision to seek help when dealing with a psychological problem [17, 18, 19].

As part of Kingdom's Vision 2030, the Saudi health authority intends to provide more counseling services to facilitate the primary mental healthcare system by increasing mental health clinics and clinicians across the Kingdom. It also attempts to promote mental health literacy (MHL) by providing knowledge and information about the causes of MI and the recognition and management of health symptoms that lead to more effective treatment [20, 21]. One study that supports this approach was targeted at college students by Cheng and collaborators [22] who found MHL to correctly identify symptoms of depression and generalized anxiety disorder and help students to develop positive attitudes toward seeking psychological help and suggest it for others if the need emerged. Hence, familiarity with MI tends to be associated with more positive attitudes and willingness toward seeking professional psychological help [23].

However, despite significant strides that have been made in improving knowledge and awareness of help-seeking behavior, underlying negative attitudes among the Saudi general public toward persons with MI still exist. A significant proportion of the population still chooses not to seek professional help when suffering from psychological distress. In a recent study held among the general Saudi population [24], knowledge about MI was found to be poor and associated with increased negative perception and

attitudes toward seeking professional help. Another similar study found that nearly half of college participants tended to hold negative attitudes toward mentally ill persons and management of MI [25]. In a large scale public study undertaken by Almubark and colleagues [26], approximately half (46%; n = 3557) of surveyed participants reported little knowledge about MHL and attributed risk factors to persons who were elderly, had low-income or lack of education, formerly married, and demonstrated a moderate pattern of utilization of health services. Akin to other Gulf Arab states [27], Saudi persons with disability may represent a stigma for their families, particularly women who are often ignored or hidden from taking part in social events out of fear of negative effects and lower marital prospects [28, 29]. This may represent a more realistic view of family member's affiliate stigma [30] identified across various sociocultural contexts [31, 32, 33, 34, 35] and associated with a greater tendency for a family member to internalize the negative consequences (e.g. shame, embarrassment, anger) linked with discriminatory public attitudes toward persons with MI [16]. Such findings point to a pressing need for further examining the beliefs about MI and MHL within the sociocultural context of Saudi laypersons.

More importantly, the need to seek psychological help can only be established when the existence of such a problem is recognized in the first place. Only then, the mental health services may be approached to solve the problem. This can be only achieved if mental health providers and policymakers are able to address two major barriers to mental health service utilization; that is, stigma and general attitudes of individuals and the society as a whole.

In a review of the extant literature, it was observed that there have been few attempts to investigate attitudes and stigma toward seeking professional help in KSA [7, 24]. Therefore, the purpose of the present study was to investigate Saudi adults' attitudes toward seeking psychological help and assess the level of stigma and other associated symptoms. We hypothesized that psychological help-seeking was significantly influenced by stigma/attitude, gender differences and distress

Method

Participants and setting

This cross-sectional study was carried out among 221 Saudi adults living in the Eastern Province of KSA. The participants were randomly selected from public places (coffee shops, universities, malls, supermarkets, hospitals, mosques, etc.). They were informed of the purpose of the study and voluntary participation including no penalty if they decided not to participate or withdraw from the study at any time without giving a reason. Three (1.4%) participants did not meet the inclusion criteria and were therefore excluded from the study. Hence, the data was collected from 218 participants who fulfilled the study's eligibility criteria (18 ≥ years old, of both genders, literate in the Arabic language, and willing to participate). The study was conducted as per the norms of the Declaration of Helsinki. Before starting the study, ethical approval (IRB – PGS –2021 –01-449) was obtained from the Ethics Committee of Imam Abdulrahman Bin Faisal University in Dammam. Data was collected after obtaining written consents from the participants.

Data collection and measures

Data was collected by using a data collection sheet consisting of four sections. The first section contained sociodemographic information, that is, gender, age, educational level, occupation, marital status, and socioeconomic status (SES). Participants were also classified based on whether they had previously received help from a mental health provider.

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF-Arabic)

The second section consisted of the Arabic version of Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF-A) [27], which is a 10-item scale evaluating attitudes of participants toward seeking professional help for psychological problems [36]. The items are rated on a 4-point Likert-type scale ranging from 0 ("disagree") to 3 ("agree"). For example, "I would want to get help if I were worried or upset for a long period of time". The items are then summed up with higher scores indicating more positive attitudes toward psychological help. The total ATSPPH-SF-A score is obtained by reversing half of the items 2, 4, 8, 9 and 10. The instrument was validated in a sample of Emirati (UAE) college students, with a reported low Cronbach's alpha of .65 and then .67 in a subsequent study by Vogel and colleagues [19]. In the current study, a similar low Cronbach's alpha value of 0.65 was obtained.

Stigma Scale for Receiving Psychological Help (SSRPH-Arabic)

The third section was comprised of the Arabic version of the Stigma Scale for Receiving Psychological Help (SSRPH-A). It is a 5-item self-reported instrument that measures the stigma associated with receiving psychological help. Items are rated on a 4-point Likert-type scale ranging from 1 ("strongly disagree") to 4 ("strongly agree") [37]. For example, the items included "It is advisable for a person to hide from people that he/she has seen a psychologist", and "people tend to like less those who are receiving professional psychological help". The SSRPH-A total score is obtained by summing up the five items with higher scores indicating levels of perceived stigma. The instrument was validated in a sample of Emirati college students, with an acceptable reported alpha of .70. In the current study, a similar satisfactory value of Cronbach's alpha of 0.72 was obtained.

Hopkins Symptom Checklist -25 (HSCL-25-Arabic)

The last section was the Arabic version of Hopkins Symptom Checklist-25 (HSCL-25 - A) validated in a sample of Palestinian college students to measure the presence and intensity of anxiety and depression symptoms (e.g., fear, self-blame) [38]. The HSCL-A is a 25-item self-report questionnaire that consists of two parts: part one has 10 items for anxiety symptoms, and part two has 15 items for depression symptoms. The scale for each question includes four response options (i.e., "Not at all", "A little", "Quite a bit", "Extremely," rated 1 to 4, respectively). The rating is based on the reported symptoms over the past week. Responses are summed and divided by the number of answered items to generate scores for anxiety and depression symptoms as well as emotional distress. Individuals with scores on anxiety and/or depression greater than 1.75 are considered symptomatic, whereas 1.75 is the cut-off point for

scientific validity. It was demonstrated that the overall scores of the inventory related to the acute emotional distress of an undetermined diagnosis. The Arabic validation sample excluded item 14, "Loss of sexual interest or pleasure", as this was culturally inappropriate to be examined. Thus, the scale was 24 items. The obtained Cronbach's alpha value was .90. In our study, we added the excluded item and obtained a highly alpha value of .92.

Data Analysis

Statistical analysis was performed using the Statistical Package of Social Sciences (SPSS) version 22.0. Frequencies and percentages were calculated to describe the data. One-way ANOVA was used to compare the stigma, psychological distress, and attitudes toward psychological help-seeking for independent variables containing multiple categories such as age groups, occupation, and marital status. An independent t-test was used for statistical testing of variables with only two categories (e.g., gender and past history of seeking treatment). Pearson's correlation was calculated to find a correlation between stigma, psychological distress, and attitudes toward psychological help-seeking and symptoms of anxiety and depression. Linear regression was used to further see which of the factors such as stigma and psychological distress influenced the attitude of a person toward seeking psychological help. Reliability statistics were concluded using Cronbach's alpha value set at $<.05$.

Results

Table 1 shows out of 218 participants, 100 (45.9%) were males and 118 (54.1%) were females. Their age ranged from 18 to 77 years, with a mean age of 33.9 (SD $\pm$ 11.9) years. The majority of the participants ($n = 167$, 76.6%) held a college degree and above. About 58 (26.6%) were professionals, 54 (24.8%) were technicians, 35 (16.1%) were students, 28 (12.8%) were housewives, 21 (9.6%) were unemployed, 15 (6.9%) were retired, and 7 (3.2%) ran private businesses. More than half of participants were married ($n = 119$, 54.6%) young adults (26–40 years; 53.7%) with middle income socioeconomic status ($n = 193$, 88.5%). Only 23 (10.6%) of all the participants had received treatment in the past.

As described in Table 1, the attitude toward seeking psychological help was found to be significantly associated with the history of previous treatment sought for the same condition. The amount of stigma for seeking psychological help was associated with gender and marital status. Moreover, the psychological distress was also significantly influenced by gender, age, occupation and history of previous treatment.

Table 2 shows the Pearson Correlation Coefficient, the correlation between stigma, psychological distress, and attitudes toward psychological help-seeking. Consistent with expectations, this revealed that attitudes toward seeking professional help were significantly negatively correlated with stigma ($r = -.242$, $p < .01$) and significantly positively correlated with psychological distress ($r = .186$, $p < .01$). Briefly, contrary to expectations, stigma was significantly positively correlated with psychological distress ($r = .197$, $p < .01$), and with depression symptoms ($r = .229$, $p < .01$).

Internal Consistency Of Self-reporting Instruments

For alpha analysis, the means and standard deviations of all measures were determined. Help-seeking (ATSPPH-SF-A) consisted of 10 items yielding a low alpha ($\alpha = .65$). Stigma (SSRPH-A) consisted of 5 items showing a satisfactory alpha ($\alpha = .72$). Psychological Distress (HSL-25-A) was found to be highly reliable (25 items; $\alpha = .92$; see Table 2).

Table 3 represents the standard linear regression, where the calculation was used to test whether the stigma and psychological distress significantly predicted participants' attitudes toward seeking psychological help. The results of the regression indicated that the predictors explained 11.5% of the variance [$R^2 = 0.115$ ($F(3,194) = 7.173, p < 0.001$)]. It was found that both stigma ($\beta = -.28, p < .001$) and psychological distress ($\beta = .24, p < .01$) significantly predicted attitudes.

Discussion

The purpose of the present study was to examine the attitudes of people toward seeking psychological treatment, evaluate the stigma that prevents them from seeking such help, and the relationship between psychological distress, attitudes and stigma.

Help-seeking Attitudes

The literature suggests that attitudes toward seeking psychological help are a strong indicator of behavior and intention to seek help when confronted with an individual psychological problem [39,40]. Our study found that the participants who previously received psychological treatment displayed more positive attitudes toward seeking psychological help than those who had not received treatment. However, the proportion of those who sought psychological help was markedly small (10.6%), perhaps suggesting participants' insufficient information on MI [26], distress level [41], or physicians' poor knowledge about MHL. Al-Atram [42] emphasized the persistence of the negative attitudes toward people with MI within Saudi mental health professionals. The author investigated knowledge and attitudes toward MI among 142 healthcare practitioners from various health fields, and the results showed that nearly two-thirds (63.9%) of participants had never referred any case to a psychiatrist. Except for only a small proportion of family practitioners (8.3%), the majority (86.3%) of practitioners reported to have no interest in psychiatry. Hence, efforts are required to be made at increasing knowledge about MI among Saudi healthcare professionals as education has consistently been linked to more favorable attitudes and readiness to make social contacts with persons with MI [16,23]. Surprisingly, in our study, education and socioeconomic variables failed to predict negative attitudes toward seeking help. This was consistent with previous research findings indicating that the two variables could predictably affect other social processes but had an inconsistent and rarely significant effect on stigma or negative attitudes [43,44].

In the literature review of previous studies, no significant gender differences were found in terms of attitudes toward seeking psychological help in one study [45,46]. Contrariwise, other researchers found a significant association between attitude and gender as women tended to have more favorable attitudes and willingness to seek psychological help [47,48,49]. While it was reversed in Khan et al.'s [45] study where women with internalizing stigma tended to consistently experience discrimination and social withdrawal that likely evoked negative attitudes toward seeking professional help. Such discrepant findings may be linked to the use of different study designs or research measures that render incomparable results.

Stigma and Help-seeking Attitudes

Stigma was the first predictor of attitudes toward seeking psychological help and was significantly and negatively associated with attitudes within the sample. This finding was similar to those of previous studies across many different sociocultural contexts [17,19,40,47].

Gender differences were identified at the level of stigma perceived for seeking help, showing that males had a higher level of perceived stigma than females. This result could be explained within the setting of the Saudi sociocultural context, whereby if a man has a psychological problem, asking for help outside the family may be seen as a sign of weakness or a source of shame to himself or his family [50]. One of the reasons why men do not ask for psychological help is that it does not fit with their cultural beliefs about masculinity and the acceptable male behavior [51]. Chatmon [52] referred to this as toxic masculinity that may lead to difficulty in expressing emotions and restriction in behaviors. Furthermore, the relationship between the stigma of mental health and the recognition of the need to seek help may reflect cultural beliefs that a mental health disorder is shameful, and issues must be solved by oneself or within the family [36,35]. Abdullah and Brown [50] suggested that those seeking mental health services are often encouraged to reveal their emotions. However, the self-disclosure required for treatment may violate the value of family honor and yield more negative consequences connected with self-stigma and discrimination in social relationships, employment and healthcare [16]. The results may be explained by the role of traditional male gender expectations, which discourage expressions of emotion and pain and demand strength and self-reliance [36,35].

Interestingly, the study found that stigma toward mental health issues was higher among married persons. This could be explained by the fear of violating the honor of the family and maintaining its image and the lack of social support from the partner to maintain marital relations. Studies in the Saudi environment have found that most persons with MI and their relatives consider these perceptions to be an obstacle for married people who require psychological help [20]. Our study showed that over half (54.1%) of the participants were married, but only a small proportion among them (10.6%) sought treatment.

Stigma was significantly and positively correlated with psychological distress, specifically with depressive symptoms. Whenever the perception of stigma increased, psychological distress also increased, as indicated in previous studies reviewed to understand mental health illnesses [37]. Moreover,

the Saudi society embodies an Islamic culture that associates a person's suffering or illness to the Will of God. It is believed that only regular prayers, healing rituals (e.g., incantation, cauterization) or a sense of personal responsibility can help treat such conditions [53]. Some scholars [16,54] argued that casual explanations attributed to the internalizing factor of self-responsibility could lower the general public's willingness to interact with persons with MI as it may focus the problem more on an individual's cognitive processing of information rather than on his or her subjective experience of stigmatization such as discrimination and isolation. However, this result needs further study to identify the differences between self-stigma and social stigma, improve education about and awareness of MI in the community and health institutions, treat it like a physical illness, and overcome the fear of people suffering from mental problems.

Psychological Distress and Help-seeking Attitudes

Expectedly, psychological distress was a significant predictor of psychological help-seeking attitudes. However, this relationship was found to be positive, as increased distress was associated with more positive help-seeking attitudes within the sample. Specifically, the results supported the hypothesis of the study [42,49]. One study found that psychological distress was a positive predictor of attitudes toward seeking professional psychological services [38].

Wide gender differences were detected at the level of distress, which found that women displayed higher levels of psychological distress and natural inclination to seek help. These differences are firmly rooted in women's greater tendency to evaluate and interpret events as threatening and a higher sensitivity to pressure from the people around them as they tend to be more emotionally involved in social and family networks compared to men [39]. The scales were collected from residents of highly urbanized areas, and literature indicated that urban areas suffer more from psychological distress than rural areas [32]. Men, on the other hand, traditionally employ action and mastery strategies to prevent and relieve psychological distress by keeping busy, exercising, helping others or taking time out, among others. Furthermore, sociocultural pressures are often more influential over women. For example, in a male-dominated society, women are expected to comply with a two sets of values i.e., domestic and professional. This results in a conflict of roles, which likely leads to more emotional distress. Denton and associates [41] found exposure to stress in social life, financial stress, parenting stress, environmental stress, family health stress, and job stress to be positively associated with psychological distress. Our analysis showed that being a married woman aged 26-40 years, employed and had a previous history of psychological treatment was associated with a considerably high level of distress, while education and SES levels insignificantly emerged as contributing factors to stressful conditions among these women. Aldossari [5] provided several potential reasons that place Saudi women at a higher risk of distress and poor health, including family caregiving roles, mobility restrictions, economic hardship, and marital conflicts, among others.

However, new legislation for improving women's rights was implemented by the Saudi Government based on granting permission to drive, providing more work opportunities and loosening restrictions on

mobility and travel abroad without approval from a *mahram* (husband or male relative whom she is prohibited to marry) [55]. These reforms remarkably increased the presence of female participation in the workforce as the rate climbed from 18.6% in 2011 to 23.37% in 2018, and during the first half of 2021, 59% of Saudi citizens recruited within the private sector were women (56,57).

Interestingly, our study found that those in the 18-25-year-old age group were mostly students and had high levels of psychological distress. This is likely due to the fact that the sample was collected during the time of student examinations, which stimulated deleterious psychological distress as opposed to a more positive, motivating stress that improves academic performance and promotes general wellbeing. This finding has also been reported and supported by other studies [58]. Finally, the study found that people who had private businesses had the highest rate of psychological distress caused by the extra workload associated with running a business. This group may also be affected by additional general stressors (e.g., parenting, childcare, work balance, and family obligations). A similar finding reported by another study from South Africa suggested that the degree of entrepreneurial stress was considerably high among immigrant owners running small businesses [59].

Limitations And Strengths

The main limitations of the study were its cross-sectional nature and the fact that the collected data was specific to one region, which may restrict the generalizability of the results. In addition, the study sample was relatively small. Hence, further analysis with a larger sample size would be useful to determine the replicability of these findings with Saudi adults. Furthermore, the study was based solely on self-report instruments, which may have a limitation due to potential participant bias indirect reporting of their behavior, beliefs, attitudes or intentions, as they were more likely to report experiences that were considered culturally and socially acceptable or preferred to their conservative community. Besides that, the low level of an alpha coefficient ($\alpha = .65$) for ATSPPH-SF-A could possibly be explained by participants' increased false positives due to reverse-coded items requiring more time to be processed [60]. Moreover, the researchers used a non-validated, single-item question on the clinical questionnaire to identify people who had previously received treatment, although there should be other clinical questions to identify what they were suffering from to know their correlation with the variables.

Notwithstanding all the limitations, our study has several clinical and scientific implications, including a high response rate to the study questionnaire (98.6%). The main contribution of this study to the literature on help-seeking attitudes was the finding of a significant interaction of stigma and psychological distress, as well as distress as defined by the expression of symptoms (HSCL-25 - A), in explaining the predictor variables in help-seeking attitudes. The focus of this study was attitudes toward seeking psychological help, as insufficient research has been conducted with respect to Saudi adults. In contrast to the previous studies, this study selected participants from the general public, and the instruments used in this study were in Arabic, and the alpha coefficient was acceptable. This study found that, at high levels of distress, individuals tended to have significantly positive attitudes toward seeking help. However, high levels of stigma significantly altered help-seeking attitudes to negative. This is an

important conclusion given that most people tended to only seek help when experiencing considerable psychological distress. More research is needed to assess specific sociodemographic disparities across more data sources. Further analyses are also needed to assess the influence of these mental health challenges on the daily lives of the people they impact.

Conclusion

The current study reported the presence of a statistically significant inverse relationship between attitudes and stigma and a positive relationship with psychological distress. The results of this study could contribute to the literature that addresses the underutilization of mental health services by stigmatized persons with MI and their families. Certainly, there is a need for increased understanding of Saudi sociocultural aspects of health stigma and its impact on psychological help-seeking attitude.

Abbreviations

ANOVA

Analysis of variance

ATSPPH-SF-A

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

HSCL-25-A

Hopkins Symptom Checklist-25

MHL

Mental health literacy

MI

Mental illness

PMC

primary healthcare

SES

Socioeconomic status

SSRPH-A

Stigma Scale for Receiving Psychological Help

UAE

United Arab Emirates

Declarations

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Authors' contributions

The senior author (BAA) initiated the idea of the study and collected the data. The second author supervised and contributed to data interpretation. Both authors contributed equally to the write-up and revision of the final manuscript.

Ethics Declarations

Ethics approval and consent to participate

This study received ethical approval from the Institutional Review Board (IRB) of Imam Abdulrahman Bin Faisal University in Dammam to which the co-author is affiliated [IRB (IRB –PGS –2021 –01-449)], and all methods were carried out in accordance with the relevant guidelines and regulations of Declaration of Helsinki. Informed consent was obtained from all participants, including the purpose and procedures of this study. All participants were informed that the information they provided would be kept strictly confidential, and they could withdraw from the study at any time without giving a reason.

Availability of data and materials:

"All data generated or analyzed during this study are included in this published article [and its supplementary information files].

Consent for publication

Not applicable

Conflict of Interest

The authors declare that they have no competing interests.

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Tables

Table 1: Sociodemographic and Clinical Characteristics of Participants (n=218)

Variables	Parameters	(N = 218)		p-value*		
		N	%	ATSPPH-SF	SSRPH	HSL-25
Gender	Male	100	45.9	0.559	0.005	0.006
	Female	118	54.1			
Age groups	18-25yrs	54	24.8	0.256	0.101	0.004
	26-40yrs	117	53.7			
	41-59yrs	33	15.1			
	60 and older	14	6.4			
Education	Intermediate	8	3.7	0.437	0.993	0.329
	Diploma	43	19.8			
	College	141	64.7			
	Graduate	26	11.9			
Occupation	Student	35	16.1	0.293	0.576	0.043
	Technician	54	24.8			
	Professional	58	26.6			
	Private Business	7	3.2			
	Unemployed	21	9.6			
	Retired	15	6.9			
	Housewife	28	12.8			
Marital status	Single	86	39.4	0.484	0.016	0.181
	Married	119	54.6			
	Divorced/Widowed	13	5.9			
SES	Low	14	6.4	0.543	0.056	0.08
	Middle	193	88.5			
	High	11	5			
Previous treatment	Non-Received	195	89.4	0.014	0.831	0.0001
	Received	23	10.6			

*p-value in bold indicates a significant p-value of less than 0.05

Table 2,3 is available in the Supplemental Files section.

Supplementary Files

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