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Stigmatization in patients with chronic skin diseases in the Eastern Region of Saudi Arabia: a cross-sectional study

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Abstract

Chronic skin diseases such as psoriasis, vitiligo, eczema, and acne can have substantial psychosocial effects beyond physical symptoms. Visible dermatological conditions often lead to stigmatization, which may negatively influence social interactions, emotional well-being, and quality of life. However, limited research has examined perceived stigmatization among patients with chronic skin diseases in the Eastern Province of Saudi Arabia. This study aimed to quantify and compare perceived stigmatization among patients with chronic skin diseases and identify demographic and clinical factors associated with stigma severity. A cross-sectional study was conducted among 446 patients with chronic skin diseases. Data were collected using a structured questionnaire, including sociodemographic characteristics, clinical information, and the 6-Item Stigmatization Scale. Descriptive statistics were used to summarize participant characteristics. Independent *t*-tests, one-way analysis of variance (ANOVA), and multivariable linear regression analysis were performed to examine associations between stigma scores and demographic and clinical variables. A total of 446 participants were included, with females comprising 264 (59.2%) and most aged 18-40 years (291, 65.2%). Vitiligo (114, 25.6%) and psoriasis (102, 22.9%) were the most common conditions. Many participants reported stigma-related experiences, including feeling unattractive sometimes or very often (326, 73.0%). Stigma scores were significantly higher among males than females (8.12 ± 3.93 vs. 7.03 ± 4.73 , $p=0.011$) and varied by monthly income ($p<0.001$). Stigma also differed across disease types ($p<0.001$), with the highest scores among vitiligo patients (8.74 ± 3.98). In regression analysis, gender ($B=1.039$, $p=0.016$), age at disease onset ($B=0.052$, $p=0.002$), disease duration ($B=-1.268$, $p=0.003$), and family history ($B=1.825$, $p<0.001$) were significant predictors of stigma. To conclude, stigmatization is a common psychosocial burden among patients with chronic skin diseases. Addressing stigma through patient support, public education, and integrated psychological care may help improve the well-being of affected individuals.

Introduction

Chronic dermatologic conditions such as psoriasis, vitiligo, and atopic dermatitis represent a significant health burden that extends beyond physical manifestations to include substantial psychosocial consequences. The visible nature of many skin diseases often exposes affected individuals to negative social reactions, particularly in societies where physical appearance strongly influences social perception and interpersonal relationships, such as Saudi Arabia.¹

Evidence from Saudi populations indicates that individuals with visible dermatologic disorders frequently experience social disadvantage. A recent national study reported that patients with visible skin conditions encountered significantly higher levels of social rejection and discriminatory attitudes

compared with individuals affected by non-visible medical conditions.² In Arab societies, where physical appearance may influence marriage prospects and professional opportunities, the social implications of dermatologic diseases may be particularly pronounced. For example, a 2021 study demonstrated that individuals with vitiligo experience marked stigmatization due to the visible contrast created by depigmented skin lesions.³ In the same body of research, 67% of dermatology patients reported experiencing at least one form of stigmatizing behavior, and 42% described discrimination within workplace settings.⁴

Stigmatization is generally defined as a social process through which individuals perceived as different are subjected to stereotyping, social exclusion, and negative judgment. In dermatology, stigma commonly arises from visible alterations in skin appearance that deviate from perceived norms.⁵ Patients with dermatologic conditions frequently report experiences such as avoidance by others, reluctance to engage in physical contact, intrusive staring, or exclusion from social and professional interactions.⁶ These experiences can have substantial psychological consequences. Numerous studies have demonstrated that stigma associated with skin disease is strongly linked to depression, anxiety, diminished quality of life, and reduced adherence to medical treatment.⁷

Importantly, perceived stigmatization does not necessarily correspond with objective disease severity. Research conducted in European psoriasis populations demonstrated that feelings of helplessness and loss of control were stronger predictors of perceived stigma than clinical indicators such as disease extent or severity scores.⁸ These findings highlight the importance of addressing psychosocial and emotional dimensions of dermatologic disease in addition to clinical symptoms.

Cultural factors may further shape the experience of stigma among dermatology patients in Saudi Arabia and other Gulf countries. Studies involving patients with vitiligo have shown that more than half avoid social gatherings due to anxiety related to their appearance, and some individuals attribute the condition to spiritual or supernatural causes.³ Such beliefs may intensify psychological distress and may discourage patients from seeking appropriate medical or psychological care. Misconceptions about skin diseases can also lead to social avoidance. For instance, individuals with vitiligo may avoid public interactions due to concerns that others perceive the condition as contagious.⁹ Additionally, national data suggest that unmarried women with psoriasis report significantly greater anxiety regarding marriage prospects compared with other patient groups.⁴

Despite increasing awareness of dermatologic stigma globally, research examining these issues in Saudi Arabia remains limited. In particular, the social and psychological consequences of skin disease in the Eastern Region of Saudi Arabia have not been extensively studied. Social structures, tribal affiliations, and conservative cultural norms within the region may influence the social perception of visible health conditions and potentially amplify stigma-related experiences.

Several validated instruments have been developed to measure stigmatization in dermatologic populations, including the 6-Item Stigmatization Scale and the Feelings of Stigmatization Questionnaire.¹⁰ These tools enable standardized assessment of stigma-related experiences among patients with skin disease. However, culturally appropriate adaptations are necessary to ensure accurate measurement across different populations. Dimitrov *et al.* (2019) translated and validated these instruments into Arabic, demonstrating excellent internal consistency (Cronbach's $\alpha=0.89$) and confirming their ability to capture culturally relevant concerns, including family-related stigma and workplace discrimination.¹¹ Nevertheless, empirical data quantifying stigmatization among dermatology patients in Saudi Arabia remain scarce, particularly in the Eastern Region. Few studies have examined how stigma varies across demographic groups or different dermatologic diagnoses within this population. Addressing this knowledge gap is essential for understanding the broader psychosocial burden of skin disease and for developing targeted interventions.

Therefore, the present study aims to assess the prevalence and determinants of perceived stigmatization among dermatology patients in the Eastern Region of Saudi Arabia using the Arabic version of the 6-Item Stigmatization Scale. Additional items exploring challenges related to marriage prospects and employment were included to capture culturally relevant aspects of stigma. The findings may contribute to the development of culturally responsive psychosocial support services and inform public health strategies aimed at reducing stigma associated with dermatologic disease.

Materials and Methods

Study design, setting, and population

This cross-sectional study was conducted to evaluate perceived stigmatization among adults with chronic dermatologic conditions and to examine its association with selected sociodemographic factors. Data collection was performed between August 2025 and February 2026. Participants were recruited through dermatology outpatient clinics and through an online version of the study questionnaire.

Eligible participants were Saudi adults aged 18 years or older who had been diagnosed with at least one of the following chronic dermatologic conditions: vitiligo, psoriasis, acne, rosacea, or atopic dermatitis. Diagnoses were based on prior clinical evaluation by dermatologists. Both male and female patients were eligible for inclusion. Individuals younger than 18 years of age, non-Saudi nationals, and patients with dermatologic conditions not included in the predefined eligibility criteria were excluded from the study.

Sample size and sampling technique

Participants were recruited using a convenience sampling approach. A minimum sample size of 384 participants was calculated using the RaoSoft sample size calculator, assuming a 95% confidence level, a 5% margin of error, and an expected prevalence of stigmatization of 50%, which provides the most conservative estimate when population prevalence is uncertain. A total of 446 participants were ultimately included in the study, exceeding the calculated minimum sample size required for adequate statistical precision.

Data collection

Data were collected using a structured questionnaire administered through face-to-face interviews in dermatology clinics and through an online survey platform. The questionnaire incorporated the validated Arabic version of the 6-Item Stigmatization Scale, which has been used to assess stigma-related experiences among patients with dermatologic conditions. Additional items were informed by the Feelings of Stigmatization Questionnaire to capture broader perceptions of stigma.¹⁰ The survey instrument was implemented using Google Forms and consisted of two sections. The first section collected sociodemographic information, including age, gender, marital status, employment status, educational level, nationality, and monthly income. The second section included the six items of the stigmatization scale, which evaluate patients' experiences of stigma related to their chronic skin condition in everyday social interactions. Cases with incomplete responses for the stigma scale were excluded from the relevant analyses.

Ethical considerations

Ethical approval for the study was obtained from the Research Ethics Committee of Almoosa Specialized Hospital, Al-Ahsa, Saudi Arabia (Approval No. ARC-25.8.05). Written informed consent was obtained from all participants prior to participation. Participants were informed about the purpose of the study and assured that their participation was voluntary. No personally identifiable information was collected, and all responses were recorded anonymously. Study data were stored in password-protected electronic files on secure institutional servers, accessible only to the research team. Participants were informed that they could withdraw from the study at any time without any consequences.

Statistical analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS), version 29. Descriptive statistics were used to summarize participant characteristics and study variables. Categorical variables were presented as frequencies and percentages, while continuous variables were expressed as means

± standard deviations (SDs). The distribution of continuous variables was assessed using the Shapiro-Wilk test prior to parametric analyses. Stigma scores were calculated based on participant responses to the 6-Item Stigmatization Scale. Independent sample *t*-tests and one-way analysis of variance (ANOVA) were used to compare mean stigma scores across demographic and clinical subgroups. Variables that demonstrated statistically significant associations in univariate analyses were subsequently included in a multivariable linear regression model to identify independent predictors of stigmatization. Statistical significance was determined using a two-tailed *p*-value of less than 0.05.

Results

A total of 446 participants were included in the analysis. Females represented most of the sample (264, 59.2%), while males accounted for 182 participants (40.8%). Most participants were aged between 18 and 40 years (291, 65.2%), followed by those aged 41-60 years (132, 29.6%), and a smaller proportion older than 60 years (23, 5.2%). Regarding marital status, single individuals constituted the largest group (198, 44.4%), closely followed by married participants (197, 44.2%), while smaller proportions were divorced (42, 9.4%) or widowed (9, 2.0%). In terms of education, more than half of the participants held a university degree (249, 55.8%), and 153 (34.3%) had postgraduate qualifications. Only a small proportion reported lower levels of education. With respect to employment status, employees represented the largest category (194, 43.5%), followed by students (143, 32.1%), retired individuals (58, 13.0%), and unemployed participants (51, 11.4%). The majority of respondents reported that they were not working or studying in the health sector (309, 69.3%). Most participants were Saudi nationals (371, 83.2%), while 75 (16.8%) were non-Saudi. Regarding monthly income, the most reported category was 5,000-10,000 SAR (168, 37.7%), followed by incomes below 5,000 SAR (135, 30.3%) and above 10,000 SAR (143, 32.1%) (Table 1).

The distribution of dermatologic conditions among participants is presented in Figure 1. Vitiligo was the most frequently reported condition (114 participants, 25.6%), followed by psoriasis (102, 22.9%). Acne was reported by 75 participants (16.8%), while atopic dermatitis and eczema accounted for 56 (12.6%) and 50 (11.2%) cases, respectively. Additionally, 40 participants (9.0%) reported having more than one dermatologic condition, and 9 participants (2.0%) indicated other skin diseases not included in the primary categories.

Table 2 summarizes the clinical characteristics of the study participants. The mean age at disease onset was 26.2 years (SD=12.3), with a range from less than 1 year to 86 years. Most participants reported a disease duration longer than 6 months (272, 61.0%), whereas 170 participants (38.1%) had experienced their condition for less than 6 months. Facial involvement was reported by 141 participants (31.6%), while the majority indicated no facial lesions (305, 68.4%). Regarding family history, 209

participants (46.9%) reported a positive family history of chronic skin disease, whereas 237 participants (53.1%) reported no such history.

Responses to the stigmatization scale items are presented in Table 3. Feelings of unattractiveness related to the skin condition were commonly reported, with 36.5% of participants indicating that they sometimes felt unattractive and another 36.5% reporting this very often. Perceived social attention was also frequently reported; 40.4% of participants indicated that others sometimes stared at them because of their skin condition, while 31.2% experienced this very often. Regarding physical contact, 38.8% reported that others sometimes appeared uncomfortable touching them.

Misconceptions regarding contagion were also noted, with 32.7% of participants reporting that people sometimes believed their skin disease to be contagious. Social avoidance was reported by a substantial proportion of participants, with 32.3% indicating that others sometimes avoided them. Additionally, 37.2% of respondents reported sometimes receiving hurtful comments related to their skin condition.

Table 4 presents the association between stigma scores and sociodemographic characteristics. A statistically significant difference in stigma scores was observed between genders, with males reporting higher mean stigma scores (8.12 ± 3.93) compared with females (7.03 ± 4.73 , $p=0.011$). Monthly income was also significantly associated with stigma scores ($p<0.001$). Participants with monthly incomes between 5,000 and 10,000 SAR reported the highest mean stigma score (8.51 ± 3.62), whereas those with incomes below 5,000 SAR and above 10,000 SAR reported lower mean scores of 6.67 ± 4.66 and 7.01 ± 4.90 , respectively. No statistically significant differences in stigma scores were observed across age groups ($p=0.602$), marital status ($p=0.107$), educational level ($p=0.430$), employment status ($p=0.350$), involvement in the health field ($p=0.351$), or nationality ($p=0.557$).

Table 5 summarizes the relationship between stigma scores and clinical characteristics. A significant difference in stigma scores was observed across different dermatologic conditions ($p<0.001$). The highest mean stigma score was observed among participants with vitiligo (8.74 ± 3.98), followed by eczema (8.30 ± 5.41) and psoriasis (7.82 ± 3.66). In contrast, participants with acne reported the lowest stigma scores (5.96 ± 4.48). Duration of illness was also significantly associated with stigma scores ($p=0.009$). Participants with disease duration shorter than 6 months reported higher stigma scores (8.21 ± 3.63) compared with those with longer disease duration (7.07 ± 4.83). In addition, individuals with a family history of chronic skin disease demonstrated significantly higher stigma scores (8.34 ± 4.51) compared with those without a family history (6.70 ± 4.25 , $p<0.001$). Facial involvement, however, was not significantly associated with stigma scores ($p=0.278$).

The results of the multivariable linear regression analysis examining predictors of stigma score are presented in Table 6. Among demographic variables, gender was the only factor significantly associated with stigma scores. Male participants demonstrated higher stigma scores compared with

female participants ($B=1.039$, $p=0.016$). Among clinical variables, age at disease onset showed a positive association with stigma scores ($B=0.052$, $p=0.002$), indicating that later onset of disease was associated with higher perceived stigma. Disease duration of six months or longer was associated with lower stigma scores ($B=-1.268$, $p=0.003$), suggesting that longer disease duration may be linked to reduced perceived stigmatization. Additionally, participants reporting a family history of chronic skin disease had significantly higher stigma scores ($B=1.825$, $p<0.001$). Facial involvement was not independently associated with stigma scores in the multivariable model.

Discussion

Chronic dermatologic conditions extend beyond physical manifestations and often impose a considerable psychosocial burden on affected individuals. Visible skin diseases such as psoriasis, vitiligo, and atopic dermatitis may alter patients' self-perception and influence social interactions, leading to experiences of stigmatization, social avoidance, and negative stereotyping. These psychosocial consequences can significantly affect emotional well-being, interpersonal relationships, and participation in social activities. Within culturally sensitive societies, including Saudi Arabia, perceptions related to visible differences in appearance may further amplify these experiences. Despite increasing global attention to dermatologic stigma, evidence describing its patterns and determinants in the Eastern Region of Saudi Arabia remains limited. The present study therefore aimed to evaluate perceived stigmatization among patients with chronic skin diseases and identify demographic and clinical factors associated with increased stigma severity.

The findings of this study demonstrate that stigmatization is a common experience among individuals with chronic dermatologic conditions. Many participants reported feeling unattractive because of their skin disease or believed that others stared at them in social settings. These findings align with previous dermatologic research indicating that chronic skin disorders frequently influence self-image and perceived social acceptance. Mahfouz *et al.* (2023) similarly reported that patients with chronic skin diseases often experience reduced social confidence and heightened awareness of their appearance in public settings.² In addition, studies conducted in dermatologic populations have shown that patients frequently interpret social behaviors such as staring, avoidance, or hesitation in physical contact as indicators of stigma.¹² These perceptions may contribute to emotional distress, diminished self-esteem, and reduced quality of life among affected individuals.

The present study also identified significant differences in stigma scores across dermatologic conditions. Participants with vitiligo and eczema reported higher levels of perceived stigmatization compared with individuals with acne. These observations are consistent with prior studies suggesting that skin conditions characterized by visible discoloration, chronic inflammation, or unpredictable

disease activity tend to impose a greater psychosocial burden.¹³ Vitiligo, in particular, has long been associated with social stigma due to the visible contrast created by depigmented skin lesions. Previous research has shown that individuals with vitiligo frequently report social embarrassment, anxiety in interpersonal interactions, and concerns about social acceptance.¹⁴ Similarly, eczema is often associated with visible skin changes and persistent pruritus, which may contribute to discomfort during social encounters and perceptions of social avoidance.¹⁵

In contrast, participants with acne reported comparatively lower stigma scores. One potential explanation is the high prevalence of acne, particularly among adolescents and young adults, which may contribute to greater social normalization of the condition. Although acne has been shown to negatively affect body image and self-esteem, its social perception may differ from other chronic dermatologic disorders that produce more distinctive or long-lasting visible changes.¹⁶

Another important finding of this study was the association between disease duration and perceived stigma. Participants with shorter disease duration reported higher stigma scores than those who had experienced their condition for a longer period. This observation suggests that individuals newly diagnosed with a chronic dermatologic condition may initially experience greater psychological distress and heightened sensitivity to social reactions. Over time, patients may gradually develop coping strategies, social adaptation, or greater acceptance of their condition, which could contribute to reduced perceptions of stigma. Similar patterns have been reported in dermatologic literature, where longer disease duration has been associated with improved emotional adjustment and psychological adaptation to chronic skin disease.¹⁷

Family history of chronic skin disease was also significantly associated with stigma scores. Participants reporting a positive family history experienced higher levels of perceived stigmatization compared with those without such history. This association may reflect increased awareness of the social implications of dermatologic conditions within affected families or shared experiences related to disease perception and social reactions.

Interestingly, gender differences were observed in the present study, with male participants reporting higher stigma scores in multivariable analysis. This finding contrasts with several previous studies suggesting that female patients often report greater psychosocial burden due to societal expectations related to physical appearance.¹⁸ The reasons for this difference remain uncertain and may reflect cultural influences, differences in coping strategies, or variations in disease perception among male participants within the study population.

Facial involvement was not significantly associated with stigma scores in this study. This finding differs from some previous research suggesting that visible facial lesions may increase psychological distress due to their direct impact on appearance.¹⁹ However, the relationship between lesion visibility

and perceived stigma may be influenced by multiple factors, including disease severity, individual coping mechanisms, and social context. It is therefore possible that facial involvement alone does not fully capture the complexity of appearance-related stigma.

Limitations

Several limitations should be considered when interpreting the results of this study. First, the cross-sectional design limits the ability to establish causal relationships between stigmatization and associated demographic or clinical factors. Second, the reliance on self-reported data may introduce recall bias or response bias. Third, the study population was recruited from a single region of Saudi Arabia, which may limit the generalizability of the findings to other regions or populations. Additionally, clinical assessment of disease severity was not included in the analysis, and disease severity may influence the perception of stigmatization.

Clinical implications and future directions

The findings of this study highlight the importance of recognizing stigmatization as a key psychosocial component of chronic dermatologic conditions. Dermatology care should therefore extend beyond the management of physical symptoms to include evaluation of psychological well-being and stigma-related experiences. Incorporating routine psychosocial assessment into dermatologic consultations may facilitate early identification of patients experiencing significant emotional distress.

Interventions such as patient education, counseling services, and support groups may help reduce the psychological burden associated with chronic skin diseases. In addition, public awareness initiatives aimed at improving understanding of dermatologic conditions may help reduce misconceptions and social stigma within the general population.

Future research should involve multicenter studies across different regions of Saudi Arabia and adopt longitudinal designs to better understand the long-term psychosocial impact of dermatologic conditions. Further studies should also evaluate targeted interventions designed to reduce stigmatization and improve the quality of life among dermatology patients.

Conclusions

This study demonstrates that stigmatization is a common experience among patients with chronic skin diseases. Higher stigma levels were observed among male participants and varied across dermatologic conditions, with vitiligo and eczema associated with the highest stigma scores. Clinical factors, including later age at disease onset, shorter disease duration, and family history of chronic skin disease, were significant predictors of stigma severity. These findings emphasize the importance of addressing

psychosocial dimensions alongside clinical management in dermatologic care and highlight the need for interventions aimed at reducing stigma and improving the well-being of individuals with chronic skin diseases.

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Table 1. Sociodemographic characteristics of study participants.

Characteristic		Frequency n (%)
Gender	Female	264 (59.2)
	Male	182 (40.8)
Age (years)	18-40	291 (65.2)
	41-60	132 (29.6)
	>60	23 (5.2)
Marital status	Single	198 (44.4)
	Married	197 (44.2)
	Divorced	42 (9.4)
	Widow	9 (2.0)
Educational level	Primary/Secondary school	8 (1.8)
	High School	36 (8.1)
	University	249 (55.8)
	Postgraduation	153 (34.3)
Employment	Unemployed	51 (11.4)
	Students	143 (32.1)
	Retired	58 (13.0)
	Employee	194 (43.5)
Working/studying in health field	No	309 (69.3)
	Yes	137 (30.7)
Nationality	Non-Saudi	75 (16.8)
	Saudi	371 (83.2)
Monthly income	<5,000 SAR	135 (30.3)
	5,000-10,000 SAR	168 (37.7)
	>10,000 SAR	143 (32.1)

Table 2. Clinical characteristics of participants with chronic skin diseases.

Characteristic		Frequency n (%)
Age at the start of disease (years)	Mean (SD)	26.2 (12.3)
	Range	<1-86
Duration of disease (months)	<6	170 (38.1)
	>6	272 (61.0)
Facial involvement	No	305 (68.4)
	Yes	141 (31.6)
Family history of chronic skin disease	No	237 (53.1)
	Yes	209 (46.9)

Table 3. Distribution of stigmatization questions among patients with chronic skin diseases (N=446).

	Never	Sometimes	Very often	Always
I feel unattractive to others because of my skin condition	68 (15.2)	163 (36.5)	163 (36.5)	52 (11.7)
I think many people stare at me because of my skin condition	84 (18.8)	180 (40.4)	139 (31.2)	43 (9.6)
Others feel uncomfortable when I touch them because of my skin condition	126 (28.3)	173 (38.8)	105 (23.5)	42 (9.4)
People believe that skin diseases are contagious	146 (32.7)	146 (32.7)	99 (22.2)	55 (12.3)
People avoid me because of my skin condition	155 (34.8)	144 (32.3)	89 (20.0)	58 (13.0)
Sometimes people make hurtful comments about my skin condition	103 (23.1)	166 (37.2)	111 (24.9)	66 (14.8)

Table 4. Association between stigma score and sociodemographic characteristics of participants.

		Mean (SD)	Test value	Sig. value
Gender	Female	7.03 (4.73)	6.53	0.011 ^a
	Male	8.12 (3.93)		
Age (years)	18-40	7.36 (4.63)	0.51	0.602 ^b
	41-60	7.78 (4.11)		
	>60	7.04 (3.97)		
Marital status	Single	7.19 (4.75)	2.05	0.107 ^b
	Married	7.39 (4.28)		
	Divorced	8.79 (3.87)		
	Widow	9.33 (2.40)		
Educational level	Primary/Secondary School	5.13 (4.05)	0.92	0.430 ^b
	High School	7.44 (5.11)		
	University	7.40 (4.48)		
	Postgraduation	7.72 (4.25)		
Employment	Unemployed	7.08 (4.26)	1.10	0.350 ^b
	Students	7.06 (4.77)		
	Retired	8.10 (3.74)		
	Employee	7.69 (4.44)		
Working/studying in health field	No	7.60 (4.21)	0.87	0.351 ^a
	Yes	7.18 (4.94)		
Nationality	Non-Saudi	7.75 (4.11)	0.35	0.557 ^a
	Saudi	7.42 (4.52)		
Monthly income	<5,000 SAR	6.67 (4.66)	7.73	<0.001 ^b
	5,000-10,000 SAR	8.51 (3.62)		
	>10,000 SAR	7.01 (4.90)		

^aIndependent test; ^banalysis of variance.

Table 5. Association between stigma score and clinical characteristics of participants.

		Mean (SD)	Test value	Sig. value
Type of skin disease	Vitiligo	8.74 (3.98)	6.02	<0.001 ^b
	Psoriasis	7.82 (3.66)		
	Acne	5.96 (4.48)		
	Atopic dermatitis	7.05 (4.17)		
	Eczema	8.30 (5.41)		
	More than one condition	6.45 (5.18)		
	Other	2.56 (2.96)		
Duration of illness (months)	<6	8.21 (3.63)	6.97	0.009 ^a
	≥6	7.07 (4.83)		
Facial lesions	No	7.63 (4.17)	1.18	0.278 ^a
	Yes	7.13 (4.99)		
Family history of chronic skin disease	No	6.70 (4.25)	15.67	<0.001 ^a
	Yes	8.34 (4.51)		

^aIndependent test; ^banalysis of variance.

Table 6. Multivariable linear regression analysis of demographic and clinical predictors of stigma score.

	B	SE	t	Sig. value	95% CI
Demographic predictors					
Gender (male)	1.039	0.430	2.416	0.016	0.194-1.885
Age	-0.216	0.421	-0.512	0.609	-1.043-0.612
Marital status	0.641	0.346	1.853	0.065	-0.039-1.320
Higher education	0.158	0.349	0.452	0.651	-0.528-0.844
Employment (yes)	0.227	0.220	1.033	0.302	-0.205-0.659
Working/studying in health field	-0.089	0.486	-0.183	0.855	-1.044-0.867
Nationality (Saudi)	-0.278	0.565	-0.492	0.623	-1.388-0.833
Higher monthly income	-0.156	0.327	-0.478	0.633	-0.798-0.486
Clinical predictors					
Higher age at disease onset	0.052	0.017	3.042	0.002	0.018-0.086
Duration of illness (≥6 months)	-1.268	0.426	-2.976	0.003	-2.105--0.430
Facial lesions (yes)	-0.257	0.457	-0.562	0.574	-1.155-0.641
Family history of chronic skin disease (yes)	1.825	0.413	4.421	<0.001	1.014-2.637