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## Self-Stigma of Seeking Help, Psychological Safety, and Employee Assistance Program Use in Nurses

Latisha Lenee Marshall  
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# Walden University

College of Nursing

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Latisha L. Marshall

has been found to be complete and satisfactory in all respects,  
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Walden University  
2026

Abstract

Self-Stigma of Seeking Help, Psychological Safety, and Employee Assistance Program

Use in Nurses

by

Latisha L. Marshall

MSN, Monmouth University, 2016

BSN, Seton Hall University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

February 2026

## Abstract

Employee assistance programs (EAPs) remain underutilized across various U.S. work sectors, including nursing. There are several barriers that impede nurses from using EAP services, including self-stigma of seeking help (SSOSH) and psychological safety (PS). The purposes of this study, which used the health promotion model as its theoretical framework, were to determine (a) if there was a difference in the level of SSOSH in nurses who have used EAPs and those who have not used EAPs, (b) if there was a difference in the level of PS in nurses who have used EAPs and nurses who have not used EAPs, and (c) if PS moderated the levels of SSOSH among nurses who have used EAPs and those who have not. A quantitative comparative research design was used. Data were gathered from 137 LPNs/licensed vocational nurses, RNs, and advanced practice nurses who worked in U.S. organizations that offered EAP services, and analyzed using an independent *t* test and a moderation analysis. This study found that the level of SSOSH and of PS were higher in nurses who used EAPs compared to nurses who did not. Finally, PS did not moderate the levels of SSOSH among nurses who used EAPs and nurses who did not. The implications for positive social change include providing knowledge that stakeholders can potentially use to further support nurses and to prevent barriers, such as SSOSH and PS, from impeding nurses' utilization of supportive services. The study also expands knowledge about nurses and barriers to supportive services, including EAPs. Further research should be conducted to expand the knowledge of SSOSH, PS, and EAP use in the nursing discipline.

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## Dedication

First and foremost, I dedicate this to God, who above all else has always extended His blessings upon me. Secondly, I dedicate this to my children, Julian and Dasia. I hope you both know how much you mean to me. I hope you understand that the sky is the limit for you both. Do not let anyone or anything stop you from achieving your goals and dreams. Know that no matter what, mommy is always going to be your biggest cheerleader! Lastly, I dedicate this to my younger self. I am so proud of the woman you are today.

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## Table of Contents

List of Tables .....	v
List of Figures .....	vi
Chapter 1: Introduction to the Study.....	1
Background.....	2
Problem Statement.....	3
Purpose of the Study.....	4
Research Questions and Hypotheses .....	5
Theoretical Framework.....	6
Nature of the Study.....	7
Definitions.....	8
Assumptions.....	9
Scope and Delimitations .....	9
Limitations .....	10
Significance.....	11
Summary .....	12
Chapter 2: Literature Review.....	13
Introduction.....	13
Literature Search Strategy.....	14
Theoretical Foundation.....	14
Behavior-Specific Cognitions and Affect.....	17
Literature Review Related to Key Variables and/or Concepts .....	21

Employee Assistance Programs .....	21
Self-Stigma of Seeking Help .....	24
Psychological Safety .....	30
Summary and Conclusions .....	35
Chapter 3: Research Method.....	38
Introduction.....	38
Research Design and Rationale .....	38
Methodology .....	39
Population .....	39
Sampling and Sampling Procedures .....	39
Procedures for Recruitment, Participation, and Data Collection.....	40
Instrumentation and Operationalization of Constructs .....	41
Data Analysis Plan.....	45
Software .....	45
Research Questions and Hypotheses .....	45
Analysis and Statistical Tests.....	46
Threats to Validity .....	49
External Validity.....	49
Internal Validity .....	50
Construct Validity.....	50
Ethical Procedures .....	51
Summary .....	52

Chapter 4: Results .....	53
Introduction.....	53
Data Collection .....	54
Results.....	55
Research Question 1 .....	58
Research Question 2 .....	62
Research Question 3 .....	65
Summary .....	68
Chapter 5: Discussion, Conclusions, and Recommendations.....	69
Introduction.....	69
Interpretation of the Findings.....	70
Confirmation of Literature.....	70
Disconfirmation of Literature .....	73
Extension of Knowledge.....	74
Theoretical Findings .....	75
Limitations of the Study.....	77
Generalizability.....	77
Validity .....	78
Reliability.....	78
Recommendations.....	78
Implications.....	80
Implications at the Individual Level .....	80

Implications at the Organizational Level.....	80
Implications at the Societal/Policy Level .....	81
Conclusion .....	82
References.....	83
Appendix A: Recruitment Flyer.....	97
Appendix B: Demographics Questionnaire .....	98
Appendix C: Self-Stigma of Seeking Help Scale-Revised.....	100
Appendix D: Permission to Use the Self-Stigma of Seeking Help Scale-Revised.....	101
Appendix E: Psychological Safety Inventory .....	102
Appendix F: Permission to Use the Psychological Safety Inventory .....	103

## List of Tables

Table 1. Participants' Demographic Characteristics.....	58
Table 2. Independent t test of Participants' Self-Stigma of Seeking Help .....	61
Table 3. Independent t test for Psychological Safety.....	65
Table 4. Collinearity Statistics.....	66

## List of Figures

Figure 1. The Health Promotion Model .....	16
Figure 2. Nursing Licensure Type .....	56
Figure 3. Highest Level of Education Completed .....	57
Figure 4. Self-Stigma of Seeking Help Boxplot .....	60
Figure 5. Psychological Safety Inventory Boxplot .....	63
Figure 6. Scatterplot for Homoscedasticity .....	67

## Chapter 1: Introduction to the Study

Employee assistance programs (EAPs) support employees when problems or stress arise in their lives, offering services that promote health tracking and education, mental health and wellness, safety, substance use and abuse prevention, and performance improvement (Doran, 2022). EAPs are essential to organizations as these programs are designed to help employees manage life and work stressors, which can directly affect employees' work performance and productivity (Moore et al., 2023). Although there are several benefits to using these programs, there continues to be low utilization rates of EAPs across varying work sectors (Babin et al., 2024). Nursing is one of the major disciplines in health care that underutilizes EAPs (Babin et al., 2024; Doran, 2022). There are numerous reasons why nurses are not utilizing EAPs, but two main factors that may be contributing to this are self-stigma of seeking help (SSOSH) and psychological safety (PS). With an increased level of self-stigma, there is more shame associated with seeking psychological support and services (Seidman et al., 2023). Furthermore, if there is a lower level of PS, then the use of EAPs would be lowered due to fear of being embarrassed, marginalization, or fear of retaliation (Carter, 2022).

In this chapter, I provide an overview of the background of this study. I also state the problem and the purpose of the study and present the research questions (RQs) and hypotheses. The theoretical framework is briefly described, along with the nature of the study, and the variables that were used in the study are defined. Last, the study's assumptions, scope and delimitations, limitations, and significance are discussed.

## Background

EAPs have been an important peer-support internal program that has been underutilized since the 1970s (Martin et al. 2024). Initially, EAPs were used to encourage and help organizations create a positive, psychologically safe work environment and culture. EAPs were implemented to support employees in resolving a variety of problems and were viewed as the link between employees and organizations (Wang et al. 2021). As time went on, EAPs expanded their program to provide resources and services for employees. These expanded resources and services encompass a range of workplace issues, including health monitoring, mental well-being, safety, performance enhancement, crisis intervention, substance abuse, and fitness for duty (Babin et al., 2024; Doran, 2022; Wang et al., 2021).

Even with the wide array of services that EAPs offer, EAPs continue to be an underused program by employees across varying work sectors (Doran, 2022; Martin et al., 2024; Wang et al., 2021). Research has identified several barriers for the underutilization of EAPs. In fact, researchers have urged organizations to understand these barriers to help increase the utilization of EAPs (Moore et al., 2023). The barriers for the underutilization of EAPs include stigma, lack of program awareness, fear of job repercussions, fear of confidentiality, and a poor psychologically safe environment (Babin et al., 2024; Doran, 2022; Moore et al., 2023).

The underutilization of EAPs has been seen across all work sectors (Babin et al., 2024). However, the underutilization of EAPs in nursing was a critical area that needed focus. A focus on nurses' well-being involved considering the impact that organizational

EAPs had on nurses (Doran, 2022). This impact was challenging as it has been difficult for researchers to accurately determine the utilization rates of EAPs specific to nurses (Babin et al., 2024). A study conducted in New York Presbyterian hospital that examined the utilization of EAPs within the hospital found that only 4.25% of the 38,000 hospital employees had used the organization's EAP (Babin et al., 2024). A recent study examining EAP utilization among health care workers during the pandemic found that fewer than 10% of health care workers utilized EAPs (Doran, 2022). Although the exact number of EAP utilization in nurses is unknown, the same barriers exist for the underutilization of EAP use in nurses. Reasons nurses have been underutilizing EAPs were due to stigma, both public and self-stigma, confidentiality, risk of job consequence, or a change in PS (Doran, 2022; Rushton & Boston-Leary, 2022). There was a gap in research regarding the use of EAPs by nurses. No literature has been found that specifically examines the SSOSH and PS in nurses who have used and those who have not used EAPs.

### **Problem Statement**

Although most organizations have EAPs, research has found that nurses continue to utilize EAPs at lower rates (Covarrubias-Lyttle, 2023; Doran, 2022). Research has shown that EAPs have a direct impact on absenteeism, productivity, and employee turnover rates (Attridge & Dickens, 2021; Langlieb et al, 2021; Zieringer & Zapf, 2024). It has been challenging for researchers to determine the rates of EAPs utilization among nurses; however, several barriers have been identified as reasons why nurses underutilize EAPs (Babin et al., 2024; Doran, 2022). Two of these barriers included SSOSH and PS.

Currently, no research has been found focused on nurses and SSOSH. In fact, when it comes to SSOSH the only studies found were conducted on students (Eagle et al., 2022; Ozdemir et al., 2023; Pfeiffer & In-Albon, 2023; Shannon et al., 2021; Sigal & Plunkett, 2024). These studies found that the higher the level of SSOSH an individual had, the less likely the individual would seek treatment services (Eagle et al., 2022; Ozdemir et al., 2023; Pfeiffer & In-Albon, 2023; Shannon et al., 2021; Sigal & Plunkett, 2024).

However, unlike the SSOSH, there were three studies for PS that were conducted with nurses (El-Gazar et al., 2024; Filiz et al., 2024; Lee & Dahinten, 2021). These three studies demonstrated that with an increased level of PS, nurses were more likely to feel safe expressing themselves, share ideas, express their creativity, and speak up (El-Gazar et al., 2024; Filiz et al., 2024; Lee & Dahinten, 2021). Even with current literature on EAPs, SSOSH, and PS, there were no studies which have examined SSOSH and PS in nurses who utilized and those who have not utilized EAPs. Because of the gap in knowledge in this area, this study was the first of its kind which has added to the nursing field.

### **Purpose of the Study**

The purposes of this study were to determine if there was (a) a difference in the level of SSOSH in nurses who have used EAPs and those who have not used EAPs, (b) a difference in the level of PS in nurses who have used EAPs and nurses who have not used EAPs, and (c) if PS moderated the levels of SSOSH among nurses who used EAPs and those who have not. By understanding the difference in SSOSH and PS within these two

nurse groups, health care organizations and the nursing profession can now better assist nurses in their environment.

### **Research Questions and Hypotheses**

The RQs and hypotheses that underpinned this study were as follows:

RQ1: What is the difference in the levels of SSOSH between nurses who use EAPs and those who do not?

$H_{01}$ : There is no difference in the levels of SSOSH between nurses who use EAPs and those who do not.

$H_{a1}$ : There is a difference in the levels of SSOSH between nurses who use EAPs and those who do not.

RQ2: What is the difference in the levels of PS among nurses who use EAPs and those who do not?

$H_{02}$ : There is no difference in the levels of PS among nurses who use EAPs and those who do not.

$H_{a2}$ : There is a difference in the levels of PS among nurses who use EAPs and those who do not.

RQ3: How does PS moderate SSOSH among nurses who use EAPs and those who do not?

$H_{03}$ : PS does not moderate SSOSH among nurses who use EAPs and those who do not.

$H_{a3}$ : PS does moderate SSOSH among nurses who use EAPs and those who do not.

The SSOSH was measured using the Self-Stigma of Seeking Help-Revised (SSOSH-7) scale, and PS was measured using the Psychological Safety Inventory (PSI).

### **Theoretical Framework**

The framework that underpinned this study was the health promotion model (HPM), initially presented to the nursing field in 1982 by Nolan Pender (Pender et al., 2011). The model's main goal was to increase well-being and self-actualization in individuals or groups while increasing the progression towards a positive state of health and well-being. The HPM also aimed to define motivating factors that were significant enough for health-promoting behaviors (Pender, 1987). The HPM was organized into three components, which were the determinants of health-promoting behaviors. The three components include individual characteristics and experiences, behavioral-specific cognitions and affect, and behavioral outcomes (Pender et al., 2011).

For the purpose of this study, I focused on the behavioral-specific cognitions and affect component. While this component has several sub-components, the specific sub-component that this study used was the perceived barriers to action. Pender (1987) discovered that perceived barriers to action were potential or actual barriers to participating in health-promoting behaviors, which should be identified early regardless of the individuals' background. The two perceived barriers to action of this study are SSOSH and PS. SSOSH is shame associated with seeking psychological services and support (Seidman et al., 2023). PS influences a person's ability to feel secure, grow, learn, contribute, and work effectively in a rapidly changing environment (Agarwal & Anantatmula, 2023). Carter (2022) suggested that PS is crucial for individual well-being

and professional performance. If there is poor PS, then the use of EAPs would be lowered due to fear of being embarrassed, marginalized, or fear of retaliation (Carter, 2022). This study determined if these perceived barriers were higher in nurses who did not utilize EAPs in comparison to those who did utilize EAPs. More detail on the HPM was presented in Chapter 2.

### **Nature of the Study**

I used a quantitative comparative research design. Comparative research designs are used when comparing the differences between two groups. In comparative studies, the independent variable is the grouping variable which defines the groups within the independent variable (Gray et al., 2017). I examined the difference between the groups of nurses who have used EAPs and those who have not. In comparative research studies, the independent variables cannot be manipulated, and the groups within the independent variables are naturally occurring (Metler, 2016).

I used instruments to collect data and address the study variables (see Thomas & Zubkov, 2023). Instruments allow participants to self-report to share their ideas, thoughts, or feelings. Cross-sectional instruments grant the researcher the ability to collect data at one moment in time (Thomas & Zubkov, 2023). I used continuous, discrete, and nominal data, which was collected by using instruments. I used the SSOSH-7 and PSI. For both instruments, permission was not needed if the test content was being reproduced or used for non-commercial research and educational purposes. The distribution of these instruments had to be controlled, meaning only to the participants engaged in the research or enrolled in the educational activity (Brenner et al., 2021; Plouffe et al., 2023). These

instruments were distributed to the participants through social media. Additionally, demographic questions provided me with information on my participants' socioeconomic background and their current occupation (Pronto, 2015). I recruited nurses from two social media platforms, which included both LinkedIn and Facebook groups. Permission was received from the administrators of these social media groups prior to recruitment.

For RQs 1 and 2, I analyzed the data using the independent  $t$  test. An independent  $t$  test is used when the researcher wants to determine the difference between two independent groups on a continuous dependent variable (Laerd Statistics, 2015). SSOSH was measured using the SSOSH-7 scale, which consisted of 10 questions. Each question was scored on a 5-point Likert scale and ranges from 1 (*strongly disagree*) to 5 (*strongly agree*; Brenner et al., 2021). PS was measured using the PSI, which consisted of 30 questions. Each question was scored on a 5-point scale, with 1 equaling *strongly disagree* and 5 equaling *strongly agree*; Plouffe et al., 2023). For RQ3, a moderation analysis was used to determine if the relationship between the independent variable and dependent variable changed based on a third variable (Laerd Statistics, 2015). In this case, I determined if the relationship between the levels of SSOSH and EAP usage among nurses, changed based on the levels of PS.

### **Definitions**

I define the following key terms to assist readers in understanding and interpreting their meaning within the context of this study:

*Employee assistance program (EAP)*: A program that aids in the overall well-being of employees. EAPs help employees manage work-related issues, personal issues,

and providing mental health resources for the employee who need assistance in their private and professional life (Brooks & Ling, 2020; Zieringer & Zapf, 2024).

*Psychological safety (PS)*: Individuals' perception on how secure their work environment is to take risks, openly communicate, and express themselves without fear of repercussions (Edmondson, 2019). PS influences a person's ability to feel secure, grow, learn, contribute, and work effectively in a rapidly changing environment (Agarwal & Anantatmula, 2023).

*Self-stigma of seeking help (SSOSH)*: A self-negative belief about public judgment if an individual seeks mental health treatment (Billman Miller et al., 2025). Self-stigma, which differs from public stigma, involves the internalized stigma of one's own self-esteem and self-worth (Miller et al., 2024; Mullen & Crowe, 2017; Tucker et al., 2017).

### **Assumptions**

An assumption of this study was that nurses with physical health concerns, mental health disorders, substance abuse, home and work stressors desired to use EAPs to assist them. A second assumption was that nurses who used EAPs for physical health concerns, mental health disorders, substance abuse, work and home stressors desired to avoid the stigma associated with EAP treatment.

### **Scope and Delimitations**

In this study, I focused on the levels of SSOSH and PS of nurses who used EAPs and nurses who did not. This area was chosen because, I was not able to find research that focused on these two variables in nurses. There was research that examined SSOSH

and PS separately; however, no research has examined how the levels of SSOSH and PS interact together to affect nurses. Additionally, there was no research that examined the differences between nurses who used EAPs and those who did not. This study only focused on the nursing population. The nursing population included advanced practice nurses (APNs), RNs, and LPNs/licensed vocational nurses (LVNs) from various health care settings, geographical locations, and demographic backgrounds, which increased the generalizability of the study. The population included participants aged 18 years and older. The sample only included nurses within the United States. I did not include other health care providers such as doctors, social workers, or physical therapists. Since this study focused on nurses, its findings may be generalized to other health care professionals.

For this study, I used the HPM. The other theory I considered using was the health belief model (HBM) which was similar to the HPM since both models have the subcomponent of perceived barriers. However, there was one major difference, the HBM focused on disease prevention, whereas the HPM focused on health promotion (Galloway, 2003). Since I was examining the use of EAPs, which is a health promoting program, the HPM was the best fit for this study.

### **Limitations**

In conducting this study there were several limitations that were considered. For one, in a quantitative study, the sample size must be an adequate size for the study to be statistically significant. Andrade (2020) suggested that a research sample size which is too large or too small can be considered unethical and unscientific. An overly large

sample size can create inaccuracies, and a smaller sample size would have insufficient statistical power (Andrade, 2020). Another limitation of this study was the response rate. With a low response rate, a study's design, results, and conclusions can be affected (Theofanidis & Fountouki, 2018). Lastly, this study had the potential for bias reporting. Since the study focused on SSOSH and PS, the participants could have responded to the questions based on perception rather than being objective.

To address these limitations, I conducted a power analysis to determine proper sample size, which I share in Chapter 3. I recruited participants from several nursing groups to obtain an adequate number of participants. To ensure a high response rate, I sent reminders to the participants to ensure that all surveys were complete. Nevertheless, I reiterated to the participants that all answers recorded were anonymous to reassure that they answered all questions objectively.

### **Significance**

The results of this study may contribute to the nursing discipline by adding more knowledge about EAPs and its use by nurses. The results provide new insight into nurses, their working environments, and how self-stigma impacts their ability to seek help. The study results may help organizations understand the importance of EAPs and its use by nurses. By exploring the relationship of EAPs, SSOSH, and PS, policymakers, shareholders, and organizations can address the growing concern of the low utilization of EAPs in the workplace. Nursing leaders would be able to utilize these studies results to address environmental safety on their units and better promote the use of EAP.

The results of my study may also provide ideas for future research focused on nurses and barriers impeding EAP use in the workplace. The results may lead to future studies that examine the impact of EAPs on nurses and nursing organizations which affects positive social change. This study impacted positive social change as it allowed health care organizations, nursing institutes, and professional nursing organizations to further improve EAPs use in nurses.

### **Summary**

EAPs are a direct link between nurses and health care organizations (Wang et al., 2021) in the way that the program promotes employee health, work performance, and productivity. Examining the influence SSOSH and PS have on the use of EAPs, may result in an increased understanding about nurses and barriers to seeking help. I used the HPM, since the theory looks to promote a state of well-being and a progression towards a positive state of health (Pender, 1987). When nurses are in a safe working environment, there is more likely to be lower turnover rates, improved patient safety, and a higher level of quality of care (Filiz et al., 2024; Moore et al., 2023; Wang et al., 2021). Nevertheless, a safe working environment assists in promoting a state of well-being and a progression towards a positive state of health.

## Chapter 2: Literature Review

### **Introduction**

EAPs are workplace initiative programs that aid employees with a variety of services. These services include addressing workplace issues, health monitoring, mental well-being, safety, crisis intervention, financial issues, substance abuse, and fitness for duty (Babin et al., 2024; Wang et al., 2022). Although EAPs provide a significant amount of support and services to employees, the program remains underutilized across all work disciplines (Doran, 2022; Martin et al., 2024; Wang et al., 2021). Nurses, in particular, are noted to have low rates of EAP use (Covarrubias-Lyttle, 2023; Doran, 2022). The low utilization rate of EAPs among nurses has been linked to several barriers. Two of these barriers include SSOSH and PS; however, there are currently no studies that examine the level of SSOSH and PS in nurses who use EAPs versus those who do not (Babin et al., 2024; Doran, 2022).

The purposes of this study were to determine if there was (a) a difference in the level of SSOSH in nurses who used EAPs and those who did not use EAPs, (b) a difference in the level of PS in nurses who used EAPs and nurses who did not use EAPs, and (c) if PS moderated the levels of SSOSH among nurses who used EAPs and those who did not. I begin this chapter by discussing the literature search strategy and the theoretical foundation I used for this study. I then provide a detailed literature review of related key variables and concepts. I describe how the present study addresses the gap in the literature and expands knowledge within the nursing discipline.

### **Literature Search Strategy**

I retrieved scholarly literature by searching several databases, which included Academic Search Complete, APA PsychInfo, CINAHL Plus with Full Text, MEDLINE with Full Text, and Ovid Nursing Journals Full Text. Keywords and phrases used to search the literature included *attitudes, employee assistance programs, EAPs, health promotion model, mental health, mental illness, mental disorders, nurses, psychological safety, seeking, services, stigma, support, and self-stigma*. I combined keywords with Boolean phrase “AND” for further literature search results. These keyword phrases included *nurses and self-stigma of seeking help, nurses and psychological safety, nurses and employee assistance programs*. I limited my search to publications between 2019 to 2024, in English, and available in full text. In instances where little research was found, I searched the databases using each individual key variable and examined how those variables were used in other disciplines.

### **Theoretical Foundation**

Pender first introduced the HPM to nursing in 1982 (Pender et al., 2011). The proposed model aimed to increase well-being and self-actualization in individuals or groups and their progression towards a positive state of health and well-being. The HPM also aimed to identify motivating factors that were significant enough to influence health-promoting behaviors (Pender, 1987). The model integrated disconnected research findings into a coherent pattern (Pender, 1987).

The HPM derived from the social learning theory and is structurally similar to the HBM (Pender, 1987). The social learning theory emphasizes the importance of the

cognitive mediating process. The HBM, developed in the early 1950s by Rosenstock, Hochbaum, and Kegeles, provided a theory, based on three components, to explain why some individuals take action to remain illness-free while others fail to take any preventative measures. The components included individual perceptions, modifying factors, and the likelihood of action. Similar to the HBM, Pender's HPM was organized into three components to determine health-promoting behaviors, which include cognitive-perceptual factors, modifying factors, and variables affecting the likelihood of action (Pender, 1987).

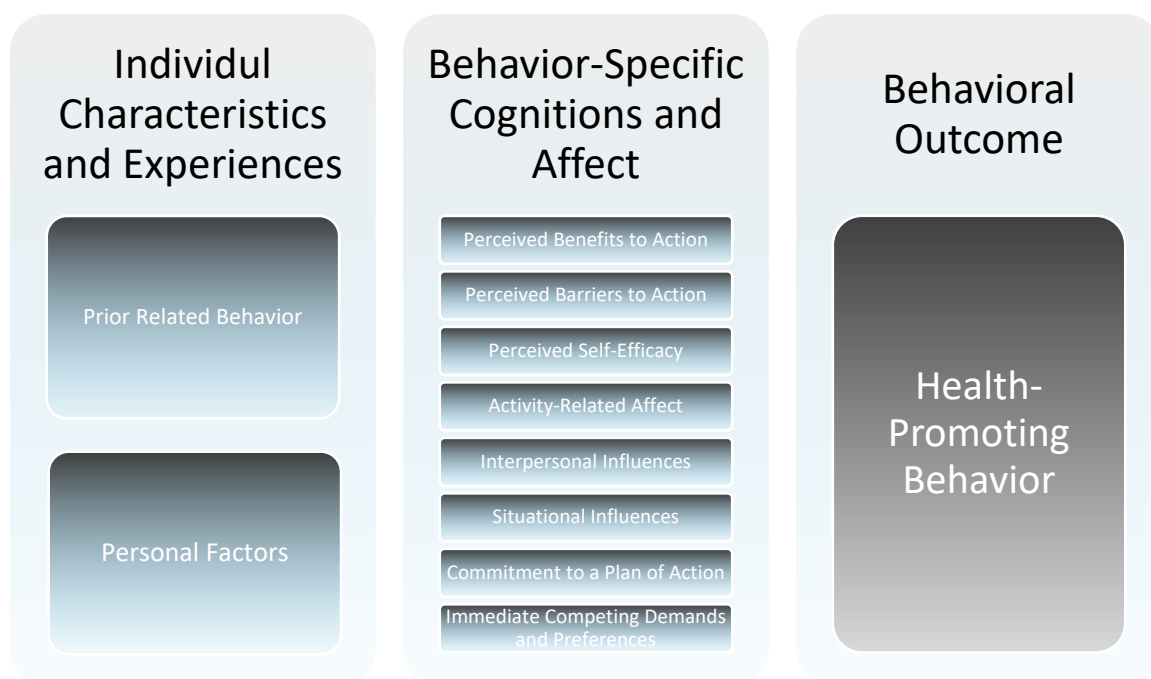
The HPM was revised by Pender in 1996 due to theoretical perspective changes and empirical findings and incorporated the Expectancy Value Theory and the Social Cognitive theory (Pender et al., 2011). The Expectancy Value Theory was a psychological concept which examined an individuals' motivation to complete a task. If individuals do not believe a task can be accomplished or are unwilling to complete it, then it is unlikely that they will be convinced to do so (Ungvarsky, 2023a). The inclusion of the Expectancy Value Theory within the HPM fostered the idea that achieved goals are based on engaging in activities that are perceived as possible (Graham, 2016). The inclusion of the Social Cognitive Theory within the HPM further cultivated how individual's thoughts, behavior, and environment all interact with one another (Pender et al., 2011).

The current HPM has three components (see Figure 1) that define the model, which include individual characteristics and experiences, behavioral-specific cognitions and affect, and behavioral outcomes (Pender et al., 2011). Individual characteristics and

experiences are individuals' prior related behaviors and personal factors. The component of behavioral-specific cognitions and affect has several subcomponents, which include perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affects, interpersonal influences, situational influences, commitment to a plan of action, and immediate competing demands and preferences. Last, the component of behavioral outcomes describes health-promoting behavior and the outcome of health decision-making (Pender, 1987; Pender et al., 2011).

**Figure 1**

*The Health Promotion Model*



*Note.* Adapted from *Health Promotion in Nursing Practice* (6th Edition), by N. J. Pender, C. L. Murdaugh, & M. A. Parsons, 2011, Pearson.

The individual characteristics and experiences component considers individuals, their personal experiences and characteristics which are unique to them, and how these experiences and characteristics affect their actions and outcomes (Ng & Caires, 2016). The individual characteristics and experiences include sub-components, which consist of prior related behaviors and personal factors (Ng & Caires, 2016; Pender et al., 2011). Personal factors such as age, personality, structure, race, ethnicity, and socioeconomic status can all impact the health behavior of individuals (Pender et al., 2011) and are predictive of a certain behavior (Ng & Caires, 2016). The goal of the behavioral outcome component of the HPM is the promotion of health behaviors (Choi et al., 2024; Pender et al., 2011) and is the desired end point or outcome (Pender et al., 2011). The behavioral outcome is the development of a commitment to a plan of action of health behaviors (Choi et al., 2024).

### **Behavior-Specific Cognitions and Affect**

Behavioral-specific cognitions and affect explore individuals' perceptions about the anticipated health outcome (Ng & Caires, 2016). Within the component of behavior-specific cognitions and affect, there are several sub-components which include perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, situational influences, commitment to action, and immediate competing demands and preferences (Ng & Caires, 2016; Pender et al., 2011).

The perceived benefit of action examines individuals' beliefs about the effectiveness of the recommended preventative action and determines how important the health-protecting behavior was to the individual (Pender, 1987). Perceived self-efficacy is

the individual's personal judgment of their own capability to organize and execute the health behavior. The activity-related effect examines individuals' subjective feelings or emotions that occur before, during, and after the health behavior.

Interpersonal influences determine the role of others in an individual's engagement in a specific health behavior (Pender et al., 2011). These other individuals typically include the family, peers, providers, role models, or the social support of the individual engaging in the specific health behavior. Situational influences studies the individual's perception of the compatibility of the life context or environment with engaging in a specific health behavior. Commitment to a plan of action involves the intent to carry out a specific health behavior, which includes identifying specific strategies. Lastly, immediate competing demands and preferences studies the alternative behaviors imposed on the conscious as "possible courses of action just before the intended occurrence of a planned health behavior" (Pender et al., 2016, p. 5). Each of these subcomponents makes up behavior-specific cognitions and affect, determining the extent to which individuals will participate in health-promoting behaviors.

In 2023, Ren and Li used the HPM to demonstrate how interpersonal relationships impacted the self-management of patients living with diabetes mellitus. This study used the intervention effect of the HPM on the physical and mental health of patients living with diabetes mellitus. Researchers found that individuals living with diabetes mellitus were more inclined to improve their cognition by observing or imitating the behaviors, attitudes, and concepts of other important members in their lives. The HPM demonstrated a better intervention effect on health knowledge in patients living with diabetes mellitus

than traditional patient education. Ren and Li's study also showed how the HPM can improve the psychological functioning of individuals living with diabetes mellitus.

Overall, Ren and Li's study of behavior-specific cognitions and affect are important to health-promoting behaviors and actions.

### ***Perceived Barriers to Action***

There are several barriers that can prevent health-promoting behaviors from taking place and are either perceived barriers, real barriers, or both. Barriers such as cost, access to care, unpleasantness, health disparities, or life changes can be both perceived and real barriers (Huntley & Heady, 2013; Pender, 1987). Perceived barriers to action are individuals' perception of barriers to changing their behavior. These blockades are often viewed as obstacles or barriers to behavioral changes which prevent the individual from carrying out health-promoting actions (Primaningtyas et al., 2023). Graham (2016) identified perceived barriers to action using the HPM in women with alcohol use disorder. The results showed found that the overall greatest barriers for these women were lack of money, self-efficacy concerns, time management issues, fatigue, and communication difficulties (Graham, 2016). Using the HPM, Haghi et al. (2021) results showed how significant perceived barriers to action are when determining the efficacy of tooth brushing twice a day. Barriers to action included level of income, parents' education level, self-esteem, the ways of understanding the issues, and different beliefs and habits in the field of oral health. Haghi et al. (2021) found that perceived barriers to action were one of the strongest predictors of commitment to plan of action for tooth brushing behavior.

Pender (1987) found that perceived barriers to action were potential or actual barriers to participating in health-promoting behaviors that are crucial and should be identified early regardless of the individuals' background. Nevertheless, Pender viewed perceived barriers to action as parallel to the perceived benefits of action, stating both components have a direct impact on predisposition to engage in health-promoting behaviors (Pender, 1987). If individuals have low barriers, they tend to engage in health-promoting behaviors. Conversely, if individuals have more barriers, they are less likely to engage in health-promoting behaviors (Pender, 1987; Primaningtyas et al., 2023).

I examined a barrier to action which was the SSOSH. SSOSH is internalized stigma, which often leads to individuals' reduction in their own self-esteem and self-worth (Tucker et al., 2017). SSOSH can increase an individual's perception of barriers to action because of the negative connotations connected with action (Vilades et al., 2024). When individuals seek care, they may be stigmatized by peers or co-workers and feel that the knowledge of having to seek care will affect work relationships and the environment. These negative connotations consist of poor attitudes towards the health-promoting behavior, lowered intention to seek psychological help, and an increase in psychological distress (Vilades et al., 2024). Another negative connotation associated with SSOSH is poor self-esteem (Vilades et al., 2024; Vogel et al., 2011).

Another barrier to action is PS, which refers to the need of individuals within an organization to feel safe to provide their opinions without ridicule, punishment, or negative consequences (Filiz, 2024; Ungvarsky, 2023). PS is a reflection of how individuals feel about their environment. When individuals perceive there is a low level

of PS within their organization, they are less likely to perform a task (Filiz, 2024). The less PS individuals feel within their work environment, there is reduced chance that individuals will offer suggestions or opinions without fear of punishment, embarrassment, or ridicule (Ungvarsky, 2023b). If a work environment provides a low level of PS, individuals are less receptive to participate in health-promoting behaviors, especially those promoted within the organization, such as EAPs. The poor reception to participate in health-promoting behaviors have been found in research that examines the impact of PS on employees, organizations, and leadership (El-Gazar et al., 2024; Filiz et al., 2024; Mrayyan & Al-Rjoub, 2024).

I focused on behavior-specific cognitions and affects, specifically the sub-component of perceived barriers to action. The use of the HPM within this study was the ideal framework because it helped to determine how perceived barriers to action, such as SSOSH and PS, hinder nurses who need support and services from utilizing EAPs, which is a health promoting service. Furthermore, the RQs demonstrated how barriers such as SSOSH and PS can be perceived barriers to action which relates to the HPM.

### **Literature Review Related to Key Variables and/or Concepts**

#### **Employee Assistance Programs**

EAPs aid in the overall well-being of employees. EAPs help employees manage work-related issues, personal issues, and provide mental health resources for employees who need assistance in their private and professional lives (Brooks & Ling, 2020; Zieringer & Zapf, 2024). A range of services are provided, which can include stress management, counseling, substance abuse programs, and workplace conflict (Brandhorst

& Compton, 2022). The use of EAPs can be useful in decreasing burnout, managing mental health issues, increasing employee productivity, decreasing absenteeism, and increasing job performance (Attridge, 2022; Brown-Berchold, 2024; Langlieb et al., 2021).

Knowledge of the effectiveness of EAPs remains consistent. Attridge and Dickens (2021) examined the impact EAPs had on employees' global health, mental health, level of presenteeism, and productive work hours. Their study found that employees' global health improved with the use of EAPs. Their study also found that with greater mental health severity, there was an increase in presenteeism, decreased productivity, and hours lost. These results are similar to those of Wang et al. (2021), whose study aimed to explore the consequence of abusive supervision on employee organizational commitment and general health in the hospitality industry, and the exploration of boundary conditions of EAPs. The results showed that EAPs help moderate the relationship between abusive supervision and organizational commitment, with increased use of EAPs, organizational commitment strengthened. This strengthened commitment and increased work performance while decreasing absenteeism and employee turnover rates.

Another study that produced similar results was by Langlieb et al. (2021). Langlieb et al. (2021) explored the role of EAPs in workplaces that use technology services such as telemedicine. The results showed that early use of EAPs can decrease hospitalizations and long-term disability. The results also demonstrated that with EAP use there is more productivity and decreased absenteeism. Nevertheless, the authors

discuss that with the use of EAPs, companies are able to retain employees and have less callouts or missed days at work.

Although EAPs have been found to positively impact employees' physical and mental health, the number of sessions that employees have can negatively impact their health. Contrary to most literature, Zieringer and Zapf's (2024) study showed that the more EAP sessions employees had workability levels were lower, and absenteeism was higher. The researchers suggested that this contradictory result could be due to a higher level of employee problem severity or not achieving the desired effect of counseling initially, which led to more counseling sessions for the client. The results of this study also found that EAPs did not have an impact on employees' physiological change. Thus, when comparing employees who use EAPs with those who do not use EAPs, both were able to return to a state of physiological homeostasis (Zieringer & Zapf, 2024).

Even with the limited literature available on EAPs, the effectiveness of these programs and their results have remained consistent. Employees who use EAPs have a reduction in work-related stress, improvement in mental health, increased work productivity and job performance, and decreased absenteeism compared to employees who do not utilize EAPs (Brown-Berchtold et al., 2024; Hsu et al., 2020). Even with research studies being conducted in places such as Taiwan (Hsu et al., 2020; Wang et al., 2021), the United Kingdom (Bajorek et al., 2024), the United States (Attridge & Dickens, 2021; Langlieb et al., 2021), or Germany (Zieringer & Zapf, 2024) the results of the studies remain consistent. EAPs, either in the private or federal programs, provide resources that support employee mental health and well-being (Brandhorst & Compton,

2022). However, the issue that remains the same is that EAPs are under-utilized globally (Brooks & Ling, 2020).

Although the results of research focused on EAPs' effectiveness remained steady, there were some notable differences between the studies. For one, there was a limited amount of research studies that explored EAP use in health care settings, and even fewer research studies that examined EAP use in nurses. There was only one study and one integrative literature review that explored nurses and EAP use (Babin et al., 2024; Doran, 2022). The integrative review (Babin et al., 2024) emphasized the lack of longitudinal studies conducted on nurses and EAPs use. Most of the studies included in the integrative review were more than 5 years old and explored different aspects in nursing, such as job satisfaction, burnout rates, workplace support, or EAPs (Babin et al., 2024). Since there was a lack of research on nurses and EAP use, it further demonstrated the importance of my study, which examined nurses who utilized and those who did not utilize EAPs. Another difference between the studies were the geographical locations. The research studies found were conducted in place such as Taiwan, the United Kingdom, the United States, and Germany. Even with research studies conducted in various locations, there was a lack of information exploring the cultural impact on EAPs which would be an important area of further research.

### **Self-Stigma of Seeking Help**

SSOSH relates to negative stereotypes such as inferiority or weakness (Vidales et al., 2024). SSOSH is “an internalized negative belief about public judgment if one were to seek treatment” (Billman Miller et al., 2025, p.4). Self-stigma, which differs from

public stigma, involves the internalized stigma of one's own self-esteem and self-worth (Miller et al., 2024; Mullen & Crowe, 2017; Tucker et al., 2017). Public stigma is the undesirable or socially unacceptable notion when individuals seek health support and services (Tucker et al., 2017). Nonetheless, there are an immeasurable number of individuals who experience health issues but do not seek help. One of the main reasons individuals avoid seeking psychological and physiological help is due to the stigma associated with seeking treatment (Billman Miller et al., 2025; Tucker et al., 2017). Although SSOSH encompasses varying treatment supports and services, the majority of the literature focuses on mental health and mental health support.

The self-stigma of seeking psychological help can potentially be lowered due to the negative connotations associated with mental health in Western culture (Vogel et al., 2011). Seeking psychological help could lower individuals' self-esteem, self-efficacy, and self-concept because the individual may feel inferior or inadequate, which may deter the individual from seeking help (Aigner, 2024; Vogel et al., 2006). Consistent with this perspective are the ideas of Billman Miller et al. (2025), who also described the impact of internalized stigma on individuals' beliefs about mental health treatment. Nevertheless, the SSOSH has been examined across various populations, including gender, race and ethnicity, and occupation.

### ***Gender***

Gender has been found to have an impact on seeking mental health treatment. Research has found that men are less likely to seek mental health treatment than women, even when experiencing the same levels of mental health stressors (Sigal & Plunkett,

2024). Research has also shown that men have higher levels of SSOSH than women (Eagle et al., 2022; Kantar & Yalcin, 2023; Sigal & Plunkett, 2024). Eagle et al. (2022) examined SSOSH with male and female student veterans transitioning from military to student life. The results showed that female students had less SSOSH than male students. The authors' suggested this may be due to the fact that male student veterans view seeking help as a sign of inferiority, and a threat to masculinity, self-confidence, and self-esteem. These results are similar to Kantar and Yalcin's (2023) research, which explored traditional masculine gender role stress and attitudes towards seeking psychological help with SSOSH and self-compassion as mediating variables. Their results found that masculine gender role stress was positively correlated to SSOSH, and both SSOH and self-compassion had a significant effect on attitudes toward seeking psychological help. Furthermore, the study showed that SSOSH had a negative effect on self-compassion. Sigal and Plunkett (2024) investigated the difference between gender, race, public stigma, and SSOSH. The results were similar the research by Kantar and Yalcin (2023) and Eagle et al. (2022). Men, compared to women, had increased SSOSH and negative attitudes towards seeking mental health treatment (Sigal & Plunkett, 2024).

Interestingly, only one study found that there was no difference between genders on the SSOSH. Pfeiffer and In-Albon (2023) investigated the SSOSH on teens and young adults. All the participants of their study had been previously diagnosed with a mental health disorder. The results of this study were opposite of what most research has shown regarding gender differences and SSOSH. The results of this study did not find higher

self-stigma in the male participants. Thus, the researchers were not able to confirm a generalized higher self-stigma in male youths (Pfeiffer & In-Albon, 2023).

The majority of the research that investigated SSOSH and gender were quantitative studies (Eagle et al., 2022; Endriulaitiene et al., 2019; Huang et al., 2023; Kantar & Yalcin, 2023; Miller et al., 2024; Ozdemir et al., 2023; Pfeiffer & In-Albon, 2023; Shannon et al., 2021; Sigal & Plunkett, 2024; Thai & Trang, 2024). The studies were conducted with students as participants, either high school or college-aged (Eagle et al., 2022; Endriulaitiene et al., 2019; Huang et al., 2023; Kantar & Yalcin, 2023; Miller et al., 2024; Ozdemir et al., 2023; Pfeiffer & In-Albon, 2023; Shannon et al., 2021; Sigal & Plunkett, 2024; Thai & Trang, 2024). The samples included in the studies reviewed is a limitation.

### ***Race/Ethnicity***

Race and ethnicity play an important role in SSOSH. African/Black, Latino, Asian, and Middle Eastern Americans have been found to use mental health services at much lower rates than White/European Americans (Mclaughlin et al., 2022; Miller et al., 2024; Shannon et al., 2022). Mclaughlin et al. (2022) explored the relationship between SSOSH and Middle Eastern individuals living in the United States. The study found that Middle Eastern individuals living in the U.S. had higher levels of SSOSH due to past therapy experiences, age, gender, and perceived Islamophobia. These results were similar to those of Miller et al. (2024) who explored the relationship of SSOSH between gender and race as well as individuals with an eating disorder. This study found that Black, Indigenous, and People of Color (BIPOC) had higher levels of SSOSH compared to

Whites and utilized mental health services at lower rates. Like these two studies' results, Shannon et al. (2022) investigated the changes of variances in African American male college students' intention to seek help explained by public stigma, mental health literacy, SSOSH, and self-construal. Results found a positive correlation between African American male college students' intention to seek help, public stigma, and SSOSH. The study showed that public stigma and SSOSH influence the help-seeking intentions of this population.

### ***Occupation***

Research indicated that there was a direct correlation between occupations and SSOSH. Four studies that found this direct correlation were conducted by Harney and Abela (2022); Huang et al., (2023); Ozdemir et al., (2023) and Thai and Trang (2024). These studies all determined that health care providers have an increased level of SSOSH which correlates to poor attitudes and low intention to seek help. Huang et al. (2023) examined the attitudes and intentions of Chinese health care providers to seek professional psychological help during COVID-19. Health care providers had negative attitudes towards seeking professional help due to increased levels of SSOSH. These results aligned with the results from Ozdemir et al., (2023) and Thai and Trang (2024) studies. Both studies found that with high levels of SSOSH, health care providers have poor attitudes toward seeking help and decreased levels of intention to seek help (Ozdemir et al., 2023; Thai & Trang, 2024). Harney and Abela (2022) examined the physical and psychological health behaviors, self-stigma and help-seeking behaviors of doctors in Malta. The results of this study demonstrated that 30% of doctors did not want

others to know that they were experiencing physical health problems in comparison to 59% who did not want others to know that they were experiencing mental health problems. This study revealed that there is a higher level of SSOSH when it comes to mental health issues in comparison to physical health issues especially in health care providers.

Thai and Trang (2024) specifically explored occupation prestige, SSOSH on medical doctors, and current mental health issues as a variable with SSOSH. Although the results were comparable to the other studies, SSOSH was found to mediate the relationship between perception of occupational prestige and mental health issues. The results also revealed that perception of occupational prestige was significantly but negatively correlated with mental health issues and SSOSH. The authors discussed that perception of occupational prestige may be a protective factor for health care providers against mental health issues. They further suggested that SSOSH increases the risk of mental health issues in health care providers because individuals with self-stigma will avoid seeking help in order to protect their self-esteem.

Endriulaitiene et al. (2019) explored the relationship between job burnout and SSOSH among nonmedical health care providers in Lithuania and the United States. Their results found that overall, social workers in the United States had about the same levels of SSOSH as social workers in Lithuania. Nevertheless, SSOSH was shown to be a predictive variable for general burnout in the Lithuanian population.

When it comes to the SSOSH and occupation, there were several studies that explored the relationship between health care workers and SSOSH. This was one of the

strengths of the literature found. Another strength of the literature found on occupation was that research on this area was conducted in different countries. Being able to understand how SSOSH impacts workers in various countries adds more knowledge to this area of research. One limitation of this study is that only one was conducted on nursing students (Ozdemir et al., 2023). Studies should be conducted on nurses in the workforce to determine any relationship between their occupation and SSOSH. More research needs to be completed on other occupations as well to explore how SSOSH impact other occupations.

### **Psychological Safety**

PS is a key component in how employees feel within their work environment. Edmondson (2019) defined PS as individuals' perception on how secure their work environment is to take risks, openly communicate, and express themselves without fear of repercussions. Employees who feel PS are found to have confidence to be their authentic selves without fear of damaging their self-image or hindering career advancement (El-Gazar et al., 2024). PS is an essential component in all work environments. Research has been conducted within health care and non-health-care fields which demonstrated the impact PS has on organizations, employees, and leadership.

In the health care field, PS is a critical component which impacts organizations, employees, and leaders. Research has shown that leaders play an important role in fostering a psychologically safe environment (El-Gazar et al., 2024; Filiz, 2024; Lee & Dahinten, 2021; Porter-Stransky et al., 2024). Lee and Dahinten (2021) conducted a correlational study which explored the relationship between inclusive leaders in health

care, nurse voice behaviors, and error reporting with PS being a mediator variable. The results of this study found that inclusive leaders provided a more psychologically safe environment for nurses which allowed nurses to speak up more and prevented less voice withholding behaviors. The nurses with more inclusive leaders felt more comfortable in reporting errors. As a result, leaders and organizations were able to provide focused education for the nurses on patient safety (Lee & Dahinten, 2021). These results were similar to the results of El-Gazar et al.'s (2024) study which examined the effect of ambidextrous leaders on nurses' creativity both directly and indirectly through PS. Their study validated that leaders could enhance a psychologically safe environment and nurses' creativity. The results found that there was a positive relationship between ambidextrous leadership, PS, and nurses' creativity.

When it comes to health care organizations and leaders, research has determined that creativity and learning are both dependent on PS. El-Gazar et al. (2024) study found a positive relationship between PS and creativity. Their study showed that in psychologically safe environments nurses had increased creativity and felt safe expressing and sharing ideas. Similarly, Lee and Dahinten's (2021) study examined nurses' voice behaviors and PS. Their study found that as PS increased, nurses' creativity and learning increased. The results also showed that PS was positively correlated with speaking up and error reporting intention while being negatively correlated to withholding voice. Applebaum et al. (2020) had similar results on the effects of PS with creativity and learning; however, their study also found that there is less power distance between team members with increased levels of PS.

Learning was another theme found among several studies that evaluated PS as a variable. In these studies, there were two aspects to learning. One focused on being educated on PS, while the other focused on PS and a positive learning environment. Porter-Stransky et al. (2024) conducted a study that provided PS education to health care workers. The results of this study found that learning about PS improved the health care workers' knowledge. Correspondingly, Mrayyan and Al-Rjoub (2024) found a correlation between PS, team learning, and organizational performance. The results of the study showed that with increased levels of PS there was a positive learning environment and employees performed better at work. The results of the study also showed that with higher levels of PS, there was more learning engagement, and employees were more committed to their organizations.

When leadership styles and PS were evaluated, research showed mix results. Mrayyan and Al-Rjoub (2024) found a correlation between PS, team learning, and organizational performance. The study also examined nurse leaders' humility and its relationship to PS. Results found that nurse leaders' humility was not associated with the PS of team members, which the researchers contributed to organizational and team commitment. These results were different in comparison to Lee and Dahinten (2024) and El-Gazar et al.'s (2024) studies which examined the relationship between ambidextrous leadership style, inclusive leaders, and PS. The results of these studies found a correlation between ambidextrous and inclusive leaders and PS.

Within the health care field, organizations and leaders have an impact on fostering PS within their employees and team members. PS, in the health care field has a

correlation on learning and creativity which has been the most researched area (Appelbaum et al., 2024; El-Gazar et al., 2024; Lee & Dahinten, 2021; Mrayyan & Al-Rjoub, 2024; Porter-Stransky et al., 2024). Additional research has also found a direct correlation on organizational justice and work engagement. The research results which have been found on PS remain consistent within the health care field. The literature which has been found on PS in health care all have been quantitative studies. Two of the studies, Appelbaum et al. (2024) and Lee and Dahinten (2021), used PS as a mediator variable, which is important as I used PS as a mediator variable as well.

Research conducted outside of the health care field has revealed similar results to literature within the health care field, PS was correlated with creativity, knowledge sharing, turnover rates. Leaders and organizations have a critical impact on PS within their employees or team members. Gao et al. (2024) examined the relationship between PS, team innovation, and perceived constructive controversy. Results showed that PS is positively related to team innovation and constructive controversy, and PS was an antecedent for team innovation. PS was also found to be related to team creativity and knowledge sharing, which in turn promotes cooperative behaviors, communication, and trust within a team. These results resemble the results from McLaren and Spink's (2022) study, which demonstrated that with an increased level of PS there was no relationship between team member information exchange and perceived task cohesion because goal attainment was better understood. The results also exposed that with increased PS there was an increase in knowledge and idea sharing within teams. Nevertheless, with less PS there is less knowledge and idea sharing which equates to less goal attainment.

Similar to the studies conducted in the health care field, Dwivedi et al. (2023) and Lehman et al. (2023) conducted studies on leadership, humility, and PS. Dwivedi et al. (2023) investigated the effects of CEOs' diversity-value behavior on the turnover rate for female executives and PS. The study's results showed some similar results to that of the health care studies but there were also some noticeable differences. There was more PS with inclusive leaders, which is consistent to what Lee and Dahinten (2021) found. However, the results also revealed that CEOs who value diversity had female leaders with an increased level of PS. Additionally, the results there were lower turnover rates of female leaders whose CEOs valued diversity. Interestingly, when the results of the male leaders were analyzed, no relationship between PS and turnover rates was found. The authors suggested that this is because female leaders are at more of a disadvantage than male leaders.

Lehmann et al. (2023) explored the relationship of humility and relationship-specific performance mediated by PS in the business field. The results echoed what was found by Mrayyan and Al-Rjoub's study, there is a relationship between PS and humility outside of the health care field. The results of Lehmann et al.'s (2023) study showed that PS mediates the relationship between humility and performance perception.

Similarly to the studies within the health care field, most of the research conducted on non-health-care fields has been quantitative studies. Two of the studies also used PS as a mediator, which I examined in this study. One major strength of these studies was that they were conducted on diverse occupational fields. For example, Gao et al. (2024) performed their research on musical bands, McLaren and Spink (2022)

conducted their study on sports teams while Dwivedi et al. (2023) and Lehmann et al. (2023) performed their study on individuals in the business field. However, there were some limitations to these studies. For one, most of the studies found were conducted in the United States. Gao et al. (2024) and McLaren and Spink (2022) performed their studies in different countries. Another limitation was that there was only one study, Woodson (2020), that was a qualitative study which explored PS in Black girls and their directness. More research needs to be done outside of the United States which can expand the knowledge we have about PS outside of the health care industry.

There are several limitations with the research literature on PS. For one, there were not any studies found that used a qualitative approach to examine staff experiences with PS. Another limitation was the location of the studies and the cultural impact. In fact, only two of the studies, Lee and Dahinten (2021) and Mrayyan and Al-Rjoub (2024), discussed the influence culture has on PS. This is an area of literature where further research could be done since there is not enough research completed on the cultural impact of PS. Although there are several studies that examined PS and nurses, the studies are very limited in describing how PS can directly impact nurses. This directly correlates with the gap that I found which demonstrates the need for more research on PS and nurses.

### **Summary and Conclusions**

Common factors such as physical ailments, mental health disorders, substance abuse, and home and work life stressors will affect every adult in the United States at some point in their lives (Bergman & Rushton, 2023). Research has shown that nurses are

at an increased risk for mental health disorders, work burnout, life stressors and physical ailments than the general population (Havaei et al., 2021; Havaei et al., 2023). However, there is a lapse in treatment services for nurses (Rushton & Boston-Leary, 2022). In this chapter, I discussed the purpose of this study, the literature search strategy, the theoretical foundation, and completed a literature review of the key variables of this study. There was a gap in research that examined the SSOSH and the PS in nurses who use and those who do not use EAPs. EAPs can aid in employee overall health and help when stressors arise; yet, the program continues to be underused by nurses (Covarrubias-Lytle, 2023; Doran, 2022).

The purposes of this study were to determine if there was (a) a difference in the level of SSOSH in nurses who used EAPs and those who did not use EAPs, (b) a difference in the level of PS in nurses who used EAPs and nurses who did not use EAPs, and (c) if PS moderated the levels of SSOSH among nurses who use EAPs and those who did not. I used the HPM to guide this research. The HPM has three components to define the model, individual characteristics and experiences, behavioral-specific cognitions and affect, and behavioral outcomes. Yet, for the purposes of this study I focused on behavior-specific cognitions and affect, more specifically the perceived barriers to action. Exploring the variables of SSOSH and PS were important as they were variables that have never been researched on and their impact on EAP use in nursing. In Chapter 3, I provided information on the study's research design and the rationale for the design. I discussed in depth the population I used, the sampling procedure, recruitment

procedures and data collection. I also discussed the data analysis plan, threats to validity, and ethical procedures.

## Chapter 3: Research Method

### **Introduction**

The purposes of this quantitative study was to provide information on (a) the difference in the level of SSOSH between nurses who used employee assisted programs (EAPs), and those who did not, (b) the difference in the level of PS between nurses who used employee assisted programs (EAPs) and those who did not, and (c) if PS moderated the levels of SSOSH among nurses who use EAPs and those who do not. In this chapter, I provide details on how the research was conducted. This chapter includes the research design and rationale, methodology, data analysis plan, threats to validity, ethical procedures, and finally the summary.

### **Research Design and Rationale**

I utilized a comparative research design, which compared the differences between two distinct groups (Gray et al., 2017). In comparative research, the independent variables cannot be manipulated and the groups within the independent variables are naturally occurring (Metler, 2016). This research design best aligned with this study as I compared the differences in two distinct groups, nurses who utilized EAPs and nurses who did not utilize EAPs. Furthermore, neither of these two groups could be manipulated. This research design was necessary to advance the knowledge in the discipline of nursing as it provided information on nurses and EAPs. Since this research design compared nurses who have utilized EAPs and those who did not, it provided insight on the effectiveness of EAPs for nurses. This research design was needed as there were no research studies that have explored SSOSH and PS in EAP use. For this study,

there were two independent variables used, nurses who utilized EAPs and nurses who did not utilize EAPs. The dependent variables for the study were SSOSH and PS for questions one and two. However, for question three, SSOSH was the dependent variable, and the moderating variable was PS. Instruments were used to collect information on these variables.

### **Methodology**

In this section, I provided details on the methodology of this study. Methodology is the type of research selected to answer a RQ (Gray et al., 2017). I provided details into the population for this study including the sample size, sampling procedures, procedures for recruitment, and the data collection. This section also provided an in-depth explanation of the instrumentation and operationalization of constructions.

### **Population**

The target population were nurses currently working in the health care field. I was interested in using nurses with different educational backgrounds, which included LPNs/LVNs, RNs, and APNs. Using G\*Power 3.1 for an independent *t* test, the sample size was calculated to be 102. This was determined with a medium effect size of 0.5, an alpha level of 0.05, and a power of 0.8.

### **Sampling and Sampling Procedures**

I drew from a sample of nurses who identified themselves as LPNs/LVNs, RNs, and APNs. The sample was a stratified sample as the participants were divided into two subgroups, nurses who used EAPs and nurses who did not use EAPs. The use of stratified sampling ensured that each group was well represented (Warner, 2013). The inclusion

criteria included RN, LPN/LVN, and APN, and age 18 years or older. Additionally, participants needed to be currently employed at a hospital, nursing home, private practice, or an academic institution that had an EAP and was located in the United States. Exclusion criteria would be a nurse who was currently not employed, had an inactive license, lived outside of the United States, or worked within an organization that did not have an EAP. To determine the sample size, the G\*Power 3.1 program was used to calculate the number of participants needed for the study. The sample size needed to determine a medium effect size of 0.5, with an alpha level of 0.05 and power of 0.8 was 102, with 51 participants in each subgroup.

### **Procedures for Recruitment, Participation, and Data Collection**

I recruited participants using social media accounts on Facebook and LinkedIn. I obtained permission from the group leaders or the contact person. Once permission was received, a recruitment flyer (see Appendix A) was posted on the social media account, either by the group administrator or me. The flyer included information on the study, university information, link to the survey, and the inclusion criteria. Individuals who wanted to participate clicked on a link within the flyer or the link that was included on the group's posting. The first part of the survey included the informed consent. Following the informed consent, the participants were provided with screening questions which determined if the participants were eligible to be included in the study. The questions were formatted in a yes or no format. If participants responded with a yes to all of the questions, they met the criteria to participate in the study and were able to move to the

demographics page (see Appendix B). If the individual did not answer yes to all of the screening questions, the survey ended automatically.

Informed consent was provided prior to collecting any survey data and before inclusion eligibility had been determined. The participants were provided the informed consent document in its entirety. The informed consent included the purpose of the study, the procedures of the study, the voluntary nature of the study, and the risks and benefits associated with the study. The participants were made aware that the survey was anonymous and that they were able to opt out of the survey at any point while completing the survey. At the end of the informed consent, participants were presented with a question that asked if they had read through the informed consent and agreed to participate in the study. If they answered no, the survey closed, and they were not presented with any study questions. If they answered yes, they were taken to the demographics page. The demographic data included age, gender, geographic location, level of education, nursing license type, and number of years as a nurse. After completing the demographics survey, the participants received the study questions. Once the survey was completed, the participants were made aware that their answers had been recorded, that they have completed the requirements for the study, and they were thanked for their time as well as participating in the survey.

### **Instrumentation and Operationalization of Constructs**

The variables used in this study were SSOSH and PS. SSOSH examined the level of self-stigma in nurses, whereas PS examined the PS in nurses.

### *Self-Stigma of Seeking Help-Revised*

The first dependent variable that was examined in this study is the SSOSH. This variable was used to determine if there was a difference in the levels of SSOSH among nurses who used EAPs and nurses who did not. The variable was measured using the SSOSH-7 scale (see Appendix C). The original SSOSH scale was developed by Vogel et al. (2006). The SSOSH scale was developed to measure individuals' perception that seeking help from mental health professionals would threaten one's self-regard, satisfaction with oneself, self-confidence, and overall self-worth (Vogel et al., 2006). The original scale consisted of 10 items that were scored using a Likert scale. However, in 2021, Brenner et al. revised the SSOSH by removing three items because they were reverse-scored items. The developers explained that the three items removed may have inadvertently reflected attitudes regarding the efficacy of therapy rather than the self-stigmatization of seeking help (Brenner et al., 2021). The revised scale consisted of seven items that are scored using a 5-point Likert scale. The SSOSH scale was appropriate for my study as it examined self-stigma in nurses who sought help in regards to EAP use.

I did not need permission to use the SSOSH-7 scale as the purpose of this study was for non-commercial research and educational purposes (see Appendix D). The SSOSH scale had been used in over 150 studies and 12 countries worldwide (Brenner et al., 2021). The scale has been used with a variety of populations including men, women, college students, teenagers, young adults, health care providers, BIPOC, and participants in countries outside of the United States (Eagle et al., 2022; Kantar & Yalcin, 2023; Miller et al., 2024; Pfeiffer & In-Albon, 2023; Sigal & Plunkett, 2024; Thai & Trang,

2024; Vidales et al., 2024). Internal consistency reliability was 0.89 (Brenner et al., 2021). Validity was established when the developers observed similar correlations between the SSOSH-7 scale and the original SSOSH scale. Validity was also demonstrated when the SSOSH-7 scale showed similar correlations with other help seeking constructs such as public stigma, attitudes, and intention (Brenner et al., 2021). The sample used to establish validity and reliability of the SSOSH-7 were community adults. The study was replicated in a sample of undergraduate students which provided evidence of internal consistency (Brenner et al., 2021).

SSOSH was defined as an internal negative belief about the perception of others if the individual seeks mental health treatment (Billman Miller et al., 2025). SSOSH was measured using the SSOSH-7 scale. With the SSOSH-7 scale, the mean of all the items calculated was the total score. The higher the total score indicated a higher level of SSOSH (Vogel et al., 2006).

### ***Psychological Safety Inventory***

I used the PSI (see Appendix E) to measure the level of PS among nurses who used EAPs and nurses who did not. The PSI was developed by Plouffe et al. (2023) to improve upon the Psychological Safety Scale. Although the PSI had many items that were correlated with the Psychological Safety Scale, the PSI also examined managerial leadership, team climate for innovation, organizational support, and one's organizational culture (Plouffe et al., 2023). The PSI consisted of 30 items which were scored on a 5-point Likert scale. The scores ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). This scale measured the components of interpersonal risk-taking, mutual trust and

respect, organizational and structural support, identity and clarity, and supportive leadership. This scale was appropriate for my study as it examined the psychological component in nurses who used EAPs and those who did not.

I did not need permission to use this scale as the scale was used for non-commercial research and educational purposes (Plouffe et al., 2023; see Appendix F). Internal consistency reliability of the PSI total was 0.95, and the subscales had a range from 0.82 to 0.93. Convergent validity of the PSI scale and subscales were all significant. The scale and subscales were all positively correlated with the Psychological Safety Scale (Plouffe et al., 2023). Plouffe et al. (2023) used a sample of 497 employees from Canada, the United States, and the United Kingdom to establish validity and reliability. The scale had been used on various populations within differing workforce fields. Populations included health care workers, musical bands, business employees, and female executives (Dwivedi et al., 2023; El-Gazar et al., 2024; Filiz et al., 2024; Gao et al., 2024; Lee & Dahinten, 2021; McLaren & Spink, 2022; Porter-Stransky et al., 2024).

PS was defined as individuals' perception of how mentally and cognitively secure their work environment is (Edmondson, 2019). PS was measured by using the PSI scale. The PSI scale was calculated similarly to the SSOSH-7 scale. The total score was calculated by obtaining the mean of all items. The subscale scores were calculated by calculating the mean of the following items, interpersonal risk-taking, mutual trust/respect, organizational/structural support, identity and clarity in context of team, and supportive leadership (Plouffe et al., 2023).

### ***Employee Assistance Programs***

I defined EAPs, as a program within an organization that assisted employees with work, personal, and mental health related issues by providing resources for the employees (Brooks & Ling, 2020; Zieringer & Zapf, 2024). EAPs were measured using a one-item question. The participants either responded with a yes or no answer about their utilization of an EAP.

### **Data Analysis Plan**

#### **Software**

To collect the data, I used the online survey software, SurveyMonkey. All data were collected anonymously. All collected data were imported to IBM Statistical Package for the Social Sciences (SPSS) Version 29. I cleaned and screened the data in SPSS for any missing values, duplicates, or outliers. If there were values missing, duplications, or outliers then the data were deleted. Prior to analysis, I tested the assumptions for each RQ. The data were also checked for normal distribution, homogeneity of variance, and data entry errors.

#### **Research Questions and Hypotheses**

RQ1: What is the difference in the levels of SSOSH between nurses who use EAPs and those who do not?

$H_0$ 1: There is no difference in the levels of SSOSH between nurses who use EAPs and those who do not.

$H_a$ 1: There is a difference in the levels of SSOSH between nurses who use EAPs and those who do not.

RQ2: What is the difference in level of PS among nurses who use EAPs and those who do not?

*H<sub>02</sub>*: There is no difference in PS among nurses who use employee assisted programs EAPs and those who do not.

*H<sub>a2</sub>*: There is a difference in PS among nurses who use EAPs and those who do not.

RQ3: How does PS moderate the levels of SSOSH among nurses who use EAPs and those who do not?

*H<sub>03</sub>*: PS does not moderate the levels of SSOSH among nurses who use EAPs and those who do not.

*H<sub>a3</sub>*: PS does moderate the levels of SSOSH among nurses who use EAPs and those who do not.

### **Analysis and Statistical Tests**

I analyzed the first and second RQs using an independent *t* test. An independent *t* test is used when the researcher wants to determine the difference between two independent groups on a continuous dependent variable (Laerd Statistics, 2015). Several assumptions had to be met for an independent *t* test to be conducted. There needed to be one dependent variable measured on a continuous or interval level, one independent variable with two categorical groups, and an independence of observations where there is no relationship between each group in the independent variable (Laerd Statistics, 2015). There also needed to be no significant outliers, the dependent variable should be normally

distributed for each independent group, and there needed to be homogeneity of variances (Laerd Statistics, 2015; Warner, 2013).

Each assumption was evaluated to ensure valid results. The dependent variable, SSOSH and PS was measured on a continuous level. The independent variables of nurses who used EAPs and nurses who did not, were the two independent categorical groups. Each participant could not be a member of both groups. If independence of observations was violated, then a paired  $t$  test was considered. Outliers were assessed by examining a boxplot. If there were outliers, the researcher could have either kept the outliers or omitted them. If the outlier were omitted, it was important for the researcher to provide information about the data being omitted. Once an outlier was omitted the researcher had to rerun the analysis. To assess for normality of independent groups, a Shapiro-Wilk test was performed. If the significance level in the Shapiro-Wilk test is greater than .05, then the data were normally distributed. If the level is less than .0, then the data were not equally distributed. If the data were not normally distributed the researcher could have transformed the dependent variable within SPSS and then re-run the tests of assumptions. Lastly, homogeneity of variances was assessed by performing the Levene's test of equality of variances. If homogeneity of variance was violated the p-value for the Levene's test would be less than .05. In this instance, the researcher would need to perform a Welch  $t$  test (Laerd Statistics, 2015).

SSOSH was measured using the SSOSH-7 scale, which had 7 questions. PS was measured using the PSI, which consisted of 30 questions. Each question was scored on a 5-point scale, with 1 equaling *strongly disagree* and 5, *strongly agree*; Plouffe et al.,

2023). For both scales, the total score was calculated by tallying the mean of all items on the scales.

For the third question, I used a moderation analysis. A moderation analysis was used to determine if the relationship between two independent and dependent variables were changed by a third, moderating variable (Laerd Statistics, 2015). According to Warner (2013), the relationship between the independent variable and the dependent variable depends on the scores of the moderating variable. In the case of this research, this statistical test was appropriate for RQ3 as I wanted to determine if PS, as a moderating variable, changed the relationship or interaction between SSOSH, the dependent variable, and EAP usage among nurses, the independent variable.

There were several assumptions associated with a moderation analysis. First, there needed to be independence of observations. If independence of observations was violated, then the study design should have been reconsidered, and another statistical test should have been used. Second, there needed to be linearity between the variables. That was, the relationships between the independent, moderator, and dependent variables were linear. If this assumption was violated, then I could have transformed the variables or apply nonlinear mediation models. The third assumption was that there was no multicollinearity. Multicollinearity could occur when the independent and moderator variables are correlated with one another. If this assumption was violated, I could have mean centre the independent variable to reduce multicollinearity and then recalculate the interaction and re-run all the tests of assumptions. The next assumption was to check for outliers. If there were outliers, I could have either kept the outliers or omitted them. If the

outlier was omitted, I would have provided information about the data being omitted.

Once an outlier was omitted the analysis would have been rerun.

The next assumption encompassed homoscedasticity. There must be homoscedasticity, meaning the variance of residuals in the regression model should be constant. If there was heteroscedasticity, the data would have been transformed, or a weighted least-squares regression would have been ran. Lastly, normality should be tested. This assumption assured that the sets of values of the independent variables were normally distributed. If the data were not normally distributed, I could have transformed the dependent variable within SPSS and then re-ran the tests of assumptions (Laerd Statistics, 2015). I also conducted a Cronbach's alpha on the SSOSH scale and the PS scale.

### **Threats to Validity**

*Validity* refers to the truthfulness of the study (Gray et al., 2017). It is the degree to which “an entity that the researcher believes is being performed, evaluated, measured, or represented is actually what is being performed, evaluated, measured, or represented” (Gray et al., 2017, p. 197). There are threats to validity that could be critical to a study. Typically, the researcher should be concerned with threats to external validity, internal validity, and construct validity.

### **External Validity**

External validity is the extent to which the findings of the study can be generalized beyond the sample or participants of the study (Gray et al., 2017). For my study, one risk to external validity would be not having an equal representation of nurses

who used EAPs compared to those who have. Another example of external validity for this study was if there were more LPNs who replied to the survey than RNs or APNs. Another possible threat was if the findings were not applicable to nurses in various settings. For example, the study may be more applicable to nurses working in hospitals or nursing homes compared to nurses working in school settings or in academia.

### **Internal Validity**

Internal validity is the assessment of the extent to which the measured relationship between the independent and dependent variables are solely due to their interaction, and the extent to which other intrusive variables might impact their relationship (Gray et al., 2017). An example of threats to the internal validity of this study would be the difference in the nurses' roles. Since the study was seeking participants that identified themselves as LPNs, RNs, and APNs, the scope of practice was different for each group of nurses. Also, each nurse may be in a different job role which could have influenced their level of SSOSH or PS. For example, if a participant was in the role of staff nurse, their level of SSOSH and PS may be different than that of a nurse working as a nurse manager within the same organization. Therefore, their role may have impacted the relationship of the variables being study.

### **Construct Validity**

*Construct validity* refers to the alignment of the study's measurement instruments with the theoretical concept which it intends to measure (Gray et al., 2017). One threat to construct validity is mono-operational bias. Since the variables were only being measured one way, there was an increased likelihood of having systematic errors. Another possible

threat to construct validity of this study was related to social interplay or social desirability. Social desirability was when the participants modify their behavior or answers to what was believed to be socially acceptable (Gray et al., 2017). For this study, nurses may have not answered the questions to the SSOSH-7 scale and the PSI truthfully, as they may have wanted to appear to have lower levels of SSOSH or an increased level of PS within their organization.

### **Ethical Procedures**

I followed the ethical guidelines outlined by Walden University's Institutional Review Board. Prior to beginning any data collection, I obtained the Institutional Review Board's approval (no. 07-28-25-1057332). Permission was also requested from the organizers of each Facebook and LinkedIn group. Participants' consent was obtained at the beginning of the survey, and each participant was made aware that they could opt out of the survey at any time. One major ethical concern for the participants was confidentiality. Confidentiality is private information which is shared by participants which must not be shared with others without the permission from the participants (Gray et al., 2017). The participants were made aware at the beginning of the survey that all of their information would be kept confidential. No identifying information was asked of the participants. I did not collect their names or any personal information that could be linked to the participants. This was done to reassure the participants that their information and responses would be kept anonymous. The participants' data were kept anonymous by using SurveyMonkey's anonymous responses collector option, which prevented tracking and storing of the participants' information. This option ensured that information such as

names, email addresses, or IP addresses were not linked to survey responses.

Demographic data were reported in aggregate. Data were preserved on a hard drive for reference and will be destroyed after 5 years.

### **Summary**

In summary, I provided details of the design and methods that was used for this study. I used a comparative research design that examined SSOSH and PS of nurses who utilized EAPs and nurses who did not. I described the research design and rationale of the design choice. The methodology section of this chapter provides information on the target population, sampling procedures, recruitment methods, and data collection for this study. I described how I analyzed the data, the instruments that I used, and the operationalization of these instruments. I presented a thorough description of the threats to validity and the ethical procedures that were performed. Next, in Chapter 4, I provided the results of the study.

## Chapter 4: Results

### Introduction

The purposes of this study were to determine if there was (a) a difference in the level of SSOSH in nurses who have used EAPs and those who have not used EAPs, (b) a difference in the level of PS in nurses who have used EAPs and nurses who have not used EAPs, and (c) if PS moderated the levels of SSOSH among nurses who used EAPs and those who have not. The RQs and hypothesis were as follows:

RQ1: What is the difference in the levels of SSOSH between nurses who use EAPs and those who do not?

$H_{01}$ : There is no difference in the levels of SSOSH between nurses who use EAPs and those who do not.

$H_{a1}$ : There is a difference in the levels of SSOSH between nurses who use EAPs and those who do not.

RQ2: What is the difference in the levels of PS among nurses who use EAPs and those who do not?

$H_{02}$ : There is no difference in the levels of PS among nurses who use EAPs and those who do not.

$H_{a2}$ : There is a difference in the levels of PS among nurses who use EAPs and those who do not.

RQ3: How does PS moderate SSOSH among nurses who use EAPs and those who do not?

$H_03$ : PS does not moderate SSOSH among nurses who use EAPs and those who do not.

$H_{a3}$ : PS does moderate SSOSH among nurses who use EAPs and those who do not.

In this chapter, I provide information on data collection, and I present the results of the study. The chapter concludes with a summary of the results in response to the RQs.

### **Data Collection**

I collected data over a 5-week period using SurveyMonkey. There was a total of 52 questions, which included a demographics survey, the SSOSH-7 scale, and the PSI. I recruited participants by posting my recruitment flyer on six social media accounts on Facebook and LinkedIn. My survey was also posted on Walden University's Participant Pool page, as well as my personal Facebook and LinkedIn pages. During the first 2 weeks of recruitment, a total of 53 individuals participated. After the first 2 weeks, I reposted the recruitment flyer on the same social media pages and received an additional 31 participants. After an additional 7 days, I reposted the recruitment flyer for a third time. I received a message from two professional group administrators recommending that I post my recruitment flyer on the group pages they manage. After posting my flyer on these two additional groups, I received an additional 70 participants. At the end of 5 weeks, a total of 154 participants consented to participating in the study.

A total of 154 participants started the survey by completing the consent section of the survey; however, not all 154 participants completed the survey. A filter was used in SurveyMonkey to view only surveys that were completed, which resulted in 137

participants with complete data. The average time it took to complete the survey was 4 min 12 s. The data from SurveyMonkey was imported into SPSS. The data were cleaned and screened for any missing data. The plan was to remove participants with missing data from the data set. This process was started by carefully reviewing each data column and row for any missing information. I found that there was no missing data in any data row and column. After reviewing the data no participant responses were removed. The final sample for my study was 137 participants.

The population of interest were nurses who have used or have not used EAPs. The participants varied in age, race, gender, geographical location, license type, level of education, length of practice, current job position, and current job status. All participants included in the analyses either have used or have not used EAPs. The participants were predominantly female (88.3%), aged 35-44 (28.5%), White (67.9%), located in the Northeast region of the United States (29.9%), were RNs (73.0%), had a bachelor's degree (43.8%), practiced for over 20 years (27.0%), worked as a staff nurse (61.3%), and worked full-time (75.2%). The sample of my study was similar to the population of interest. According to the American Association of College of Nursing (2024), as of 2022 the population of RNs were 80% White, 88.8% were female, and 71.7% of RNs held a baccalaureate degree or higher.

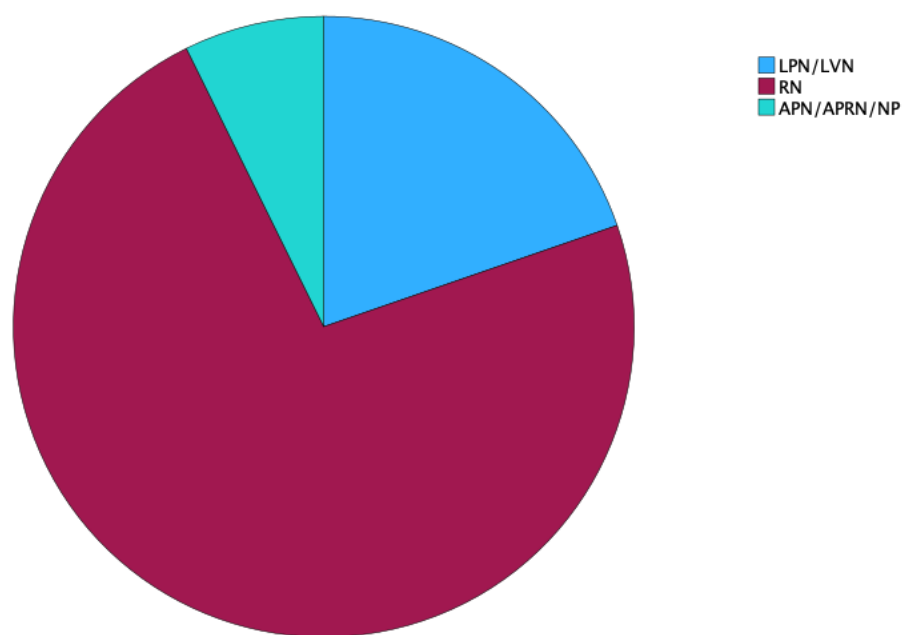
## **Results**

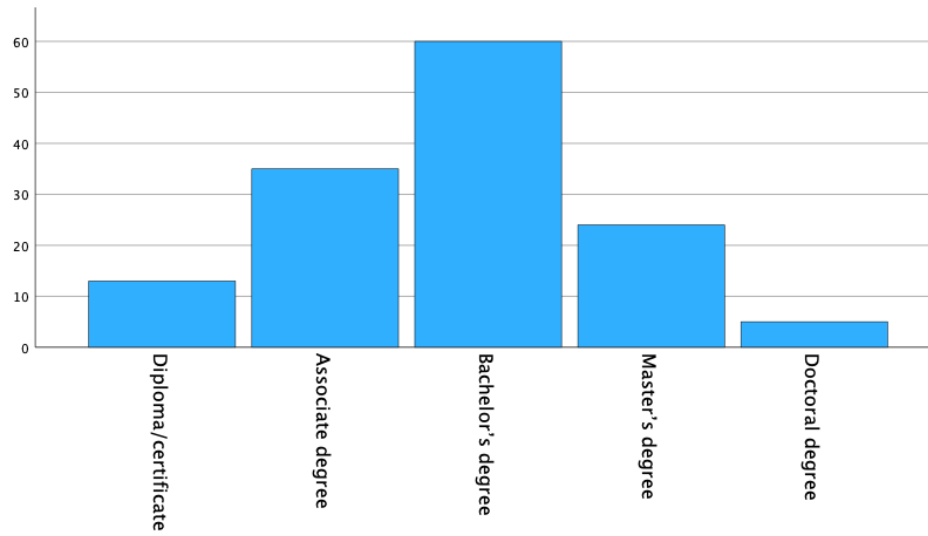
Of the 52 questions asked using SurveyMonkey, nine were demographic questions (see Appendix C). Figures 2 and 3 and Table 1 show the demographic

characteristics of the sample. The majority of the participants were White, women, aged 35-44, who were registered nurses, with a bachelor's degree.

**Figure 2**

*Nursing Licensure Type*



**Figure 3***Highest Level of Education Completed*

**Table 1***Participants' Demographic Characteristics*

Characteristics	<i>f</i>	%
Region		
Northeast	41	29.9
Southeast	32	23.4
Midwest	27	19.7
Southwest	20	14.6
West	17	12.4
Length of practice (years)		
< 1 year	3	2.2
1–5	35	25.5
6–10	27	19.7
11–15	19	13.9
16–20	16	11.7
> 20	37	27.0
Role/position		
Staff nurse	84	61.3
Supervisor/manager	11	8.0
Advanced practice nurse	18	13.1
Clinical nurse specialist	3	2.2
Educator	5	3.6
Administrator	3	2.2
Other	13	9.5
Job status		
Full-time	103	75.7
Part-time	22	16.2
Per diem	11	8.1

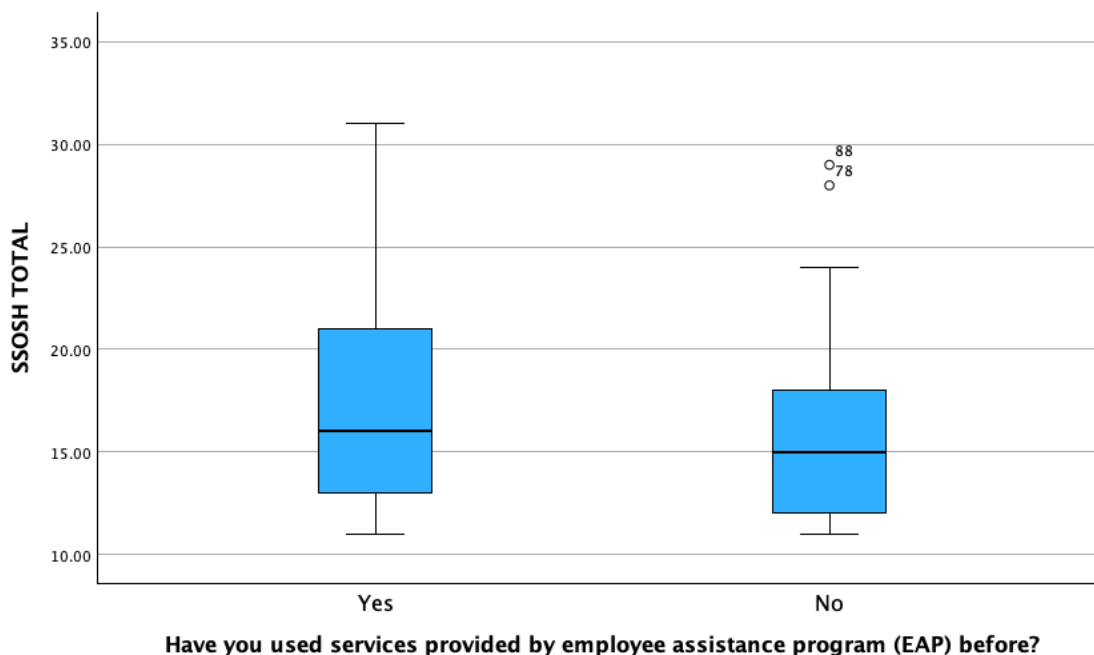
**Research Question 1**

RQ1: What is the difference in the levels of SSOSH between nurses who use EAPs and those who do not?

*H*<sub>0</sub>1: There is no difference in the levels of SSOSH between nurses who use EAPs and those who do not.

$H_{a1}$ : There is a difference in the levels of SSOSH between nurses who use EAPs and those who do not.

To evaluate the difference in the levels of SSOSH between nurses who use EAPs and those who do not, I conducted an independent  $t$  test. Prior to analyzing the data, the assumptions of the  $t$  test were assessed. The first assumption was met since the dependent variable, SSOSH (SSOSH\_Total), was measured on a continuous level. The second assumption was met because there was one independent variable that consisted of two categorical, independent groups. The independent variable was whether nurses used EAPs or not (EAP\_USE), measured as a categorical variable with two options: “yes” or “no.” These groups were independent of each other, as nurses either used EAPs or they did not. The third assumption was met, there was an independence of observations, and there was no relationship between each group in the independent variable. The fourth assumption for this test was that there were no significant outliers from the independent variable in terms of the dependent variable. I evaluated this by examining the boxplot for this RQ. For RQ1 (see Figure 4), there were no outliers greater than 1 box-length from the edge of the box in the Yes group. Two data points were identified as outliers in the No group. These data points were not extreme outliers because they were not greater than 1.5 boxplots from the outer edge and therefore were not removed from the analysis.

**Figure 4***Self-Stigma of Seeking Help Boxplot*

The fifth assumption was assessed using the normal quartile–quartile (Q–Q) plots and the Shapiro-Wilk test. SSOSH scores were normally distributed for both groups of EAP use, as assessed by visual inspection of normal Q–Q plots. However, the Shapiro-Wilk test found SSOSH total scores based on EAP use were not normally distributed,  $p < .001$ . The sample sizes in each group were nearly equal, with 70 in the yes group and 67 in the no group. Since the independent-samples  $t$  test was utilized due to its robustness, deviations from normality and non-normality does not substantially affect Type I error rates (Laerd Statistics, 2015).

The last assumption for RQ1 was homogeneity of variances. There was homogeneity of variances for SSOSH total scores for nurses who used EAPs and nurses

who did not use EAPs, as assessed with Levene's test for equality of variances ( $p = .098$ ).

The independent  $t$  test was performed to determine if there were differences in SSOSH between nurses who used EAPs and nurses who have not used EAPs. Higher levels of SSOSH were found in nurses who have used EAPs than nurses who have not used EAPs. A statistically significant difference of 1.80, 95% CI [0.22 to 3.39],  $t(135) = 2.250$ ,  $p = .026$  was noted (see Table 2). There was a statistically significant difference between the group means; therefore, the null hypothesis was rejected, and the alternative hypothesis was accepted.

**Table 2**

*Independent t test of Participants' Self-Stigma of Seeking Help*

		Levene's test for equality of variances				$t$ test for equality of means					
		F	$p$	$t$	$df$	$p$		$M$	$SE$	95% CI of the difference	
						One-sided	Two-sided	differe nce	differe nce	$LL$	$UL$
SSOSH Total	Equal variances assumed	2.784	.098	2.2	135	.013	.026	1.8017 1	.80068	.21821	3.3852 1
	Equal variances not assumed			2.2	132	.013	.026	1.8017 1	.79749	.22424	3.3791 7

*Note.* CI = confidence interval;  $df$  = degrees of freedom; F = F- statistic;  $LL$  = lower limit;  $M$  = mean;  $p$  = p-value;  $UL$  = upper limit;  $SE$  = standard error; SSOSH = Self-stigma of seeking help;  $t$  = t-distribution.

**Research Question 2**

RQ2: What is the difference in the levels of PS among nurses who use EAPs and those who do not?

*H<sub>0</sub>2*: There is no difference in the levels of PS among nurses who use EAPs and those who do not.

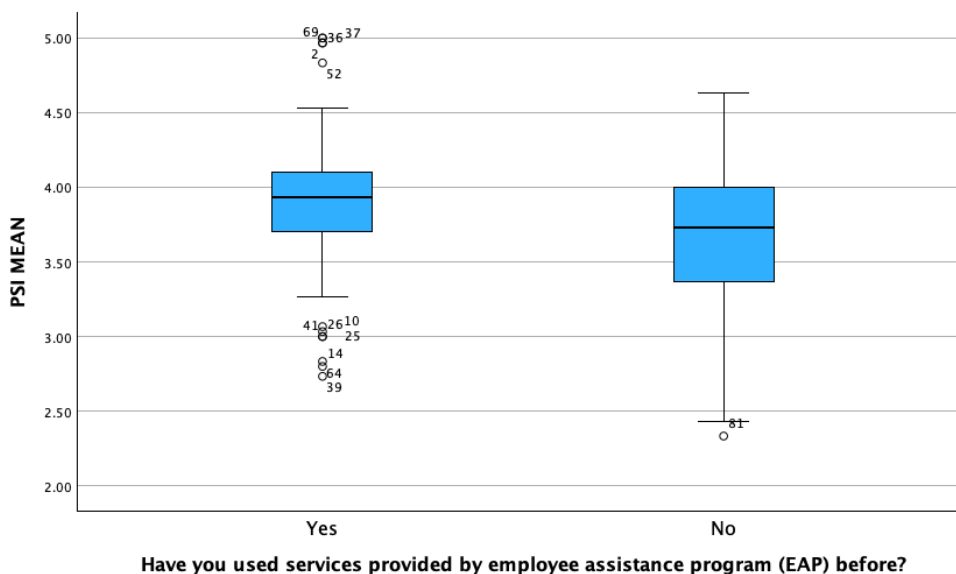
*H<sub>a</sub>2*: There is a difference in the levels of PS among nurses who use EAPs and those who do not.

The same statistical assumptions that were evaluated for RQ1 were evaluated for RQ2 prior to analyzing any data. The analysis used for this question was the independent *t* test. The first assumption was met since the dependent variable, PSI (PSI\_Mean), was measured on a continuous level. The second assumption was met because there was one independent variable that consisted of two categorical, independent groups. The independent variable was nurses who used EAPs and nurses who did not (EAP\_USE), which was measured with a category of “yes” or “no.” These groups were independent of each other as nurses either used EAPs or they did not, this ensured that the third assumption was met. The fourth assumption for this test was that there were no significant outliers from the independent variable in terms of the dependent variable. To determine if the fourth assumption was met, I examined the boxplot for any significant outliers. There were several outliers in the Yes group (nurses who have used EAPs). All these outliers were less than 1 box-length away from the edge of the box, except for one which was 2 box-lengths away from the edge of the box. Since this outlier was an

extreme outlier, it was removed from the data, and the analysis was re-tested. The results showed there were no further extreme outliers after the analysis was rerun (see Figure 5).

**Figure 5**

*Psychological Safety Inventory Boxplot*



*Note.* PSI = Psychological Safety Inventory.

Next, I examined normality, which was the fifth assumption. This assumption ensured that the dependent variable was normally distributed for each group of the independent variable. The fifth assumption was assessed using the normal Q–Q plots and the Shapiro-Wilk test. PSI scores were normally distributed for both groups of EAP use, as assessed by visual inspection of normal Q–Q plots. The Shapiro-Wilk test showed that the mean score for PSI was not normally distributed in the Yes group ( $p < .012$ ) but was normally distributed in the No group ( $p > 0.5$ ). Again, the sample sizes in each group

were nearly equal, with 69 in the yes group and 67 in the no group. The independent-samples *t* test was utilized due to its robustness to deviations from normality, and non-normality does not substantially affect Type I error rates (Laerd Statistics, 2015).

Lastly, the assumption of homogeneity of variances was determined for RQ2. This was determined by evaluating the Levene's test of equality of variances. There was homogeneity of variances for PSI mean scores for nurses who used EAPs and nurses who did not use EAPs, as assessed by the Levene's test for equality of variances ( $p = .298$ ). The independent *t* test was performed to determine if there were differences in the levels of PS between nurses who used EAPs and nurses who have not used EAPs. Higher levels of PS were found in nurses who have used EAPs than nurses who have not used EAPs. A statistically significant difference of 0.21, 95% CI [0.03 to 0.38],  $t(134) = 2.355$ ,  $p = .020$  was noted. There was a statistically significant difference between the group means; therefore, the null hypothesis was rejected, and the alternative hypothesis was accepted (see Table 3).

**Table 3***Independent t test for Psychological Safety*

		Levene's test for equality of variances				<i>t</i> test for equality of means					
		F	<i>p</i>	<i>t</i>	<i>df</i>	<i>p</i>		<i>M</i> difference	<i>SE</i> difference	95% CI of the difference	
						One-sided	Two-sided			<i>LL</i>	<i>UL</i>
PSI	Equal variances assumed	1.093	.298	2.3	134	.010	.020	.20913	.08879	.03351	.38474
ME	Equal variances not assumed			2.3	132	.010	.020	.20913	.08889	.03330	.38496
AN				53	.51						
					3						

*Note.* CI = confidence interval; *df* = degrees of freedom; F = F- statistic; *LL* = lower limit; *M* = mean; *p* = p-value; PSI = Psychological Safety Inventory; *UL* = upper limit; *SE* = standard error; *t* = t-distribution.

**Research Question 3**

RQ3: How does PS moderate SSOSH among nurses who use EAPs and those who do not?

*H*<sub>03</sub>: PS does not moderate SSOSH among nurses who use EAPs and those who do not.

*H*<sub>a3</sub>: PS does moderate SSOSH among nurses who use EAPs and those who do not.

For RQ3, I conducted a moderation analysis; however, prior to analyzing the data there were several assumptions that needed to be met. First, the data were analyzed to determine that there was independence of observations. This meant that one observation did not provide information about another observation. Second, the data were tested for

linearity. The scatterplot graph, which was examined to determine if a linear relationship existed between the variables. A fit line was added to the graph and shows that linearity was established by visual inspection of the scatterplot.

The next assumption that was explored was multicollinearity. Testing for multicollinearity can be determined by examining the collinearity statistics. Two of the three variables, as shown in Table 4, had a tolerance value less than 0.1, which indicated a collinearity issue. Because of the concern with collinearity a nonparametric correlation test, Kendall's tau, was performed. Results showed that the correlation was -.148 which is a very small correlation; therefore, there was no multicollinearity concern.

**Table 4**

*Collinearity Statistics*

Collinearity statistic	Tolerance	VIF
Constant		
EAP_NO	.018	55.809
PSI_x_EAP_NO	.019	53.743
PSI M	.451	2.219

*Note.* VIF = variance inflation factor; EAP = employee assistance program; PSI = Psychological Safety Inventory.

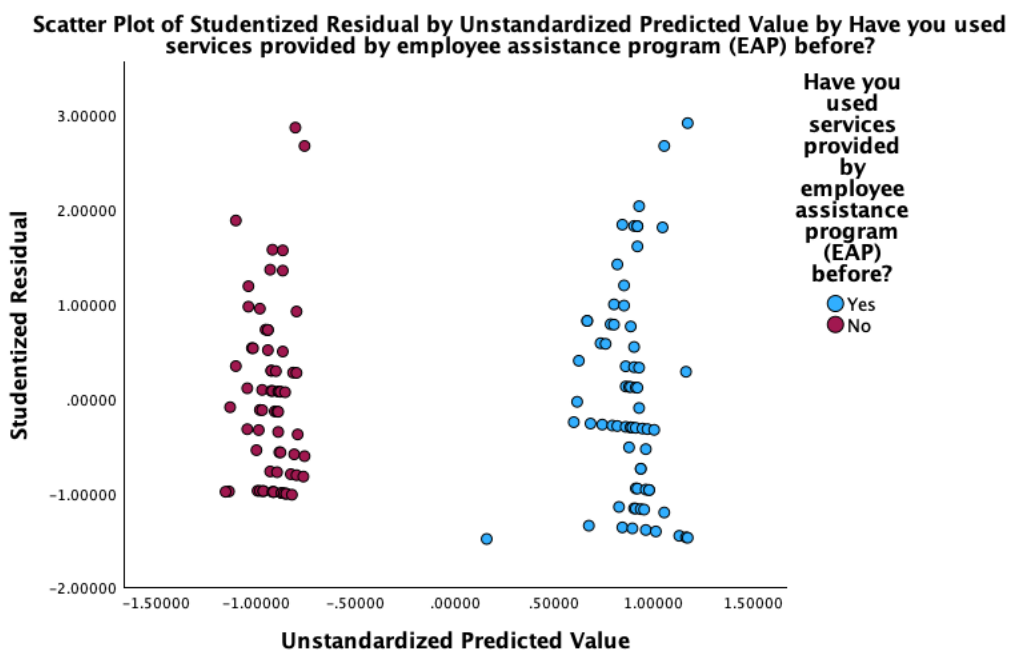
Next, I inspected the data for any outliers, leverage points, and influential cases. A studentized deleted residuals test was run, which detects any outliers. This test demonstrated that there were five cases that were greater than +2 standard deviations, which can be classified as potential outliers. To determine if these outliers should be omitted or left in the analysis, they were further investigated to establish if they were high

leverage points and influential cases. With careful inspection of these cases, it was determined that they were not high leverage points nor were they influential cases.

Next, I tested the assumption of homoscedasticity by examining a scatterplot graph (see Figure 6). There was homoscedasticity, as assessed by visual inspection of the studentized residuals plotted against the predicted values for nurses who have used EAPs and nurses who have not. The data appear random, with no noted pattern. Lastly the assumption of normality does not apply because the independent variable is categorical and not continuous (Laerd Statistics, 2015).

**Figure 6**

*Scatterplot for Homoscedasticity*



The third RQ evaluated whether PS moderated SSOSH among nurses who used EAPs and nurses who did not. The null hypothesis stated that PS did not moderate

SSOSH among nurses who used EAPs and nurses who did not. The regression analysis model summary demonstrated that PS did not moderate SSOSH in nurses who used EAPs and nurses who did not, as evidenced by an increase in total variation explained of 3.7%, which was not statistically significant ( $F(3, 133) = 1.697, p = .171$ ). The regression coefficient also demonstrated that PS did not moderate SSOSH in nurses who used EAPs and nurses who did not as  $\beta = -.080, t(133) = -.056, p = .942$ . Therefore, the null hypothesis was accepted.

### Summary

Based on the statistical analyses completed, the first two RQs showed statistical significance. I was able to reject the null hypothesis and accept the alternative hypothesis which stated that there was a difference in the levels of SSOSH between nurses who used EAPs and nurses who did not. Similarly, for the second RQ, I was able to reject the null hypothesis and accept the alternative hypothesis which stated that there was a difference in the levels of PS between nurses who used EAPs and nurses who did not. Contrary to RQ1 and RQ2, RQ3 was not statistically significant. In this case, I had to accept the null hypothesis and reject the alternative hypothesis which stated that PS did not moderate SSOSH among nurses who used EAPs and nurses who did not. With this information, in Chapter 5, I interpreted the findings, presented the limitations of the study, my recommendations, and the implications of this study.

### **Introduction**

The purposes of this study were to determine if there was (a) a difference in the level of SSOSH in nurses who have used EAPs and those who have not used EAPs, (b) a difference in the level of PS in nurses who have used EAPs and nurses who have not used EAPs, and (c) if PS moderated the levels of SSOSH among nurses who used EAPs and those who have not. This study was conducted to add knowledge to the nursing discipline about EAP use, SSOSH, and PS. Research has shown that nurses utilize EAPs at low rates due to several barriers (Covarrubias-Lyttle, 2023; Doran, 2022). However, no studies have been found that have examined the relationship of SSOSH and PS in nurses who have used EAPs and nurses who have not.

The results of this study showed that there was a significant difference in the level of SSOSH between nurses who had used EAPs and nurses who had not. Nurses who used EAPs had a mean SSOSH score which was 1.80, 95% CI [0.22 to 3.39] higher than nurses who had not used EAPs. There was also a significant difference in the level of PS among nurses who had used EAPs and nurses who had not. Nurses who used EAPs had a mean PS score which was 0.21, 95% CI [0.03 to 0.38] higher than nurses who had not used EAPs. However, PS did not moderate the level of SSOSH in nurses who had used EAPs and in nurses who had not.

## **Interpretation of the Findings**

The results of the study will be interpreted based on confirmation of the current literature, disconfirmation of the current literature, the expansion of knowledge, and the theoretical findings.

### **Confirmation of Literature**

One of the main reasons individuals avoid seeking psychological and physiological help is due to the stigma associated with seeking treatment (Billman Miller et al., 2025; Tucker et al., 2017). SSOSH refers to the expectation or belief that seeking help will result in negative self-judgment, inadequacy, or feelings of shame (Jung & Duys, 2025; Lannin et al., 2025). These feelings of inadequacy, inferiority, and low self-esteem may deter an individual from seeking help (Aigner, 2024; Vogel et al., 2006). Although there are no previous research studies that have examined SSOSH specifically in nurses, several research studies have explored SSOSH among all health care providers. Previous research indicated that there were higher levels of SSOSH in health care providers (Harney & Abela, 2022; Huang et al., 2023, Ozdemir et al., 2023; Thai & Trang, 2024). In fact, in Thai and Trang's (2024) study, not only did health care providers have high levels of SSOSH, but health care providers were also shown to have poor attitudes towards seeking help and decreased levels of intention to seek help. Their study further suggested that SSOSH increases the risk of mental health issues in health care providers because individuals with self-stigma will avoid seeking help in order to protect their self-esteem (Thai & Tran, 2024).

A study conducted by Harney and Abela (2022) examined both physical and psychological health behaviors, self-stigma and help-seeking behaviors in doctors. Their results found that there were higher levels of SSOSH in doctors with mental health issues compared to physical health issues. The results of their study are similar to all the literature about SSOSH and health care providers, which indicates that health care providers have high levels of SSOSH. While there is an abundant amount of research on SSOSH, there are no studies that explored SSOSH and EAP use.

This study was the first, according to my review of the literature, to examine SSOSH and EAP use in nurses, and the results aligned with previous research done on SSOSH. Based on the results of this study, nurses who have utilized EAP services were found to have higher levels of SSOSH when compared to nurses who have not utilized EAP services. These results support previous research which indicated that health care providers, including nurses have high levels of SSOSH. However, the results of my study also expanded the knowledge as it examined the differences in SSOSH of nurses based on the usage of EAP.

PS is defined as individuals' perception of how secure their work environment is in taking risks, openly communicating, and expressing themselves without fear of repercussions (Edmondson, 2019). Asfour et al. (2025) described PS as employee's perceptions of communication, sharing ideas, thinking critically, developing teamwork, and speaking up without fear. Employees who feel psychologically safe are found to have confidence to be their authentic selves without fear of damaging their self-image or hindering career advancement (El-Gazar et al., 2024). Previous research has indicated

that leadership plays a critical role in PS in nurses (Asfour et al., 2025; El-Gazar et al., 2024; Filiz, 2024; Lee & Dahinten, 2021; Porter-Stransky et al., 2024). Lee and Dahinten (2021) explored PS, nurses, and leadership. Their study demonstrated that inclusive leaders were able to provide a more psychologically safe environment for nurses which allowed nurses to speak up more and prevented nurses from less voice withholding behaviors.

Similarly, Asfour et al. (2025) explored the relationship between servant leadership and PS in nurses. The results of their study indicated that leaders who prioritized serving and empowering their team tended to create an environment where nurses felt safe expressing themselves and sharing their ideas and concerns without fear of retribution or criticism (Asfour et al., 2025). Esmailbeigi et al. (2025) performed a study which evaluated the impact of health-promoting leadership on nurses' PS. The results of their study revealed that health-promoting leadership had a significant positive impact on PS.

The results of the current study aligns with current research on PS. I found that nurses who used EAPs had higher levels of PS than nurses who did not use EAPs. If nurses are in a psychologically safe environment, then one would expect them to use EAPs more frequently than nurses who are not in a psychologically safe environment, because they feel more comfortable voicing their needs for help. One possible reason for the higher levels of PS in nurses who used EAPs, could be due to leadership style. Research has shown that leadership style plays a critical role in fostering PS (El-Gazar et al., 2024; Filiz, 2024; Lee & Dahinten, 2021; Porter-Stransky et al., 2024). Lee and

Dahinten (2021) examined the relationship between inclusive leaders in health care, nurse voice behaviors, and error reporting with PS being a mediator variable. The results of their study demonstrated that inclusive leaders provided a psychologically safe environment for nurses which allowed nurses to speak up more and prevented less voice withholding behaviors. El-Gaza et al. (2024) also explored leadership style in their study and how nurses' creativity was impacted by PS. Their study revealed that leaders can enhance a psychologically safe environment and nurses' creativity.

### **Disconfirmation of Literature**

EAPs are a workplace program designed to assist employees with personal challenges, health tracking and education, mental health and wellness, safety, performance improvement, substance abuse, and fitness for duty (Brandhorst & Compton, 2022; Brooks & Ling, 2020; Khairallah et al., 2025; Zieringer & Zapf, 2024). EAPs have been effective in reducing burnout, enhancing employee productivity, decreasing absenteeism, and improving job performance (Attridge, 2022; Brown-Berchold, 2024; Khairallah et al., 2025; Langlieb et al., 2021). Nevertheless, EAPs are considered an essential component in employee wellness (Chee et al., 2025; Moore et al., 2023). Fan et al. (2025) performed a qualitative study that explored the experiences of clinical nurses participating in EAPs. Their study found that nurses who used EAPs had an improvement in interpersonal relationships, an improvement in their mental health, developed and mastered mental health management skills, and facilitated career development. Fan et al. (2025) study's results were comparable to the results of a study conducted by Yang et al (2025). Yang et al. (2025) also completed a qualitative study

which aimed to provide a description of experiences, attitudes, and evaluations of nurses who utilized EAPs. The results of their study revealed that EAPs improved nurses' mental health and had a positive impact on nurses' pressure, problem-solving solutions, and self-promotion (Yang et al., 2025).

The results of my study did not align with most of the research found on EAPs. My study found that nurses who used EAPs had higher levels of SSOSH than nurses who did not use EAPs. This was an unexpected result, as one would have expected nurses who have used EAPs to have lower levels of SSOSH than nurses who did not use EAPs. If EAPs are assisting nurses with mental health and wellness, problem-solving solutions, and self-promotion, then their level of SSOSH should be lower than nurses who have not used EAPs.

### **Extension of Knowledge**

The results of this study expand the knowledge in the nursing discipline because this study was the first of its kind. There were no prior studies found that investigated SSOSH, PS, based on EAP use in nurses. PS has been the only variable that has been researched on nurses. The results of this research revealed that nurses who used EAPs had higher levels of SSOSH than nurses who did not use EAPs. Previous literature also confirmed that health care providers had negative attitudes towards seeking professional help due to increased levels of SSOSH (Huang et al., 2023). However, there were no studies that examined the levels of SSOSH in nurses who sought professional help through EAPs and those who did not.

Similar to SSOSH, the results of this study expanded the knowledge in the nursing discipline with PS because it was the first study that explored PS and EAP use. The results of this study found that nurses who used EAPs had higher levels of PS than nurses who did not. Edmondson (2019) defined PS as individuals' perception on how secure their work environment is to take risks, openly communicate, and express themselves without fear of repercussions. Previous literature examined how organizations and leadership impacts PS in employees. Most research demonstrated that leaders and organizations play an important role in fostering a psychologically safe environment (El-Gazar et al., 2024; Filiz, 2024; Lee & Dahinten, 2021; Porter-Stransky et al., 2024). However, there were no research studies that specifically explored PS in nurses and EAP use.

### **Theoretical Findings**

The HPM aims to increase well-being and self-actualization in individuals or groups and their progression towards a positive state of health and well-being (Pender, 1987). The model has three components, yet for the basis of this study, I focused on one subcomponent of the HPM, which was perceived barriers to action. Perceived barriers to action can prevent individuals or groups from health-promoting behaviors. These barriers are often viewed as obstacles that block behavioral changes, which prevent the individual from carrying out health-promoting actions (Pender, 1987; Primaningtyas et al., 2023).

There are several barriers that can prevent health-promoting behaviors from taking place, and are either perceived barriers, real barriers, or both. Perceived barriers to action are individuals' perception of blockades to changing their behavior (Primaningtyas

et al., 2023). SSOSH and PS are barriers which can prevent nurses from utilizing health-promoting services such as EAPs. SSOSH is internalized stigma, which often leads to individuals' reduction in their own self-esteem and self-worth (Tucker et al., 2017). SSOSH can increase an individual's perception of barriers to action because of the negative connotations connected with action (Vilades et al., 2024).

When individuals seek care, they may be stigmatized by peers or co-workers and feel that the knowledge of having to seek care will affect work relationships and environment. These negative connotations consist of poor attitudes towards the health-promoting behavior, lowered intention to seek psychological help, and poor use of health-promoting services such as EAPs (Vilades et al., 2024). PS refers to the need of individuals within an organization to feel safe to provide their opinions without ridicule, punishment, or negative consequences (Filiz, 2024; Ungvarsky, 2023). If a work environment provides a low level of PS, individuals are less receptive to participate in health-promoting behaviors, especially those promoted within the organization, such as EAPs.

The results of my study found that the levels of the perceived barriers, SSOSH and PS, were different in nurses who used EAPs and nurses who did not. Nurses who used EAPs had higher levels of SSOSH than nurses who did not use EAPs. Nurses who used EAPs had higher levels of PS than nurses who did not use EAPs, and PS did not moderate SSOSH among nurses who use EAPs and nurses who did not. Applying the HPM to my study demonstrated that individuals with more barriers are less likely to engage in health-promoting behaviors (Pender, 1987; Primaningtyas et al., 2023). The

levels of SSOSH may be higher in nurses who used EAPs because there was the need for the health-promoting service which may have prompted nurses who used the service to experience internalized stigma, low self-esteem, and low self-worth. If SSOSH was not a barrier to action, then the results would have shown that the levels were higher in nurses who did use EAPs. The results of my study also indicated that PS was a barrier to action as nurses who used EAPs had higher levels of PS than nurses who did not use EAPs. If nurses were feeling safe in their environment, they would be more likely to use health-promoting services such as EAPs, which was seen in my study. However, the less psychologically safe individuals feel within their work environment, there is a reduced chance that individuals will offer suggestions, opinions, or seek help without fear of punishment, embarrassment, or ridicule (Ungvarsky, 2023b). Moreover, there is less of a chance that the individual would use EAPs, which was seen in the results of my study.

### **Limitations of the Study**

Even though this study contributes to the nursing discipline by adding valuable insights to literature, there were several limitations that should be considered when interpreting the results. The limitations of my study affect the generalizability, validity, and reliability of this study.

#### **Generalizability**

One generalizability limitation of this study was the lack of diversity in the study's sample. My study was limited to only nurses and did not include other nursing roles, such as nursing assistants or patient care assistants. The participants were mostly from the Northeast region of the United States and in terms of demographics, represented

a homogenous group when examining race, gender, nursing license, and role. This lack of diversity can limit the generalizability of the findings as it may not reflect the experiences of nurses who are from other regions in the United States, different racial backgrounds, and those who work outside of the staff nurse role.

### **Validity**

Another limitation of this study is the use of self-report instruments. Using self-report scales could lead to response bias. The participants may not have accurately reported on the scales due to social desirability. Additionally, this study only collected data at a single point in time. Because data were collected at one point, the study cannot allow for causal inferences. Therefore, the results of this study are limited to associations rather than cause-and-effect relationships.

### **Reliability**

Reliability may have also been a limitation of this study. Even though SSOSH and PS scales were established psychometric tests, how the participants interpreted the scale may have introduced inconsistencies in responses. Lastly, test-retest reliability could not be determined because the data were collected at a single point in time. By collecting the data at a single point in time, the confidence in the stability of the scores may be limited over time.

### **Recommendations**

Because this study was potentially the first to examine SSOSH, PS, and EAP use in nurses, there are several areas of future research that should be conducted. For one, further research should explore how different socioeconomic backgrounds are affected by

SSOSH, PS, and EAP use. Performing research on a more diverse background increases generalizability, reduces bias, and improves validity. A study with a diverse background would be more likely to produce results that are more authentic to the general population.

More qualitative studies exploring the experiences of nurses who have used EAPs would provide a more in-depth perception of their experience. Yang et al. (2025) explored clinical nurses' experience with EAPs in hospitals in China. The results of this study showed that EAPs helped nurses release pressures from being overwhelmed with workload, family relationships, and career planning. They also found that EAPs assisted nurses in solving problems, allowed for personal growth and changes, helped nurses think from various perspectives, and effectively communicate with patients (Yang et al., 2025). Expanding qualitative research to include nurses from the United States would provide a preceptive on the experiences of EAP uses from nurses in America.

Furthermore, more research is needed to explore the variables of SSOSH and PS in nurses, especially from a qualitative standpoint. Research on these barriers would also provide a deeper understanding into how nurses are affected by these obstacles. Currently, there are no research studies that have examined these two barriers in nurses. Understanding how SSOSH and PS impact nurses' decisions to utilize EAPs could help organizations change the way EAPs are presented to nurses. For example, if organizations knew how these barriers are impacting nurses' decisions to use EAPs, there would be more of an effort to promote EAPs from the beginning of employment and all throughout an individual's time of employment. Organizations would make a conscious

effort to monitor leadership styles since research has shown that leadership plays an essential role in PS and EAP use.

### **Implications**

This study has the potential to impact not only the nursing discipline, but organizations such as health care organizations, professional nursing organizations, and nursing institutes. This study has provided insight into EAP uses, SSOSH, and PS in nurses. Leaders of organizations and nursing institutes could potentially use the information presented throughout this study to explore further use of EAPs. This study showed there is a need for continued research into EAPs and barriers impeding nurses from utilizing EAPs. Since EAPs are a direct link between nurses and health care organizations, understanding the barriers preventing nurses from using EAPs, would more than likely better benefit health care organizations and nurses alike (Wang et al., 2021).

#### **Implications at the Individual Level**

On an individual level this study provided insight into the barriers that prevent nurses from utilizing EAPs. Research has demonstrated that EAPs are underused by nurses; however, prior to this study, there were no studies that explored what prevented nurses from using EAPs (Babin et al., 2024; Doran, 2022). This study provides information to nurses on two reasons why there is a low utilization rate for EAPs.

#### **Implications at the Organizational Level**

On an organizational level, this study provides information for organizations and nursing institutes on the use of EAPs. This study explored two barriers that impacted the

use of EAPs by nurses. This information is essential for organizations because of the impact EAPs have on employees. The use of EAPs have a positive influence on absenteeism, productivity, and employee turnover rates (Attridge & Dickens, 2021; Langlieb et al., 2021; Zieringer & Zapf, 2024). It is important for organizational leaders to understand how barriers such as SSOSH and PS can be prevented in order to promote their EAPs within their company. The more organizations can prevent these barriers from occurring, the more likely the organizations will have lower turnover rates, improved patient safety, and higher levels of quality of care (Filiz et al., 2024; Moore et al., 2023; Wang et al., 2021).

### **Implications at the Societal/Policy Level**

On a societal/policy level, this study provided insight into the growing concern of the barriers preventing utilization of EAPs in nurses. Nurses' well-being is critical to the health care field as nurses make up the largest profession in health care (American Association of Colleges of Nursing, 2025). Recognizing the importance of EAP use in nursing is essential for society as there continues to be a nursing shortage and nurses leaving the field due to reasons such as burnout, stress, unsafe patient to staff ratios, and incivility (American Nurses Association, 2023). By promoting EAP use for nurses and addressing barriers such as SSOSH and PS, the more likely nurses will have an improved overall well-being, which could lead to retention of nurses in the field and an improvement in the quality of nursing care.

## **Conclusion**

Nurses work under stressful and emotionally straining conditions, yet many avoid seeking help due to internalized stigma and poor psychologically safe environments. These barriers influence whether nurses feel comfortable expressing their concerns, accessing available resources, or utilizing services such as EAPs. The relationship between SSOSH, PS, and EAP use in nurses is critical in understanding nurses' willingness to seek support for their overall well-being. EAPs are designed to provide support to employees; thus, understanding how SSOSH and PS influence nurses' use of EAPs is essential for the nursing discipline. This study offers valuable insights into the barriers to care that prevent nurses from utilizing health-promoting resources, which may ultimately enhance nurse retention and the overall quality of nursing care.

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Appendix A: Recruitment Flyer

## Appendix B: Demographics Questionnaire

Please indicate your gender:

- Male
- Female
- Gender diverse

Please indicate your age:

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 and over

Please indicate your race:

- White/Caucasian/European descent
- Black/African/Caribbean descent
- Hispanic/Latino descent
- Native American/American Indian descent
- Asian/Pacific Islander descent
- Other

Please indicate in which region of the United States you work in:

- Northeast (ME, NH, VT, MA, RI, CT, NY, PA, NJ)
- Southeast (DE, MD, DC, VA, WV, NC, SC, GA, FL, KY, TN, MS, AL)
- Midwest (IL, IN, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD)
- Southwest (AZ, NM, OK, TX)
- West (AL, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY)

Please indicate your nursing license:

- LPN/LVN
- RN
- APN/APRN/NP

Please indicate your highest level of education completed:

- Diploma/certificate
- Associate degree
- Bachelor's degree
- Master's degree

- Doctoral degree

Please indicate your length of practice

- Less than one year
- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- Over 20 years

Please indicate your current position/role:

- Staff nurse
- Supervisor/Manager
- Advanced Practice Nurse
- Clinical Nurse Specialist
- Educator
- Administrator
- Other

Please indicate your current job status:

- Full time
- Part time
- Per diem

## Appendix C: Self-Stigma of Seeking Help Scale-Revised



doi: <http://dx.doi.org/10.1037/t81057-000>

**Self-Stigma of Seeking Help Scale--Revised**  
**SSOSH-7**

Items

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1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. It would make me feel inferior to ask a therapist for help.
5. I would feel okay about myself if I made the choice to seek professional help.
6. If I went to a therapist, I would be less satisfied with myself.
7. I would feel worse about myself if I could not solve my own problems.

---

*Note.* Participants are presented with, "Directions: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation." Participants rate items on the following scale: 1 (strongly disagree), 2 (disagree), 3 (agree/disagree equally), 4 (agree), 5 (strongly agree).

## Appendix D: Permission to Use the Self-Stigma of Seeking Help Scale-Revised

**Self-Stigma of Seeking Help Scale--Revised**

## PsycTESTS Citation:

Brenner, R. E., Colvin, K. F., Hammer, J. H., & Vogel, D. L. (2021). Self-Stigma of Seeking Help Scale--Revised [Database record]. Retrieved from PsycTESTS. doi: <https://dx.doi.org/10.1037/t81057-000>

## Instrument Type:

Rating Scale

## Test Format:

Participants rate items on a 5-point Likert-type scale from 1 (strongly disagree) to 5 (strongly agree).

## Source:

Brenner, Rachel E., Colvin, Kimberly F., Hammer, Joseph H., & Vogel, David L. (2021). Using item response theory to develop revised (SSOSH-7) and ultra-brief (SSOSH-3) Self-Stigma of Seeking Help Scales. *Assessment*, Vol 28(5), 1488-1499. doi: <https://dx.doi.org/10.1177/1073191120958496>, © 2021 by SAGE Publications. Reproduced by Permission of SAGE Publications.

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## Appendix E: Psychological Safety Inventory

### Psychological Safety Inventory

**Instructions:**

For the following statements, please select the number that best reflects your agreement or disagreement based on your perceptions and experiences within your team environment. There are five possible responses to each statement ranging from ‘Strongly Disagree’ (number 1) to ‘Strongly Agree’ (number 5).

**Items:**

1. I am not afraid to ask for honest feedback from my team.
2. I do not worry about repercussions when I seek help from my team.
3. When I disagree with the team, I feel comfortable voicing my opinion.
4. I am not afraid to speak up to my team about my concerns.
5. I am not afraid to advocate for others within my team.
6. My team cares about my well-being.
7. I trust my team members.
8. My team makes me feel included.
9. I feel respected by my team.
10. I have a good relationship with my team members.
11. I feel a sense of belonging on my team.
12. People in the team embrace members’ diverse perspectives.
13. There are services in the organization to help those in need.
14. There are policies in place to protect me.
15. Supportive resources are accessible.
16. I know where to seek help in my organization when I need it.
17. Resources are available to enhance my performance.
18. If something goes wrong, I know where to find information to solve the issue.
19. My position is secure.
20. My future with the team is clear.
21. I identify myself as an important member of my team.
22. I do not worry about being let go from the team.
23. I am stable in my position.
24. I feel confident in my position.
25. My leader(s) encourage a culture of inclusion.
26. I trust my leader(s) to be honest with me.
27. My leader(s) provide effective guidance.
28. I receive constructive feedback from my leader(s).
29. My leader(s) coach me to be better.
30. My leader(s) act quickly to correct problems.

## Appendix F: Permission to Use the Psychological Safety Inventory

### Psychological Safety Inventory

APA PsycTests Citation:

Plouffe, R. A., Ein, N., Liu, J. J. W., St. Cyr, K., Baker, C., Nazarov, A., & Don Richardson, J. (2023). Psychological Safety Inventory [Database record]. Retrieved from APA PsycTests. doi: <https://dx.doi.org/10.1037/t90056-000>

Instrument Type:

Inventory/Questionnaire

Test Format:

Items are rated on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Source:

Adapted from: Plouffe, Rachel A., Ein, Natalie, Liu, Jenny J. W., St. Cyr, Kate, Baker, Clara, Nazarov, Anthony, & Don Richardson, J. (2023). Feeling safe at work: Development and validation of the Psychological Safety Inventory. *International Journal of Selection and Assessment*, Vol 31(3), 443-455. doi: <https://dx.doi.org/10.1111/ijsa.12434>. © 2023 The Author(s). Reproduced under a Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>).

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