

EAP Treatment Stigma as a Barrier to Employee Help-Seeking: Predictors and Validation of a Brief Scale for its Measurement

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ABSTRACT. *Research has consistently shown that perceptions of stigma in relation to receiving professional psychological help can be a barrier to the seeking of mental health services. Very few systematic investigations on stigma in relation to receiving help from EAP counseling services have however been conducted. This article reports on validation analyses conducted for the Brief EAP Treatment Stigma Scale (BETSS-4), an instrument designed to measure an individual's perception of stigma in relation to receiving help from EAP counseling services. The study also investigated predictors of EAP treatment stigma as assessed by the scale in a large sample of Canadian workers (N=1001). The validation analyses indicated that the BETSS-4 has high reliability and validity and is suitable for the assessment of perceptions of EAP treatment stigma in working populations. A notable proportion of the Canadian workers reported perceptions of EAP treatment stigma and higher scores on the BETSS-4 predicted a lower self-reported likelihood of accessing EAP counseling services in the event of personal problems. A number of independent demographic, occupational and psychological predictors of the degree of EAP treatment stigma were identified by multiple regression analyses. The BETSS-4 may be used by EAP practitioners, researchers, and evaluators interested in EAP treatment stigma, its*

determinants, as well as its association with EAP utilization rates. Greater understanding of EAP-related stigma may help employers and EAP providers develop strategies and interventions aimed at breaking down this barrier and attaining utilization rates unhindered by worker perceptions about help-seeking.

Introduction

Employee Assistance Programs (EAPs) provide help through face-to-face, online or telephonic counseling with professionals, and employees often self-refer to services. From a psychological standpoint, an employee's motivation and perceptions are factors that can influence their likelihood of accessing EAP services in a time of need, especially for self-referrals versus mandatory (e.g., managerial) referrals where self-motivation may not be as central. Because of this, different employees with similarly problematic personal issues will self-refer to (i.e., access) EAPs at different rates despite the same potential benefits of doing so. While a number of psychological, motivational or other factors could potentially influence whether an employee seeks help via an assistance program, these are poorly understood. One of the possible

psychological barriers or obstacles to the use of an EAP by covered workers involves their perceptions of stigma in relation to receiving help from a professional counselor.

Outside the EAP field, research has consistently shown that perceived stigma in relation to receiving professional psychological help can be a barrier to the seeking of mental health services (e.g., mental health “treatment stigma”).¹⁻³ In one study, highly reported reasons for not seeking professional help included embarrassment and shame associated with mental health help-seeking². Mental health treatment stigma, therefore, involves negative perceptions and attitudes regarding the seeking of psychological help, and can include feelings of personal weakness and inadequacy associated with seeking help.¹ Such perceptions and feelings can inhibit individuals from seeking help despite an underlying need for assistance.

EAP counseling services have been found to overlap with other types of therapy-based psychological and mental health services⁴ and many EAP users might be suffering from an underlying mental health issue.⁵ From this perspective, treatment stigma might too be expected to occur in relation to EAPs where services are provided by professionals in psychology, counseling or social work. Indeed, one recent survey study showed that some Canadian workers report stigma in relation to receiving help from EAP counseling services (i.e., “EAP treatment stigma”) and that greater perceptions of stigma were associated with a reduced likelihood of their use. Gender-based patterns of EAP utilization may also be explained, at least in part, by gender differences in perceptions of stigma.⁶ Additional attention to the topic of EAP treatment stigma might consequently be warranted given its apparent association with rates of program utilization.

Very few systematic investigations of EAP treatment stigma have however been conducted. Aside from early exploratory analyses⁷, there are no known validated scales

available for the assessment of EAP treatment stigma in working populations. This article reports on the validation of the Brief EAP Treatment Stigma Scale (BETSS-4) developed by Workreach Solutions. The BETSS-4 is brief four-item measure designed to assess an individual’s perception of stigma in relation to receiving help from EAP counseling services. The study also investigated predictors of EAP treatment stigma, including multiple demographics, along with occupational and psychological characteristics of the working population that might be associated with perceptions of stigma. The ability to measure EAP treatment stigma in the workplace and a greater understanding of its determinants may help employers and assistance program providers develop strategies and interventions aimed at breaking down this likely psychological barrier to the seeking of EAP services in a time of need. Such activities may contribute to achieving optimal utilization rates unhindered by worker perceptions of stigma, and by proxy, helping to improve overall employee and organizational health.

Methods

Sample

The sample included 1,001 employed Canadians between the ages of 20 and 65 that completed an online survey in October 2018. Participants were drawn from a large panel of the general Canadian population (N= 400,000) via an online sampling company providing digital research services. The sample was designed to be closely representative of the cohort of employed workers in the country between the ages of 20 and 65 in gender, age, ethnicity (white versus non-white), educational attainment, region, and employment status (full versus part-time) as per Canada census records. A two-stage probabilistic sampling procedure was used, involving initial use of random sampling within the sample frame, followed by additional random sampling within specific sections of the sample frame to reach approximate

representativeness across the above demographic and socioeconomic variables. There were 517 men (51.65%) and 484 women (48.35%) respondents and the margin of error for the study survey was +/- 3.09%.

Measures

The Brief EAP Treatment Stigma Scale. The BETSS-4 was designed to assess an individual's perception of stigma in relation to receiving help from EAP counseling services. A previous article outlined multiple components of EAP-related stigma⁷, but no formal measurement tool has since been developed and validated. The BETSS-4 consists of four items scored on a 5-point scale ranging from "strongly disagree", "neutral", to "strongly agree". The items assess perceptions of stigma associated with receiving help from an EAP counselor ("Seeing an EAP counselor for help would..."), including feelings/perceptions of personal weakness, worry about losing respect, and shame (See Table 1 for items). The BETSS-4 items assess internalized EAP treatment stigma, which refers to "felt stigma" versus externalized or public stigma which refer to "enacted stigma" (e.g., discrimination) and perceptions about the negative beliefs and attitudes held by the general population, respectively. An average is calculated based on the scores on the four items. Higher average scores on the BETSS-4 indicate greater perceptions of stigma in relation to the use of EAP counseling services for help. The proportion of respondents experiencing EAP treatment stigma can be estimated by calculating the percentage (%) of those with average scores above 3.0, indicating at least some degree of agreement regarding the perception of EAP stigma (conservative estimate). A less conservative estimate uses average scores including 3.0 and above as evidence of potential stigma and includes respondents that are neutral regarding the perception of EAP stigma. With these calculations, a range of the proportion of workers likely experiencing some degree of EAP treatment stigma can be determined, including the conservative estimate as the lower value

and the less conservative estimate as the higher value. The percentage of respondents reporting "agree" or "strongly agree" on at least one of the items can also be reported. It is also recommended to provide a brief description of the general functioning and role of EAPs before the respondents complete the BETSS-4 (see Procedures section). No permission is required to reproduce, translate, display or distribute the BETSS-4. The official scale and scoring document is available online.^a

Measures used for validation. Four additional measures were used for the validation of the BETSS-4. The Stigma Scale for Receiving Psychological Help (SSRPH)¹ was used to assess the construct validity of the BETSS-4, which is demonstrated by correlation with another measure of a similar construct (specifically, convergent validity). The SSRPH assesses perceptions of how stigmatizing it is to receive psychological treatment/ "see a psychologist" (i.e., mental health treatment stigma). It consists of five questions rated from 0 to 3 ("strongly disagree" to "strongly agree") with higher scores indicating greater perceptions of stigma with receiving help (for example: "It is advisable for a person to hide from people that he/she has seen a psychologist" or "It is a sign of personal weakness..."). Three measures were used to assess the criterion validity of the BETSS-4, which refers to the ability of a test to predict scores or outcomes on another instrument in a way that is theoretically supported or practical. One item assessed the self-reported likelihood of accessing an EAP for help: "If you were to experience significant and distressing personal problems in the future, how likely is it that you would access the counseling services of an employee assistance program (EAP) for help (assuming you had access to such services at your work)?" Responses to this question were scored on a 6-point likelihood scale ranging from extremely unlikely (1) to extremely likely (6). An item from the National Comorbidity Survey Replication (NCS-R) survey assessing

^a <https://www.workreachesolutions.com/betss-4>

attitudes toward treatment-seeking behavior was also included⁸; specifically the item assessed the degree of comfort one feels about talking with a professional about personal problems: “How comfortable would you feel talking about personal problems with a professional?” Responses to this question were scored on 4-point scale ranging from not at all comfortable (0) to very comfortable (3). Criterion validity would be supported by a negative correlation between BETSS-4 scores and the self-reported likelihood of seeking help via an EAP and also a negative correlation with the degree of comfort with speaking with a professional (specifically, concurrent validity). Finally, the Patient Health Questionnaire-2 (PHQ-2) is a measure of depression and previous research has shown that increased depression severity can be associated with higher perceptions of mental health treatment stigma.^{9, 10} Thus, criterion validity would be supported by a positive correlation between BETSS-4 scores with those of the PHQ-2 (also concurrent validity).

Table 1: Items, Item-total Correlations, and Factor Loadings for the BETSS-4 (N=1,001)

Seeing an employee assistance program (EAP) counselor for help would...		
Item	Item-total	Factor loading
1. ...make me feel like a weak person	.83	.90
2. ...make me worry about losing the respect of others	.85	.92
3. ...mean that I am unable to cope	.80	.89
4. ...make me feel ashamed or embarrassed	.85	.92

Cronbach’s alpha= .92

Predictor variables. A number of variables assessed the demographic, occupational and psychological characteristics of the Canadian workers for use in the regression analyses. Age group was coded on a 9-point ordinal scale in

increments of 5 years: 20-24 (1), 25-29 (2), 30-34(3) ... 60-64(9). Gender was a binary variable coded as male (1) or female (0). Ethnicity was coded as white only (1) versus non-white (0). The highest educational attainment was scored on a 5-point ordinal scale and included high school or less (1), non-university certificate or diploma (e.g., apprenticeship/trades, college, CEGEP or other) (2), university certificate or diploma below bachelor level (3), university certificate, diploma or degree at bachelor level (4), and postgraduate certificate, diploma or degree (above bachelor level)(5). Marital status included four categories: single (never married), common law, married, and separated/divorced/widowed. Annual income from work (Can\$ pre-tax) was coded on an ordinal scale including <\$25,000 (1), \$25,000-49,999 (2), \$50,000-74,999 (3), \$75,000-99,999 (4), \$100,000-124,999 (5), \$125,000-149,000 (6), \$150,000-174,999 (7), \$175,000-249,999 (8), >\$250,000 (9). A binary variable indicated whether respondent had children (1) or not (0). Household size was scored on a 5-point ordinal scale including one (1), two (2), three (3), four (4), five or more (5). City size was scored on an ordinal scale including rural area (1), village (2), town (1,000 to 20,000) (3), large town (20,000 to 100,000) (4) and city (over 100,000) (5). The seven-region model of Canada was used which combines Manitoba and Saskatchewan, as well as the Atlantic provinces (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador). Canada’s territories (Yukon, Northwest Territories, Nunavut) were excluded due to the relatively small proportion of people living in these areas (public opinion research typically excludes these residents), leaving a total of six provinces/regions. The occupation type variable included seven categories: executive or senior manager, professional, technical support, sales, clerical and administrative support, service occupation, precision worker or operator/labourer. A binary variable coded whether participants worked in the private sector (1) or the public/para-public sector (0). Employment status included full-time work (30 hours or

more per week) (1) and part-time work (less than 30 hours per week) (0). The industry sectors of work included four categories: the goods-producing sector (e.g., agriculture, forestry, manufacturing), service-producing sector 1 (government and citizen-centered services; e.g., government, health care, social assistance, education and training), service-producing sector 2 (white collar; e.g., finance, professional services, insurance, administrative services, information technology), and service-producing sector 3 (blue/pink collar; e.g., retail and wholesale, accommodation and food services, transportation and warehousing). Organization size was scored on a 6-point ordinal scale, including less than 5 (1), 6 to 19 (2), 20 to 99 (3), 100 to 499 (4); 500 to 1500 (5), and 1500+(6). The degree of office work was assessed via a question inquiring: "Do you work in an office environment where you sit at a desk and work on a computer?" Responses to this question were scored on a 4-point ordinal scale including No, never (0), Yes, but only some of the time (1), Yes, most of the time (2), and Yes, practically all the time (3). Length of time at current job was scored on a 6-point ordinal scale including 0-1 years (1), 1-2 years (2), 2-5 years (3), 5-10 years (4), 10-15 years (5), and 15+ (6). Job insecurity was assessed using the average of two items selected from the Job Insecurity Scale¹¹, including "I feel insecure about the future of my job" and "I think I might lose my job in the near future", scored on a 5-point ordinal agreement scale ranging from strongly disagree (1) to strongly agree (5). For the psychological variables, the Patient Health Questionnaire-4 (PHQ-4) and its subscales of depression (PHQ-2) and anxiety (GAD-2)^{12, 13} were used to assess psychological health; positive screening for depression and anxiety is indicated by a score of 3 or above on these two subscales. Screening was coded on a binary variable of positive (1) versus negative screening (0). The degree of familiarity with EAPs was ascertained with the question "Before today, how familiar were you with the types of services and potential benefits provided by an employee assistance program (EAP)?"

Responses to this question were scored on a 5-point ordinal scale ranging from not at all familiar (1) to extremely familiar (5).

Procedures

Prior to answering the questions pertaining to EAP treatment stigma or other EAP-related questions (e.g., familiarity), participants were provided with a brief description of what an EAP entails. This served to remind or inform participants about the role and functioning of an EAP, including the confidential short-term counseling services provided by social workers, psychologists or other licensed counselors to help workers with a wide range of personal or work-related problems. After completing the BETSS-4 the participants answered the question assessing the likelihood of accessing an EAP for help in the event of distressing personal problems in the future.

Analysis

The BETSS-4 validation analyses included assessments of internal consistency (a measure of scale reliability), factor structure, construct validity, and criterion validity. The internal consistency was determined by Cronbach's alpha.¹⁴ Internal consistency is a measure of the homogeneity of items of a scale and indicates whether they measure the same general construct or latent variable^{15,16}, with alpha coefficients greater than .70 considered sufficient for internal consistency. In addition, factor analysis using a one-factor solution for a unidimensional scale was conducted to determine the factor structure (e.g., number of factors extracted) and factor loadings; factor loadings greater than .80 indicate that the items are conceptually as close as possible to the intended factor (in this case EAP treatment stigma). Two-tailed correlation analyses assessed the relationships between scores on the BETSS-4 and the four measures used for validation. For validation purposes, the BETSS-4 scores should correlate positively with the degree of stigma for receiving psychological help as assessed by SSRPH (construct validity, specifically, convergent validity). They should

also negatively correlate with the self-reported likelihood of seeking help via an EAP and the degree of comfort felt about speaking with a professional about personal problems, and positively correlate with the degree of depression symptomology as measured by the PHQ-2 (criterion validity, specifically, concurrent validity).

For the analyses investigating predictors of EAP treatment stigma, initial bivariate tests examined the basic relationships between the variables and the degree of stigma as measured the BETSS-4 using two-tailed correlational analyses for ordinal and binary scores. Analysis of variance (ANOVA) was used for the four multi-categorical predictor variables. Multiple hierarchical linear regression analyses were then conducted to determine the independent contributions of the variables to variance in the degree of EAP treatment stigma not explained by their correlation to (i.e., communality with) other variables (e.g., covariance and confounding). Multiple linear regression analyses help to narrow the list of potential predictors down to a manageable list for practitioners and are also useful for the comparison of determinants' effect sizes allowing for their ranking and prioritization regarding potential interventions. The multiple hierarchical linear regression analyses were run with dummy coded multi-categorical variables, including demographic and occupational measures in the first block and psychological variables in the second block. These hierarchical steps were chosen to initially determine the contribution of common demographic/occupational factors to the variance in perceptions of EAP treatment stigma, followed by the determination of the added contribution (if any) of the psychological variables. The linear regression findings provided effect sizes (β), helping to interpret the magnitude of the effects of the variables in relation to the degree of reported EAP treatment stigma. The reference groups for the marital status, province/region, occupation type and industry sector variables were single, Ontario, executive

or senior management, and the goods-producing sector, respectively. Finally, because linear regression analyses based on dummy-coded categorical variables do not provide estimates of omnibus main effects for multi-categorical variables, additional (and identical in terms of variables) general linear modelling (GLM) analyses were conducted to determine the main effects of the four multi-categorical variables. Statistical significance for all tests was ascertained at $p < .05$.

Main Findings

The means and standard deviations of the BETSS-4 were calculated ($M=2.42$, $SD=1.04$) and the minimum average score was 1 and the maximum score was 5. The percentage of respondents reporting overall EAP treatment stigma was 17% (conservative estimate) and 23% (less conservative estimate) (see Measures section). Thus approximately 17-23% of the Canadian workers might be expected to experience internalized EAP treatment stigma as measured by the BETSS-4. Considering each of the items separately instead of the average, 33% of the workers reported being in some degree of agreement ("agree" or "strongly agree") with at least one of the stigma items.

Reliability, Factor Structure, and Validity

The international consistency (reliability) of the BETSS-4 as measured by Cronbach's alpha was high ($\alpha=.92$). The factor analysis resulted in the extraction of one factor. Table 1 shows the BETSS-4 items, item-total correlations and factor loadings. The high factor loadings ($>.8$) confirmed that the four items measure the same general construct of EAP treatment stigma. Together, these initial findings indicated that the BETSS-4 has adequate reliability and a unidimensional factor solution. Finally, evidence of the construct validity of the BETSS-4 was provided by the finding of a high positive correlation between the degree of EAP treatment stigma and the degree of mental health treatment stigma as measured by the

SSRPH ($r = .62, p < .001$; convergent validity). Evidence of criterion validity was provided by the negative correlations between the BETSS-4 scores and both the self-reported likelihood of accessing an EAP in the event of distressing personal problems ($r = -.24, p < .001$) and the degree of comfort felt about talking with a professional about personal problems ($r = -.26, p < .001$), as well as by the positive correlation between the degree of EAP treatment stigma and the severity of depression symptomology as measured by the PHQ-2 ($r = .37, p < .001$; concurrent validity).

Other Associations

The analyses confirmed the inhibitory role of an individual’s perception of EAP stigma in their likelihood of seeking help via an assistance program. Additionally, women ($M = 2.25, SD = .99$) scored lower on the BETSS-4 than men ($M = 2.58, SD = 1.06$), consistent with expectations and previously reported gender differences in perceptions of stigma in relation to mental health treatment stigma and help-seeking.^{17,18} As indicated in a previous research report, gender differences in perceptions of stigma may explain, at least in part, gender differences in the seeking and use of EAPs⁶, which generally involve lower use by men workers.¹⁹⁻²¹

Bivariate Analyses

These initial analyses identified a number of significant associations between perceptions of EAP treatment stigma and select demographic, occupational and psychological variables (Table 2). Regarding demographic characteristics, older workers reported lower levels of EAP treatment stigma; men workers reported higher levels of stigma, and white respondents reported lower levels versus non-white respondents. A higher level of educational attainment was associated with increased perceptions of EAP stigma; having children was associated with reduced perceptions of stigma. In terms of occupational characteristics, differences in EAP treatment stigma levels were observed between different occupation types as well as between industry sectors; full-time

employment was also positively correlated with the degree of stigma. In terms of psychological variables, screening for depression or anxiety was correlated with increased perceptions of EAP treatment stigma, and an increased degree of familiarity with EAPs predicted reduced perceptions of stigma. Finally, while time at current job and income level were not significantly associated with degree of EAP treatment stigma, the threshold of statistical significance was almost reached ($p < .075$) thus can be considered trending correlations.

Table 2: Bivariate Analyses – Correlations with the BETSS-4 Scores (N=1,001)

Variable	Type ¹	r	F	Sig.
Age	D	-.16	–	.001*
Gender	D	.16	–	.001*
Ethnicity	D	-.14	–	.001*
Education	D	.06	–	.041*
Marital Status	D	–	1.91	.126
Income	D	.06	–	.051
Has Children	D	-.07	–	.024*
Household Size	D	.02	–	.557
City Size	D	-.01	–	.750
Province/Region	D	–	1.33	.249
Occupation Type	O	–	2.75	.012*
Private Sector	O	-.01	–	.797
Industry Sector	O	–	4.50	.004*
Full-time Job	O	.07	–	.023*
Organization Size	O	.01	–	.797
Office Work	O	.08	–	.011*
Time at Job	O	-.06	–	.065
Job Insecurity	O	.33	–	.001*
Depression Screening	P	.33	–	.001*
Anxiety Screening	P	.32	–	.001*
Familiarity with EAPs	P	-.08	–	.017*

¹ Variable Type: D = demographic, O = occupational, P = psychological; *Statistically significant ($p < .05$)

Together these initial findings identified a number of significant predictors of EAP treatment stigma as measured by the BETSS-4, but alone could not ascertain how they independently relate to such perceptions after controlling for the combination of predictors,

thus after accounting for correlation to (e.g., communality with) other variables (covariance and confounding).

Multiple Hierarchical Linear Regression Analyses

Findings from the multiple hierarchical linear regression analyses identified a number of independent predictors of degree of EAP treatment stigma as measured by the BETSS-4 (Table 3). Block 1 of the linear regression model, using the dummy-coded multi-categorical variables and including all demographic and occupational variables, explained 16.1% of the variance (Adjusted R square) in the level of EAP treatment stigma reported by the Canadian workers [$F(31, 968) = 7.17, p < .001$]. Addition of the psychological variables to block 2 of the model contributed an additional 5.4% (Adjusted R Square) of variance [$F(3, 965) = 22.75, p < .001$]. In total 21.4% of the variance in the degree of EAP treatment stigma was explained by the combination of all of the variables.

Multiple regression analyses taking into account all variables resulted in a smaller number of variables remaining independently predictive of the level of EAP treatment stigma as measured by the BETSS-4. In the final block, for the demographic variables gender, ethnicity and having children were independent and statistically significant predictors of the degree of EAP treatment stigma reported by workers. Specifically, males, non-whites, and respondents without children reported a greater degree of EAP stigma. Age was no longer associated with EAP stigma level, but the relationship approached statistical significance and can be considered a trend ($p < .075$, greater age associated with less stigma). From the occupational variables only the reported degree of job insecurity remained associated with the degree of EAP stigma; increased levels of job insecurity predicted increased levels of stigma. None of the multi-categorical variables were significantly associated with perceptions of EAP stigma including the worker's marital status

[$F(3, 965) = .763, p = .52$], province/region of residence [$F(5, 965) = 1.242, p = .29$], occupation type [$F(6, 965) = .850, p = .53$], and industry sector of work [$F(3, 965) = .634, p = .59$]^b. The three psychological variables all remained important independent predictors of the degree of EAP treatment stigma reported by the Canadian workers. Both depression and anxiety screening were associated with an increased level of EAP treatment stigma. Conversely, and as might be expected, an increased degree of familiarity with EAPs was associated with a lower degree of EAP treatment stigma.

A range of effect sizes were observed for those variables remaining associated with perceptions of EAP treatment stigma in the multiple regression analyses. Using previously established norms for interpretation of effect sizes [22]^c, medium effects were observed for ethnicity ($\beta = .08$) and having children ($\beta = .075$), medium-large effect sizes for gender ($\beta = .11$), anxiety screening ($\beta = .10$) and degree of familiarity with EAPs ($\beta = .11$), and large effect sizes for degree of job insecurity ($\beta = .23$) and depression screening ($\beta = .16$).

Discussion

This article reported on validation analyses conducted for the BETSS-4, a brief scale designed to measure an individual's perception of stigma in relation to receiving help from EAP counseling services. The study also investigated predictors of EAP treatment stigma as assessed by the scale in a large sample of working Canadians. The validation analyses indicated that the scale has high internal consistency (reliability) and that it measures the single construct of EAP treatment stigma; there was

^b The GLM statistics are presented here instead of tables due to space considerations

^c small (0.01), medium (0.06), and large (0.14) effect sizes

Table 3: Regression Analysis – Independent Predictors of EAP Treatment Stigma (N=1,001)

Variable	Block 1				Block 2			
	<i>b</i>	β	<i>t</i>	Sig.	<i>b</i>	β	<i>t</i>	Sig.
Age	-.054	-.124	-3.13	.002*	-.032	-.073	-1.88	.061
Gender	.246	.118	3.59	.001*	.233	.112	3.51	.001*
Ethnicity	-.215	-.090	-2.82	.005*	-.193	-.081	-2.61	.009*
Education	.020	.026	.766	.444	.021	.027	.82	.412
Marital Status		N/A ¹		.447		N/A ¹		.515
Income	-.054	.040	1.15	.251	.029	.048	1.42	.156
Has Children	.246	-.089	-2.31	.021*	-.156	-.075	-1.98	.048*
Household Size	-.215	.048	1.29	.198	.029	.033	.907	.365
City Size	.020	-.029	-9.18	.359	-.026	-.028	-.895	.371
Province/Region		N/A ¹		.210		N/A ¹		.287
Occupation Type		N/A ¹		.185		N/A ¹		.532
Private Sector	-.085	-.040	-1.21	.226	-.030	-.014	-.441	.659
Industry Sector		N/A ¹		.241		N/A ¹		.593
Full-time Job	.015	.005	.158	.875	.043	.015	.467	.641
Organization Size	-.011	-.019	-.575	.565	.013	.023	.684	.494
Office Work	.056	.064	1.67	.095	.048	.054	1.45	.149
Time at Job	.024	.035	.982	.326	.018	.028	.786	.432
Job Insecurity	.284	.301	10.13	.001*	.212	.225	7.38	.001*
Depression Screening	–	–	–	–	.383	.163	4.13	.001*
Anxiety Screening	–	–	–	–	.255	.104	2.62	.009*
Familiarity with EAPs	–	–	–	–	-.084	-.107	-3.40	.001*

*Statistically significant ($p < .05$); ¹See main findings paragraph for GLM omnibus statistics

also evidence of the construct and criterion validity of the scale. A notable proportion of the surveyed Canadian workers experienced EAP treatment stigma (up to an estimated 23%) and higher scores on the BETSS-4 (i.e., higher stigma) predicted a lower self-reported likelihood of accessing EAP counseling services in the event of distressing personal problems. The latter finding supports the notion that the perception of treatment stigma is an important barrier to the seeking of EAP counseling services, a phenomenon similar to that observed with non-EAP mental health/psychological services. Given that many workers self-refer to EAP counseling services, greater understanding of (and the ability to measure) this important psychological and motivational barrier may help employers and EAP providers develop strategies and interventions aimed at attaining utilization rates that are as much as possible unhindered by stigma.

The study identified a number of independent predictors of the degree of EAP treatment stigma reported by Canadian workers. Initial bivariate analyses identified a large number of predictors and the multiple regression analyses narrowed them down to a more manageable list (7 versus 13), including a number of demographic, occupational, and psychological characteristics. The top predictors of EAP treatment stigma as measured by the BETSS-4 included at least one demographic, occupational and psychological variable. Notably, in order of importance as determined by effect size coefficients, the top four predictors of higher levels of EAP treatment stigma in the Canadian workers included: reporting higher levels of job insecurity, screening for depression, being of the male gender, and reporting lower levels of EAP familiarity.

Findings from the current study supported the notion that workers who could benefit from an EAP might choose not to access services due to

perceived stigma in relation to receiving help. The deployment of workplace interventions aimed at reducing worker perceptions of EAP treatment stigma should therefore be considered by employers and EAP providers looking to address low or potentially unoptimized EAP utilization rates. Path analysis findings from a recent research report suggested that reducing mental health treatment stigma and increasing familiarity with EAPs may contribute to reducing perceptions of EAP treatment stigma and increasing the likelihood of EAP use⁶. In this context, workplace educational interventions or sessions aimed at addressing perceptions of both mental health and EAP treatment stigma should be considered to break down this barrier and optimize utilization rates. Such interventions are often formulated to increase mental health literacy and challenge negative stereotypes associated with mental health and receiving help and could also focus on increasing familiarity with EAPs.

From a Canadian perspective, and as start, one possibility might be to consider deploying educational interventions in “high-stigma” segments of the workplace as informed by the top independent determinants identified by current study. These could include male-dominated workplaces, industries or occupations, as well as those that are known to have greater levels of job insecurity. Populations with workers with greater mental health issues or lower levels familiarity with EAPs may also be considered, although these may be more difficult to readily discern versus the aforementioned ones. In the current study, men workers reported both greater perceptions of EAP treatment stigma and a reduced self-reported likelihood of utilization versus women workers (data not shown). Such findings could be related to the emphasis of the traditional male gender role on being independent and in control, which might lead to increased concern about seeking help or admitting there is a problem.²³ Addressing perceptions of EAP-related stigma in male-dominated industries

may also help close existing gender gaps in EAP use, generally involving lower use by men.¹⁹⁻²¹

Further, although only about one-fifth of the Canadian workers reported perceptions of EAP treatment stigma, additional correlation analyses conducted with the remaining workers revealed statistically significant associations between variations in EAP treatment stigma (i.e., averages score on the BETSS-4) and the self-reported likelihood of EAP use (data not shown). This latter finding suggests that targeting and positively influencing perceptions of EAP stigma even in workers with little or no existing overall stigma might still help towards increasing the likelihood of EAP use in a time of need. More research is however needed to better understand the association between EAP treatment stigma and the likelihood of EAP use taking into consideration the degree of familiarity with EAPs, mental health states and other contextual factors.

The BETSS-4 may be used by EAP practitioners, researchers, and evaluators interested in better understanding EAP treatment stigma, its determinants, as well as its association with EAP utilization rates. The scale could be also deployed in workplaces that have low EAP utilization rates to help determine the degree of EAP treatment stigma experienced by workers, identifying the segments of the workforce reporting the highest levels that could potentially benefit from educational interventions or sessions aimed at addressing such perceptions. Finally, the BETSS-4 could be deployed to ascertain the success of such interventions by incorporating baseline and follow-up measurements to track any resulting changes in perceptions of EAP treatment stigma.

In summary, the topic of EAP-related stigma has received little attention to date, and there remain many avenues of research and investigation. Additional research on the degree (and determinants) of EAP treatment stigma experienced across different countries would help to determine the comparability of the

current findings to different populations. There are also numerous types and conceptualizations of stigma (e.g., externalized and/or public stigma), and incorporating their assessments in future studies may help identify additional psychological barriers to the use of EAPs as well as their interrelationships. A closer examination of the relationship between severity of mental health issues and perceptions of EAP treatment stigma might also be warranted. The finding by this study that workers screening for depression or anxiety reported greater levels of stigma can be considered unsettling, particularly if it implies that those that potentially need help the most have even greater psychological obstacles to overcome in order to seek and receive help from their assistance program (or other services). Finally, it may be interesting to investigate whether there exists an association between the degree of treatment stigma measured at time of EAP access and the outcomes observed after EAP use. Perceptions of stigma, for example, could potentially influence the openness or receptivity of workers to counseling in ways that impact outcomes.

Regarding some of the limitations of the current study, the self-reported likelihood of accessing an EAP was assessed and not patterns of actual use. Future research could investigate perceptions of EAP treatment stigma and actual patterns of EAP utilization using prospective (versus cross-sectional) study designs to gain a better understanding of their association. Also, the associations reported in this study represent overall trends and might not capture some of the unique experiences of certain workers. For example, although EAP treatment stigma was found positively correlated with the severity of depression symptomology, it is of course possible that employees with low EAP treatment stigma experience high levels of depression. Finally, the strength of the association between EAP treatment stigma (BETSS-4) and the self-reported likelihood of EAP use can be considered moderate versus strong. Thus, EAP treatment stigma is just one

of the many factors that contributes to variance in EAP utilization patterns and these should also be taken into account when developing a strategy to increase the use of assistance programs.

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