# A survey of student nurses' attitudes toward help seeking for stress

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# A survey of student nurses' attitudes toward help-seeking for stress.

**Abstract**

**Background**

Globally, stress in student nurses may have serious implications for health, absenteeism and attrition. Despite this, there is scant research on student nurses' attitudes towards help-seeking.

**Objectives**

To examine student nurses' attitudes towards stress and help-seeking.

**Design, methods and statistical analysis**

A cross-sectional questionnaire, survey design was employed to gather data from 219 student nurses at two large UK Universities. Two-sample chi-square tests and Fisher's Exact tests were used to analyse categorical associations between responses.

**Results**

Most had experienced stress before, believed the incidence within the profession was high, and would disclose their own stress to family/friends rather than to colleagues or professional institutions. The most popular out-patient treatment choice was social support, few would choose formal advice. The most common factor influencing in-patient treatment choice was confidentiality, for many this factor would also lead them to seek distant rather than local in-patient care. Encouragingly, most would not lose confidence in a stressed colleague.

**Conclusions**

Negative attitudes towards stress and help-seeking may be entrenched even before training, and may have a marked influence on how/whether students seek help. Nurse

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employers and educators should foster more supportive and accepting attitudes towards stress in order to tackle its unwanted consequences.

**Key Words**

Nursing, survey, questionnaire, help-seeking, stress

**Introduction**

The dominant theoretical perspective on stress is the transactional model, developed by Lazarus and Folkman (1984), which emphasises the importance of people's appraisals both of the situations they face and their ability to face those challenges. Stress can occur when the demands placed upon an individual exceed their perceived ability to cope (Cohen, Kessler & Gordon, 1995). It has been well documented that nurses experience job-related stress (Lu, 2011; Sveinsdottir, Biering & Ramel, 2006; Johnston, Jones, Charles, McCann & McKee, 2013). In an international study (including the UK), levels of burnout in 40 percent of hospital nurses were higher than the norms for healthcare professions (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovanetti, Hunt, Rafferty & Shamian, 2001). In the same study, the level of professional dissatisfaction expressed by US nurses was four times greater than that of the average US worker. Many nurses also believed that levels of staffing were inadequate for high-quality patient care (Aiken et al., 2001). Elsewhere, there is evidence that burnout may be associated with medical errors (Kang, Lihm & Kong, 2013).

**Background**

Stress in student nurses has been demonstrated in a number of studies (see Pulido-Martos, Augusto-Landa & Lopez-Zafra, 2012) and has been found to be common: in more than 50 percent of a cohort, and greater than the prevalence in senior medical students and the general population (Jones & Johnston, 1997). Academic pressures, practical demands, death and suffering in patients and financial concerns have been identified as sources of stress for student nurses (Rhead, 1995, Stewart-Brown, Evans, Patterson, Petersen, Doll, Balding & Regis, 2000) and calls have been made for

healthcare employers to implement stress management interventions for both student and registered nurses (Jones & Johnston, 2000).

Although the sources of stress are well researched, research on students' attitudes toward help-seeking for stress is less abundant. Findings suggest that nursing students anticipate development of burnout at some point in their career as inevitable (Michalec, Diefenbeck & Mahoney, 2013). However, there is some evidence that student nurses are often reluctant to seek help for stress (Kernan & Wheat, 2008), and may often have negative attitudes toward seeking psychological help (Cankaya & Duman, 2010). Furthermore, student nurses may harbour general negative attitudes toward those with mental health difficulties (Halter, 2004; Llerena, Cáceres & Peñas-LLedó, 2002; Schafer, Wood & Williams, 2011), which may contribute to concerns about how help-seeking will be perceived by peers. This corresponds with findings that doctors' help-seeking decisions are often influenced by concerns about confidentiality and stigma (Hassan, Ahmed, White & Galbraith, 2009; White, Shiralkar, Hassan & Galbraith, Callaghan, 2006). Elsewhere it is reported that many nurses who have suffered from a mental illness have shown concern that their colleagues and superiors might hold prejudiced opinions of them (Farrell, 2001). Indeed, poor relationships with clinical colleagues is a significant source of stress in student nurses (Evans & Kelly, 2004) and many may cope with stress by simply keeping quiet about it (Burnard, Haji Abd Rahim, Hayes & Edwards, 2007). Such negative attitudes may leave student nurses less inclined to seek help for stress should they need it and there is a wealth of literature within social and health psychology demonstrating that attitudes predict behaviour (Ajzen, 1991, 2011; Eagly, & Chaiken, 1993). Indeed, evidence shows that nursing students may often resort to avoidant

coping strategies when under stress, which may raise the risk of burnout or stress
(Gibbons, 2010; Pines, Rauschhuber, Norgan, Cook, Canchola, Richardson & Jones,
2012).

Although the literature suggests that student nurses may sometimes hold maladaptive
attitudes towards stress and help-seeking, the volume of research into these attitudes
is inadequate and many of the existing studies are limited methodologically.
Additionally, very few studies target attitudes as the main focus of the study (e.g.
Kernan & Wheat, 2008), and therefore student nurses' views about help-seeking are
rarely described. In many cases, studies report only on registered nurses (Farrell 2001)
or on other types of healthcare professional (e.g. White et al., 2006) and therefore
students' attitudes and perceptions of stress and help-seeking are under-researched. If,
as is argued, doctors' negative attitudes towards mental health difficulties begin
during training (Chew-Graham, Rogers & Yassin, 2003), the study of student nurses
during this formative period is especially pertinent.

*Aims and predictions*

Given the prevalence of stress in the nursing profession, and the high degree of public
awareness of nursing as a stressful profession, we aim to gather data on student
nurses' experience of and beliefs about the incidence of stress (aim 1). The aim here is
to measure students' perceptions about stress in their chosen profession – what is their
view on its prevalence? We are also interested in whether the students believed they
had experienced stress before. In this regard we do not aim to gather objective data on
current or previous levels of stress, instead we wish to discover what proportion of the
sample *believe* that they themselves have experienced stress before. This is important,

as students' beliefs and experiences of their own stress may influence their attitudes to disclosure or treatment for example. Additionally, in light of the findings that nurses with mental health difficulties experience stigma and prejudice, the study will also examine attitudes towards the disclosure of stress (aim 2), as well as getting treatment for stress (aim 3) and attitudes toward colleagues with stress (aim 4). There are also some specific predictions, all relating to associations between questions, and tested with two-sample chi-square analyses.

*Prediction 1 (Association between Q10 and Q 11).* See Table 2 for the list of non-demographic questions). Based on previous studies into doctors' attitudes to developing mental illness (e.g. Hassan et al., 2009; White et al., 2006) it is predicted that those who would opt for professional advice when stressed will be influenced by concerns over quick recovery and convenience, whereas those who would prefer social support and self-medication when stressed will be influenced by issues of confidentiality or stigma.

*Prediction 2 (Association between Q 12 and Q 13).* Again based on previous studies (Hassan et al., 2009; White et al., 2006), it is predicted that those who would choose distant care for stress will be influenced by concerns over confidentiality or stigma whereas preference for local care will be influenced by convenience or quick recovery.

Previous findings show that student nurses are reluctant to seek help, and also possess negative attitudes toward help-seeking. Hence we also predict that those who would lose confidence in a stressed colleague will also be influenced by:

Stigma or career implications when disclosing their own stress. *Prediction 3 (Association between Q14 and Q9)*

Confidentiality or stigma when choosing out-patient treatment. *Prediction 4 (Association between Q14 and Q11)*

Confidentiality or stigma when choosing in-patient treatment. *Prediction 5 (Association between Q14 and Q13).*

**Method**

*Design*

A cross-sectional questionnaire survey design was employed, whereby data was collected at one-point in time using anonymous printed questionnaires.

*Participants*

Purposive sampling was used to recruit 219 student nurses was recruited (197 females) from lectures at two UK universities, most of the students were aged between 18 and 30 years. The inclusion criterion was that respondents had to be currently in training to become a registered nurse. The two university courses were chosen because they were representative of UK nursing programmes. Furthermore it was anticipated that response rates would be high thus reducing self-selection bias. Courses were over three years full-time and the sample included a mixture of cohorts (see Table 1 for the demographic data). The target sample size was established in anticipation of calculating two-sample chi-square ($\chi^2$) tests. A required sample size of 193 was computed, using G*Power 3 software, incorporating $\alpha$ at 0.05, power at .80, a medium effect size of .30 and a maximum df of 12.

*Materials and Procedure*

The questionnaire (see Tables 1 and 2) was based on the measure employed by White et al. (2006) and Hassan et al. (2009) designed to examine attitudes towards developing mental illness and help-seeking. The current questionnaire was adapted to measure student nurses' attitudes to stress and help-seeking. The construct validity of this questionnaire was not measured because the questionnaire itself does not attempt to measure a latent construct (such as stress or burnout for example), rather it was designed to ask frank questions about respondents' experiences and beliefs, and what they would do in certain situations and why. The first part of the questionnaire gathered demographic and background information. This was followed by questions about experiences of stress and beliefs about the incidence of stress (questions 5 to 7). The question regarding experience of stress is not intended to represent a valid measure of the degree of stress present within the sample. Instead it indicates the proportion of the sample who believe and self-report, they have had stress. In this study, it was the degree to which respondents believe they have had stress which was important to us, rather than a more objective test of how stressed the sample was. There were also questions on attitudes towards disclosing information about stress (questions 8 and 9). Again the aim was to simply ask who respondents believe they would first turn to, if they had to tell someone about their stress. There were further questions about preferences when receiving treatment for stress (questions 10 to 13) and finally frank questions about attitudes towards colleagues experiencing stress (questions 14 and 15). The response format for all of the questions was categorical, yielding nominal data. The questionnaire was piloted on a small sample of students as well as academic and clinical colleagues to establish content and face validity.

Ethical approval was granted by ethics committees at both universities from which data was collected. All participants were approached either at the end, or at the beginning of lecture sessions, in agreement with their course tutors. The researcher announced the aims of the study to the class and emphasised the voluntary nature of participation. All of the students that were approached gave informed consent to participate. It was explained to the students that when answering questions about colleagues and employers, they should relate these questions to their clinical placement colleagues and managers. The researcher then emphasised the importance of completing the questionnaires in silence. Participants handed their questionnaire packs to the researcher once they had finished.

*Analysis*

The initial data analysis is descriptive. As the quantitative data is nominal, frequency data is presented for each question – the number (and percentage) of respondents choosing each response option. Subsequently, two-sample chi-square tests examine associations between particular questions (see predictions 1-5). The two-sample chi-square test examines the relationship between two categorical variables, and compares the observed data across categories with the data one would expect by chance. One of the assumptions of chi-square is that no more than 20% of cells have frequencies <5, when this assumption was violated, we applied Fisher's Exact test, which unlike chi-square, is accurate when frequencies are low. Cramer's V was used as a measure of effect size for the two-sample chi-square tests, it provides an association coefficient between 0 and 1. Statistical analysis was carried out using SPSS 16.

**Results**

Activity before training (Q4, see Table 1) was not associated with any of the questions about stress and help-seeking (Q5-15) (*p*> 0.05). Stage of training (Q3, see Table 1) was not associated with any of the questions about stress and help-seeking apart from with question 11 ($\chi^2$ = 28.28; df = 6; *p* = 0.001; Cramer's V = 0.26), where although stage 1 and stage 3 students' in-patient treatment preferences were most likely to be influenced by confidentiality, stage 2 students were most likely to be influenced by convenience. The demographic information is displayed in table 1.


Table 1 about here.


The frequencies of responses to the non-demographic questions (questions 5 to 15) are shown in Table 2.


Table 2 about here


*Experience and Incidence of Stress (Aim 1)*

The majority of participants (74.9 %) reported that they had experienced stress which had affected their personal, social or occupational life (Q5). Additionally, 72.1% felt that the incidence of stress was higher amongst nurses than the general population (Q6), and a third of respondents (37.4%) agreed that the incidence of stress was higher in nurses than in other health professions (Q7).


*Disclosure of Stress (Aim 2)*

In the event of developing stress, the vast majority of respondents (87.2%) would choose to disclose this to family and friends (Q8). Very few would prefer disclosure

to colleagues or professional/Governmental institutions, 5% would choose to disclose to no-one. The factors affecting this choice (Q9) varied somewhat: 24.7% cited stigma, 45.2% reported career implications and 14.6% cited professional integrity. Eleven percent of respondents chose other reasons, which either focused on the benefits of family support (e.g. 'Maybe able to offer advice', 'Quick recovery') or the disadvantage of disclosing to non-family/friends (e.g. 'No sympathy', 'Negative attitudes, dismissive behaviour, not taken seriously').

*Getting Treatment for Stress (Aim 3)*

As a first treatment preference for stress requiring out-patient care (Q10), nearly half of all respondents (47.9%) would opt for social support, (unsurprisingly, all but six of these individuals would also opt to *disclose* to family and friends). Thirty percent would prefer informal professional advice but only 11.4% would opt for formal professional advice. Six percent would choose no treatment and 4.1% would self-medicate. The factors influencing preferences for out-patient treatment, were spread across the four options (Q11), the most common being confidentiality (37.4%). A two-sample chi-square test was computed to examine the association between out-patient treatment preference and the factors which influence this preference (Q10 and Q11; Prediction 1). There was no significant association between these two variables ($\chi^2$ = 16.50; df = 12; *p* = 0.170; Cramer's V = 0.16) therefore prediction 1 was not supported.

In the event that they would require in-patient treatment for stress (Q12), a local private facility was the most popular choice (41.1%), and a distant NHS hospital (National Health Service, i.e.UK public hospital) the least (11.0%). The most commonly cited factor which influenced this treatment preference (Q13) was

confidentiality (40.6%). A two-sample chi-square test revealed a significant association between in-patient treatment preference (Q12) and factors influencing treatment preference (Q13) (Fisher's Exact = 97.72; df = 9; $p$ = 0.001; Cramer's V = 0.39). As can be seen from Table 3, the majority of those choosing distant NHS (public) or distant private care, were influenced by confidentiality. In contrast, the majority of those who chose the local NHS option were influenced by convenience. Of those who would choose a local private facility, most were influenced by either quality of care or by confidentiality. Thus prediction 2 was supported.

Table 3 about here

*Attitudes towards Colleagues with Stress (Aim 4)*

It was made clear to respondents they were to reflect on their experiences in clinical placements when answering questions about colleagues and employers. In the event that one of their colleagues developed stress (Q14), the majority of respondents (69.4%) claimed that they would not lose confidence in the ability of their colleague to do their job. In response to whether a stressed colleague should stop working until they had recovered (Q15), 42.0% said 'No'. Three further two-sample chi-square tests were computed to test predictions 3, 4 and 5. Those choosing 'Don't know' to question 14 were omitted from the analysis. There was no significant association between responses to question 14 and the factors affecting disclosure (Q9) ($\chi^2$ = 2.78; df = 3; $p$ = 0.426; Cramer's V = 0.13), therefore prediction 3 was not supported. However there was a significant association between question 14 and the factors affecting out-patient treatment preference (Q11) ($\chi^2$ = 8.53; df = 3; p = 0.036; Cramer's V = 2.2). As shown in Table 4, those who would lose confidence in a stressed colleague would be proportionately more influenced by confidentiality or stigma when choosing out-patient care for their own stress. Of those who would not lose confidence in a

colleague, a greater proportion would be influenced by convenience or quick recovery. Therefore prediction 4 was supported.

Table 4 about here

There was also a significant association between responses to question 14 and the factors affecting in-patient treatment preference (Q13) ($\chi^2 = 18.80$; df = 3; p = 0.001; Cramer's V = 0.33). As shown in Table 5, of those who would lose confidence in a colleague, a greater proportion would be influenced by confidentiality or stigma when choosing in-patient care for stress. Of those who would not lose confidence in a colleague, a greater proportion would be influenced by convenience or quick recovery. Thus prediction 5 was supported.

Table 5 about here

**Discussion**

*Experience and Incidence of Stress (Aim 1)*

Three quarters of participants reported having experienced stress. Although this is consistent with levels reported in previous literature (e.g. up to 67 percent reported by Jones & Johnston, 1997), this question was not designed to gather objective data regarding the incidence of stress. Instead we were interested in participants' perceptions of their own stress, and their beliefs about its incidence. Although retrospective reports of stress may be prone to inaccuracy and exaggeration, such high reporting of stress at this early stage in nursing careers is noteworthy. It suggests that a high proportion of nursing students can already identify with the term and recognise that they have experienced it. This is perhaps not surprising given that more than half of the sample have had previous careers before starting their training, and therefore could have had previous exposure to occupation stress. Furthermore, it could be that for many, previous experiences of stress were not entirely negative, and it has been shown that minor hassles relating to university or clinical placements, can often enhance the wellbeing and learning experience of nursing students (Gibbons, 2010). On the other hand, it should be noted that over time, the cumulative effect of even minor stressors, can impact negatively on well-being (Vasiliadis, Forget & Préville, 2012). Most respondents felt the incidence of stress in the nursing profession was relatively high, and these estimates are consistent with incidence rates from previous studies (Lu, 2011; Aiken et al., 2001). This shows that nursing students have existing beliefs about high levels of stress in the profession at this early stage of their career.

*Disclosure of Stress (Aim 2)*

The vast majority of respondents would prefer to disclose stress to family and friends and very few would prefer to confide in colleagues or professional institutions.

Furthermore their disclosure would be influenced by concerns about stigma, their careers or professional integrity. This suggests that stress would be under-reported in the current sample and is consistent with accounts of trained and student nurses' reluctance to admit stress for fear of prejudice and stigma (Burnard et al., 2007; Cankaya & Duman, 2010; Farrell, 2001; Kernan & Wheat, 2008). The preferences for disclosure observed in this study are significant, as reluctance to officially report stress often results in a delay in getting help, which may lead to unhealthy coping styles such as alcohol and drug abuse (Tully, 2004). Furthermore, under-reporting of mental health difficulties is recognised as a cause of sickness absence and attrition, both of which represent common challenges for the profession given the global shortage of nursing staff (Currie & Carr Hill, 2012; Deary, Watson & Hogston, 2003).

*Getting Treatment for Stress (Aim 3)*

Social support was also the most common choice for *out-patient* care with very few opting for formal professional advice. Nearly half of respondents would be motivated by confidentiality or stigma when making this choice. Similarly, in nearly half the sample, preferences for *in-patient* care were influenced by either confidentiality or stigma, many would opt for distant care rather than local because of concerns over confidentiality (prediction 2). Thus the issue of confidentiality would be more important to these students than quality of care when seeking help for stress. This echoes the findings from similar studies on doctors (White et al., 2006; Hassan et al., 2009). Such a finding is seemingly at odds with the valued notion of confidentiality within the nursing profession (Deshefy-Longhi, Dixon, Olsen & Grey 2004), and perhaps signifies a perception that their personal records will not remain private. Hassan et al. (2009) argue that the advent of computerised medical records and the

interconnectivity of record systems across the healthcare system may contribute to this lack of faith in confidentiality – a view which is supported by empirical research (e.g. Likourezos, Chalfin, Murphy, Sommer, Darcy & Davidson, 2004). The current questionnaire did not directly address *why* confidentiality would be so important to respondents when making treatment choices, examination of these reasons may be a line of inquiry for future studies.

*Attitudes towards Colleagues with Stress (Aim 4)*

More encouraging was the finding that most students would not lose confidence in a colleague who was stressed. However this still left nearly a third who either would lose confidence or are unsure. Interestingly, those who would lose confidence in a stressed colleague would be more influenced by confidentiality and stigma when choosing out-patient or in-patient care for themselves (predictions 4 and 5). This suggests that students' attitudes towards stressed colleagues may resemble their attitudes towards their own stress (and/or the perception of how they would be treated by others). This is consistent with previous studies which report stigmatised views amongst some student nurses towards patients and colleagues with mental illness (Halter, 2004; Llerena et al., 2002; Schafer et al., 2011).

The current study shows that negative attitudes towards stress and help-seeking are common amongst student nurses and that help-seeking for stress is influenced by concerns about confidentiality and career. Few studies have emphasised the importance of such attitudes in this population, instead the focus has mainly been on the causes of stress and on stress management programmes. Many healthcare employers provide stress management for their employees but often these suffer from poor uptake (Jones & Johnston, 2000). The current study suggests that for many

student nurses, attitudes toward getting help for stress need to be addressed before they engage with such programmes, and indeed this is the main recommendation of the paper. A volume of literature inspired by Ajzen's (1991) theory of planned behaviour demonstrates that attitudes are important predictors of behaviour (e.g. Kraft, Rise, Sutton & Røysamb, 2005) and there is ample evidence that help-seeking is inhibited by negative attitudes (e.g. Barney, Griffiths, Jorm & Christensen, 2006). Changes in attitudes must be at the organisational as well as at the individual level if they are to be effective however (Jones & Johnston, 2000). This study suggests that maladaptive attitudes towards stress are already entrenched during the training phase of nurses' careers. This does not imply that the training process itself causes such attitudes, it is perhaps more likely that students generate their perceptions and attitudes about stress and help-seeking before they become a student. Nevertheless there are important implications: if strong negative attitudes already exist during this early, formative period, they may be especially difficult to modify later.

The sample of student nurses, although of moderate size and yielding a 100 percent response rate, was one of convenience and was drawn from just two universities, both situated within the UK. Therefore some caution should be exercised before generalising these findings to all student nurses. Test re-test reliability was not examined and therefore consistency of responses over time cannot be assumed. One should also consider the context in which the data collection took place: during University teaching time, responses may have been different if questionnaires had been completed in the clinical environment. Furthermore, it may be that some responses reflected beliefs about what was professionally or culturally desirable and the self-report nature of the study may have led some to exaggerate their answers

(Holden, 2008). Despite this, the results make an important contribution and warrant consideration with regard to action on stress and help-seeking.

**Conclusions**

This study shows how student nurses' attitudes towards developing stress may affect their subsequent help-seeking behaviour and that negative attitudes to help-seeking may already exist even in the training stage of the profession. Follow-up studies employing longitudinal designs may shed further light on how attitudes affect reported stress and absenteeism. Closed questions provide only a limited insight into attitudes and behaviour, therefore future studies may collect more in-depth data by using open-ended questions or semi-structured interviews. We should note that many participants may not have experienced stress and that predictions about how one *would* act may be markedly different from the actual behaviour in a real situation. To address this, future studies should collect more detailed, in-depth data on respondents' previous experiences of stress.

Evidence of stress in trained and student nurses is found across the world e.g. Korea (Yoon & Kim, 2013), Iran (Changiz, Malekpour & Zargham-Boroujeni, 2012), South Africa (Görgens-Ekermans & Brand, 2012), Spain (Fornés☐Vives, J., García☐Banda, G., Frías☐Navarro, 2012). Given the global shortage of nurses (Currie & Carr Hill, 2012) and the high drop-out rates from the profession (Deary, Watson & Hodgston, 2003), governments around the world have recognised the importance of addressing stress (American Nurses Association 2000; Department of Health 2002a, 2002b). The current study suggests that negative attitudes toward stress may be a barrier to help-seeking, however such attitudes are likely to be culturally diverse and further research

is needed to explore them (see Burnard, Edwards, Bennett, Thaibah, Tothova, Baldacchino, et al., 2008). A greater emphasis on stress awareness in nurse and management training may also improve attitudes, although this may be difficult for undergraduate courses which are already heavily burdened (Jones & Johnston, 2006). A confidential counselling service for registered and trainee nurses may also be of benefit, and indeed there is evidence that such services would be supported by healthcare professionals (Young & Spencer, 1996). But our data suggest that some nursing students have concerns about confidentiality, so such a service would perhaps need to be perceived by students as independent from course administrators and the organisation hosting their clinical placement.

Given the policy of healthcare organisations to implement stress management programmes for employees, more research needs to be done to establish the effect of attitudes to help-seeking on engagement with such programmes. The current results suggest that nurse educators should be wary when implementing support for stress in students, that low buy-in to such programmes may be due to negative attitudes towards help-seeking, rather than the absence of need for such support. An important issue for future research is the question of whether students' attitudes toward help-seeking endure longitudinally into their subsequent career as a trained nurse.

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1

**Tables**

| Q1. Sex | Female | Male | | |
|---|---|---|---|---|
| | 197 (90.0) | 21 (9.6%) | | |
| Q2. Age | 18-30 | 31-40 | 41-50 | 51 and over |
| | 146 (66.7%) | 47 (21.5%) | 24 (11.0%) | 2 (1%) |
| Q3. What stage of training are you at? | Year 1 | Year 2 | Year 3 | |
| | 119 (54.3%) | 85 (38.8%) | 15 (6.8%) | |
| Q4. What did you do before you began your nurse training? | School, college or university | Previous career lasting less than 5 years | Previous career lasting 5 years or more | Other |
| | 86 (39.3%) | 63 (28.8%) | 61 (27.9%) | 9 (4.1%) |

Table 1. Demographic data

2

| | | | | |
|---|---|---|---|---|
| Q5. Have you ever experienced stress which has affected your personal, social or occupational life? | Yes | No | | |
| | 164 (74.9%) | 55 (25.1%) | | |
| Q6. Is the incidence of stress amongst nurses higher than the general population? | Yes | No | Don't know | |
| | 158 (72.1%) | 18 (8.2%) | 43 (19.6%) | |
| Q7. Is the incidence of stress amongst nurses higher than other healthcare professions? | Yes | No | Don't know | |
| | 82 (37.4%) | 53 (24.2%) | 84 (38.4%) | |
| Q8. If you were to develop stress, to whom would you be most likely to disclose this? | Family/ friends | Colleagues | Professional institutions | No-one |
| | 191 (87.2%) | 3 (1.4%) | 4 (1.8%) | 11 (5.0%) |
| Q9. What is the most important factor that would affect your decision to disclose your stress? | Stigma | Career implications | Professional integrity | Other |
| | 54 (24.7%) | 99 (45.2%) | 32 (14.6%) | 24 (11.0%) |
| Q10. If you required out-patient treatment for stress what would be your first treatment preference? | Informal advice | Formal advice | Self-medication | Social support / No treatment |
| | 65 (29.7%) | 25 (11.4%) | 9 (4.1%) | 105 (47.9%) / 13 (5.9%) |
| Q11. In choosing your treatment preference which of the following influenced your decision most? | Quick recovery | Convenience | Confidentiality | Stigma |
| | 60 (27.4%) | 55 (25.1%) | 82 (37.4%) | 17 (7.8%) |
| Q12. If you required in-patient treatment for stress where would be your first treatment preference? | Local NHS | Distant NHS | Local private | Distant private |
| | 66 (30.1%) | 24 (11.0%) | 90 (41.1%) | 37 (16.9%) |
| Q13. In choosing your in-patient treatment preference which of the following influenced your decision most? | Quality of care | Convenience | Confidentiality | Stigma |
| | 51 (23.3%) | 62 (28.3%) | 89 (40.6%) | 13 (5.9%) |
| Q14. If a colleague developed stress would you lose confidence in their ability to do their job? | Yes | No | Don't know | |
| | 23 (10.5%) | 152 (69.4%) | 44 (20.1%) | |
| Q15. If a colleague developed stress, would you expect them to stop working until they recovered? | Yes | No | Don't know | |
| | 60 (27.4%) | 92 (42.0%) | 66 (30.1%) | |

Table 2. The frequency of responses to questions 5 - 15.

3

|  |  | Q13 Factor influencing in-patient treatment preference | | | |
|---|---|---|---|---|---|
|  |  | Quality of Care | Convenience | Confidentiality | Stigma |
| Q12    In-patient preference | Local NHS | 15 (22.7%) | 43 (65.2%) | 7 (10.6%) | 1 (1.5%) |
|  | Distant NHS | 1 (4.2%) | 0 (0.0%) | 22 (91.7%) | 1 (4.2%) |
|  | Local Private | 31 (35.2%) | 16 (18.2%) | 34 (38.6%) | 7 (8.0%) |
|  | Distant Private | 4 (11.1%) | 3 (8.3%) | 25 (69.4%) | 4 (11.1%) |

Table 3. Frequency table showing the choices for in-patient treatment and the factors which influenced those choices (observed frequencies are shown, with percentages for rows in parentheses).

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| | | | Q11 Factor influencing out-patient treatment preference | | | |
|---|---|---|---|---|---|---|
| | | | Quick recovery | Convenience | Confidentiality | Stigma |
| Q14        Lose confidence     in colleague? | Yes | | 2 (9.1%) | 5 (22.7%) | 10 (45.5%) | 5 (22.7%) |
| | No | | 45 (30.0%) | 40 (26.7%) | 54 (36.0%) | 11 (7.3%) |

Table 4. Frequency table showing the association between question 14 and question

11 (observed frequencies are shown, with percentages for rows in parentheses).

5

| | | | Q13 Factor influencing in-patient treatment preference | | | |
|---|---|---|---|---|---|---|
| | | | Quality of care | Convenience | Confidentiality | Stigma |
| Q14 Lose confidence in colleague? | Yes | | 1 (4.5%) | 5 (22.7%) | 11 (50.0%) | 5 (22.7%) |
| | No | | 39 (26.2%) | 41 (27.5%) | 65 (43.6%) | 4 (2.7%) |

Table 5. Frequency table showing the association between question 14 and question 13 (observed frequencies are shown, with percentages for rows in parentheses).