

A Systematic Review of Self-Care Measures for Professionals and Trainees

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Despite the lack of a universally accepted definition, the concept of self-care has been long recognized in the health care literature (e.g., nursing, behavioral medicine), and research findings have established a foundation to support the importance of self-care in optimizing health and well-being in patients. In recent decades, more attention has been paid to self-care in health service professionals (Wise, Hersh, & Gibson, 2012), and emerging evidence has supported the benefits of self-care in facilitating psychology graduate trainees' professional gains and well-being (Colman et al., 2016). To facilitate more empirical research in this area, the current systematic review was conducted to summarize the current availability of self-care measures among health care professionals and trainees (e.g., psychologists, social workers, and nurses) and assess their psychometric properties and clinical utilities. An electronic search was performed for self-care measures in 3 databases (i.e., PsycINFO, CINAHL, and PubMed). Eight articles published from 2013 to 2019 met the inclusion criteria, and 10 measures assessing self-care among mental health care professionals were identified. The key features of these measures are summarized. Although all the scales have some psychometric support, only a few had adequate support that was demonstrated through high-quality empirical studies. Recommendations are provided for future use of the self-care measures, especially for psychologists, psychology trainees, and social or child welfare workers. Research gaps and future directions of self-care measurement studies to promote self-care practice among mental/health care professionals and trainees are also discussed.

Public Significance Statement

This review summarizes the self-care measures that can be used to assess self-care practices in health care professionals and trainees. The findings offer the guidelines for selection of self-care measures in research and/or training and practice, especially in mental health care fields, such as psychology and social work.

Keywords: self-care, health care professional, trainee, measure, systematic review

A lack of self-care in health service professionals has been considered a cause of compromised quality of services and burn-out, and sufficient self-care has been suggested to be part of ethical practices (Barnett, Baker, Elman, & Schoener, 2007; Wise & Reuman, 2019). There is a compelling need to study self-care to increase the awareness and use of self-care in professional training and continuous development throughout the health service career. However, to date, there has been no review of self-care measures for mental health professionals.

Based on current (and limited) literature on this topic, self-care for professionals typically refers to activities or processes that are

initiated and managed by the professional for the purpose of providing stress relief and supporting one's health and well-being (Lee & Miller, 2013; Newell & Nelson-Gardell, 2014). However, it must be noted that there has not been a well-established definition of self-care for professionals, and the conceptualization of this construct will likely evolve as more research becomes available. In a similar vein, how to assess self-care for professionals is far from clear. For example, many researchers selected one or multiple activities that have been linked to healthy lifestyles, such as exercise and healthy diet, or those associated with psychological well-being, such as mindfulness and seeking social support, to

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represent self-care (for a review, see [Colman et al., 2016](#)). In studies that aimed to develop measurements to investigate self-care, researchers tended to characterize self-care as a multidimensional phenomenon and grouped behaviors that serve similar functions into the same dimensions, although these dimensions varied greatly across measures. In this systematic review, we provide a comprehensive picture of how self-care is being assessed for professionals based on the current understanding of this concept.

Who Needs Self-Care: Growing Emphasis on the Professional Sphere

The interest in conceptualizing self-care as a tool to maintain professional functioning stems from the acknowledgment of the emotional and physical toll of caregiving professions. A contemporary review of studies reported that burnout among mental health professionals ranged from 21% to 67% ([Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012](#)). Described as “the terminal phase of therapist distress” ([Baker, 2003](#), p. 21), burnout has been shown to lead to decreased engagement with clients, disruptions in continuity of care, and high turnover rates ([Chiller & Crisp, 2012](#); [Schaufeli, Bakker, & Van Rhenen, 2009](#)). Since the 1990s, scholars have pointed out that insufficient self-care is one of the distal causes of the deterioration of professional functioning, which may lead to burnout (e.g., [Brady, Norcross, & Guy, 1995](#); [O’Halloran & Linton, 2000](#)). More specifically, insufficient self-care was found to contribute to emotional depletion and exhaustion, which subsequently impaired one’s functioning at work and significantly impacted the quality of service provision ([Collins, 2005](#)). In contrast, sufficient self-care was thought to have three primary functions for professionals: (a) protection of the therapist by reducing occupational hazards such as burnout; (b) enhancement of psychotherapy by modeling healthy behavior; and (c) protection of the client by reducing risks of ethical violations ([Porter, 1995](#)). Notably, the “Ethical Principles of Psychologists and Code of Conduct” ([American Psychological Association \[APA\], 2017](#)) has long regulated psychologists’ professional behaviors to practice within the boundaries of their competence (Section 2.03) and be aware of and take appropriate measures to address personal problems that may interfere with their practice (Section 2.06). Given the professional risk of chronic, insufficient self-care, more scholars have called upon professional self-care as an ethical imperative for psychologists ([Norcross & Guy, 2007](#); [Wise et al., 2012](#)).

Furthermore, a preventive view of the importance of self-care is on the rise in the recent decade. Specifically, sufficient self-care has been thought to be one preventive coping strategy to reduce the risk of distress, impairment, and burnout ([Boellinghaus, Jones, & Hutton, 2013](#); [Smith & Moss, 2009](#)). Indeed, empirical research findings showed associations between self-care practices and lower burnout in social workers ([Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015](#)), higher resilience in practitioners whose work focuses on mental health and/or trauma ([Bober & Regehr, 2006](#); [Newell & MacNeil, 2010](#)) and death and bereavement ([Alkema, Linton, & Davies, 2008](#); [Berzoff, 2008](#)). Self-care practices were also found to be associated with improvement in overall mental, physical, and spiritual well-being ([Christopher & Maris, 2010](#); [Harrison & Westwood, 2009](#)). Taken together, self-care is considered a crucial component to not only avoid negative conse-

quences in professional functioning but also to assure competent and flourishing lifelong practices ([Wise et al., 2019](#)).

Self-Care: Integrating the Professional and the Personal Behaviors

For health care professionals, the concept of self-care has an additional component compared with general populations because the self is divided into the professional self and the personal self, either implicitly or explicitly ([Pipes, Holstein, & Aguirre, 2005](#); [Skovholt, Grier, & Hanson, 2001](#)). The professional self engages in working relationships with clients that are guided by professional role expectations of engagement with those client relationships. In contrast, the personal self exists outside the workplace as guided by role expectations influenced by family, economic factors, and other ecologies ([Skovholt et al., 2001](#)). As aforementioned, current APA ethics codes allude to the importance of self-care, specifically as it pertains to professional competence. However, the boundary between personal and the professional behaviors is not always clear, and there is often a reciprocal relation between elements in both spheres (for details see [Pipes et al., 2005](#)). To maintain a high professional standard, it was recommended that the aspirational principles might be applied to personal behavior ([Pipes et al., 2005](#)). Principle A (beneficence and nonmaleficence) is especially relevant to the context of self-care because it suggests that psychologists should “strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” ([APA, 2017](#), p. 3). Along these lines, any distress or competence problems in professional functioning is at least partially due to an imbalance between the professional self and the personal self. In particular, when the personal self is weakened because of cumulative stress from work, in turn, it compromises the competencies of the professional self’s ability to function and further address the stress. The core purpose of self-care is to maintain homeostasis within a self-system, and the professional self should not impinge on the personal self or vice versa ([Skovholt et al., 2001](#)). Distress is not a sudden state but occurs after a prolonged process of gradual stress; there are thus opportunities to prevent this from occurring or minimizing more severe consequences (e.g., compromised competency, burnout). Hence, professionals should exercise self-care when the self-system is intact, long before distress occurs.

Self-Care in Graduate Training

Considering the significance of self-care in health service professionals’ careers, scholars have paid greater attention to the promotion of self-care during the training phase ([Bamonti et al., 2014](#); [Wise et al., 2012](#)). It is widely accepted that graduate training is associated with high levels of stress ([El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012](#); [Pakenham & Stafford-Brown, 2012](#)). In studies conducted with psychology graduate trainees, results showed that such stress has a negative impact on trainees’ health and well-being ([Alleyne, Alleyne, & Greenidge, 2010](#); [DeBerard & Masters, 2014](#)). Some scholars have indicated that self-care can be one potential method for alleviating the stress associated with graduate training in professional psychology ([Barnett & Cooper, 2009](#)). By defining self-care as a variety of activities that supposedly promote holistic well-being, [Colman et al.](#)

(2016) conducted a meta-analysis to examine the efficacy of self-care activities in different outcomes for graduate students. Based on the search results yielding 17 studies, three types of self-care activities were categorized: mindfulness, seeking social support, or mixed/other (not specified because of a small number of studies using other different strategies). Results indicated that overall, students who practiced self-care had more positive outcomes than those who did not. The effect size across studies was moderated by the types of outcomes, with larger improvements in the areas of self-growth (e.g., self-compassion) followed by psychological well-being (e.g., decreased psychological distress and enhanced life satisfaction), in contrast to smaller effects in stress reduction. In addition, the effect size did not appear to vary significantly across the type of self-care, study design/quality characteristics, or participant characteristics. This study is an important step to aggregate the emerging but promising research on self-care in graduate trainees, and the results provide a foundation for future self-care investigation in this population. This study also revealed significant gaps in self-care research for trainees, including narrow definitions of self-care along with inadequate measurement, highlighting the need for the development of more validated self-care tools.

The Present Study

Emerging evidence has supported the importance of self-care in maintaining professionals' functioning (e.g., Barnett et al., 2007; Wise et al., 2012), although this line of empirical research is still limited. To our best knowledge, no systematic review has been conducted on the instruments designed to assess self-care in the professional population. Such instruments are important in health care practice because they allow more quality empirical research on self-care in professionals and subsequently help professionals pay close attention to issues of personal health and well-being to prevent burnout, to avoid ethical violations, and to facilitate optimal professional functioning (Fouad et al., 2009). Therefore, the primary aim of the present study is to systematically review the self-care measures designed for or applied in professional settings by summarizing the key parameters of the measurement, synthesizing the themes and trends in professional self-care research, and suggesting gaps in research and future directions.

Method

Search Strategy

The protocol for this review complies with the latest Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Moher, Liberati, Tetzlaff, Altman, & the PRISMA Group 2009). The search terms were generated from assessing searches and were kept broad to capture all potentially relevant studies. Four search terms focused on the measurement of the construct self-care. The following terms were used: self-care AND scale; self-care AND measurement; self-care AND instrument. The last searches were conducted in August 2019, using the following electronic bibliographic databases: PsycINFO, CINAHL, and PubMed. Databases were searched within the title, abstract, and keyword fields. Manual searches of the reference lists of relevant papers were conducted for additional papers.

Eligibility Criteria

Besides using the search terms above, the inclusion criteria for the search are: published between the years of 1988 and 2019, adult samples aged 18 years and older, and scales assessing adults in professional settings. The search was limited to empirical articles published in English in peer-reviewed journals and conference proceedings. The exclusion criteria are: samples below the age of 18 years, scales focusing on self-care among patient populations (i.e., chronic illnesses), and scales that did not have a clear focus on self-care (e.g., self-management and self-efficacy). Books or book chapters, dissertations or master's theses, and newsletters were excluded. Titles and abstracts were examined to identify relevant studies for inclusion in the review, and full articles were retrieved for the identified studies and assessed for inclusion.

Search Outcomes

Records retrieved from the literature search were saved, and duplicate records were eliminated. The resulting measures were screened via titles, abstracts, and keywords against the eligibility criteria. After obtaining the measures, two researchers independently reviewed the contents of the scales and met to discuss the final number of scales to include. The literature search identified 7,983 records, of which 29 were duplicates. Initial screening excluded 7,910 records based on the exclusionary criteria. The remaining 44 full-text articles were examined for each inclusionary eligibility criterion. Thirty-six articles were then excluded, and a total of eight articles met all the inclusion criteria. In total, 10 instruments were identified in the eight included articles. The flow diagram in Figure 1 shows the search process.

Quality Appraisal

The methodological quality of the studies was assessed using the four-point rating scale, the CONsensus-based Standards for the selection of health status Measurement INSTRUMENTS (COSMIN) checklist, which was developed to determine whether a study of measurement properties of a self-reported instrument would meet methodological-quality standards (Terwee et al., 2012). The measurement properties assessed include: internal consistency, reliability, content validity, structural validity, hypotheses testing, and cross-cultural validity. Although the criterion validity is shown on the COSMIN checklist, because of a lack of gold standards for self-reported self-care instruments, this property was not rated, as recommended by the COSMIN panel; instead, the comparison with another instrument was considered hypothesis testing (Mokkink et al., 2010). Five to 18 items that identify specific quality standards describe each measurement property, and a score (poor, fair, good, excellent) is attributed to each item on the basis of the level of adherence to a specific standard. The overall score for each measurement property was obtained by considering the lowest rating assigned to any item in the checklist. For example, if one item in the checklist related to structural validity is scored poor, the overall methodological quality of the structural validity is rated poor. Two reviewers independently rated the studies. The ratings were compared, and any differences were resolved by discussion. Quality assessment of the included studies and measures are presented in Table 1.

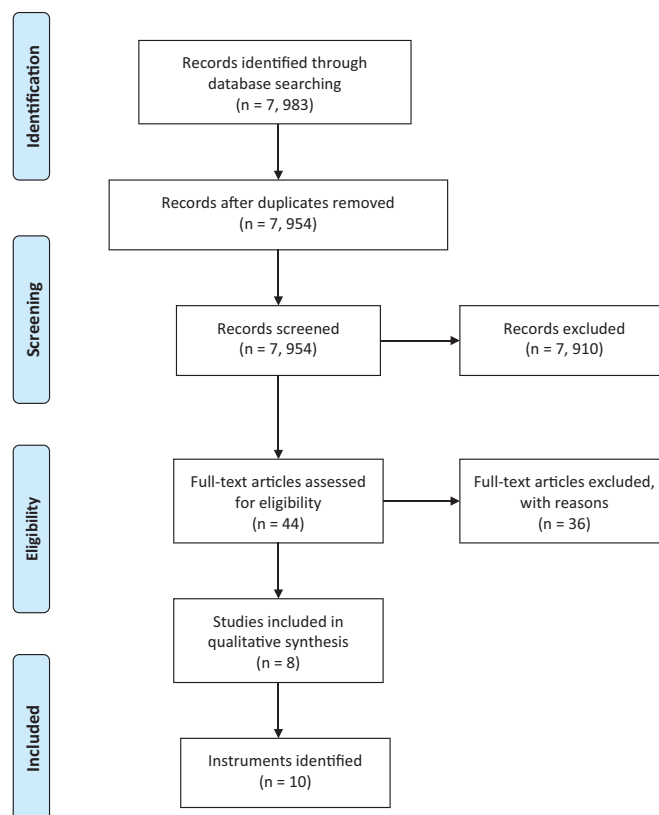


Figure 1. Details of literature search and study selection. See the online article for the color version of this figure.

Data Abstraction

The following information was extracted independently and was reported in a predesign table: instrument's name, first author and publication year, factor structure, number of items, scaling, target population, sample size, sample age ranges, mean and standard deviation, and reliability and validity.

Planned Synthesis of Results

A synthesis of evidence of the measurement properties for each instrument was undertaken based on the number of studies, their methodological quality, and the consistency of the results (Terwee et al., 2012). An instrument was considered supported by (a) strong evidence (positive or negative) when consistent findings were derived by one study of excellent methodological quality or by at least two studies of good methodological quality; (b) moderate evidence (positive or negative) when consistent findings were derived by one study of good methodological quality or by at least two studies of fair methodological quality; (c) limited evidence when findings were derived by one study of fair methodological quality; (d) conflicting evidence when conflicting findings were shown in two or more studies; and (e) unknown evidence when findings were derived only by studies of poor methodological quality.

Results

Eight articles published from 2013 to 2019 were identified to meet all the search criteria (Bloomquist et al., 2015; Cook-Cottone & Guyker, 2017; Dorociak, Rupert, Bryant, & Zahniser, 2017; Goncher, Sherman, Barnett, & Haskins, 2013; Lee, Miller, & Bride, 2016; O'Neill, Slater, & Batt, 2019; Salloum, Kondrat, Johnco, & Olson, 2015; Santana & Fouad, 2017). In total, 10 measures assessing self-care among mental health care professionals were identified within these eight articles, with two articles including two scales in each (Bloomquist et al., 2015; Goncher et al., 2013). All studies were conducted in the United States and focused on self-care practices among mental health service providers, including licensed psychologists, social workers, child welfare employees, hospice professionals, undergraduate and graduate social work students, and clinical and counseling doctoral students. Nine of the 10 measures reported support for acceptable reliability and some support for validity. The scales are described in detail below in alphabetical order based on the first author's last name. The major findings of all reviewed scales are presented in Table 2.

Self-Care Practice Scale and Self-Care Perceptions Scale (Bloomquist et al., 2015)

A self-care practice scale was developed as part of a larger study that assessed self-care and professional quality of life among social

Table 1
Methodological Quality of Each Study per Measurement Property and Instrument

Instrument/reference	Internal consistency	Test-retest reliability	Content validity	Structural validity	Hypothesis testing	Cross-cultural validity	Strengths	Weaknesses
Self-care practice (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015)	Full scale: good; subscales: fair	—	Fair	Poor	Fair	—	Have selected items based on extant literature. Measure five domains of self-care practices and cover a wide variety of self-care activities.	Evidence to support its validity is inadequate. A more thorough evaluation is needed.
Self-care perceptions (Bloomquist, et al., 2015)	Fair	—	Fair	Poor	Fair	—	Attend to the perception of self-care, which is overlooked in many other scales. Also include items measuring perceived support to self-care at systems level (e.g., training program, employer, family, community). Incorporate the concept of mindfulness into self-care. Have final items selected based on a thorough scale development and initial validation process. Scale is developed for general population but also can be applied to health care professionals.	Evidence to support its validity is inadequate. A more thorough evaluation is needed.
MSCS (Cook-Cottone & Guyker, 2017)	Full scale: good; subscales: fair to good	—	Good	Fair	Good	—	Measure various dimensions of self-care behaviors under both personal and professional self-care domains. Have final items selected based on wide self-care literature and a thorough scale development and initial validation process.	The fit between the theoretical model (i.e., positive embodiment) and empirical data is not tested. Initial validity evidence is acceptable but more support, to its structural and criterion validity is needed.
PSCS (Dorociak, Rupert, Bryant, & Zahniser, 2017)	Good	—	Excellent	Excellent	Excellent	—	Measure is specifically designed for assessing and improving self-care in psychology training. Adequately measure trainees' perception of self-care emphasis within training programs. Items reflect both individual self-care practices and specific self-care structure or activities at the program level.	Initial validity evidence to is good, but further evidence for its generalizability across time and populations (e.g., other than licensed psychologists) is needed.
PSEQ (Goncher, Sherman, Barnett, & Haskins, 2013)	Good	—	Fair	Good	Good	—	Measure is specifically designed for assessing and improving self-care in psychology training. Adequately measure trainees' perception of self-care emphasis within training programs. Items reflect both individual self-care practices and specific self-care structure or activities at the program level.	Initial validity evidence is acceptable, although further support to its content validity and generalizability (e.g., outside clinical psychology) is needed.
SCUQ (Goncher et al., 2013)	Good	—	Fair	Good	Good	—	Have final items selected based on extant literature on self-care behaviors and career-sustaining behaviors. Contribute to the lack of literature on measuring self-care utilization in trainees.	Initial validity evidence is acceptable, although further support to its content validity and generalizability (e.g., outside clinical psychology) is needed.

(table continues)

Table 1 (continued)

Instrument/reference	Internal consistency	Test-retest reliability	Content validity	Structural validity	Hypothesis testing	Cross-cultural validity	Strengths	Weaknesses
SCPS (Lee et al., 2016)	Full scale: good; subscales: good	—	Fair	Good	Fair	—	Assess both personal and professional self-care practices. Have final items selected based on wide self-care literature and spanning studies including the concepts of wellness, resilience, and coping. Is designed for a wider range of mental health service providers (e.g., social workers, counselors, psychologists, and psychiatrists).	The validation process was not thorough. Further support to its validity and generalizability (e.g. outside social workers) is needed.
Self-care planning and participation (O'Neill, Slater, & Batt, 2019)	—	—	Fair	—	—	—	Emphasize both self-care planning and practices. Short (only seven items).	The foundation of item selection is not clear. Scale utilizes only dichotomous items. Validity evidence is lacking.
TISC (Salloum, Kondrat, Johnco, & Olson, 2015)/TISC-R (Salloum, Choi, & Stover, 2018)	Good/—	—	Good/ good	Good/—	Good/good	—	With a trauma-focused emphasis so is especially helpful for professional working with traumatized clients. Measure both personal self-care practices and support for self-care at the organizational levels.	The construct, trauma informed self-care, is newly created and the measure for this construct needs more validation.
SCBI (Santana & Fouad, 2017)	Good	—	Excellent	Good	Excellent	—	Have final items selected based on an existing tool for clinicians and a thorough validation procedure. Scale is designed for trainees but also can apply to professionals.	The specificity in the training context is low. Further support to its generalizability (e.g. outside clinical and counseling psychology doctoral students) is needed.

Note. MSCS = Mindful Self-Care Scale; PSCS = Professional Self-Care Scale; PSEQ = Perceived Self-Care Emphasis Questionnaire; SCUQ = Self-Care Utilization Questionnaire; SCPS = Self-Care Practices Scale; SCBI = Self-Care Behavior Inventory; TISC = Trauma-Informed Self-Care. — denotes not reported.

Table 2
The Main Characteristics of Self-Care Instruments for Professionals

Instrument (author, year)	Factors	Number of items	Scaling	Intended use in target population	Sample size/participants	Age— <i>M</i> (<i>SD</i>) [age range]	Reliability	Validity evidence/key procedure
Self-care practice (Bloomquist, et al., 2015)	1. Physical 2. Professional 3. Emotional 4. Psychological 5. Spiritual	45	6-point scale	Measure self-care practices in social workers.	786 social workers	41.52 (12.59) [Not reported]	Full scale $\alpha = .90$	Not reported
Self-care perceptions (Bloomquist, et al., 2015)	1. Appreciation 2. Value 3. Awareness	11	5-point scale	Measure self-care perceptions in social workers.	786 social workers	41.52 (12.59) [Not reported]	Full scale $\alpha = .76$	Not reported
MSCS (Cook-Cottone & Guyker, 2017; Horchkiss & Cook-Cottone, 2019)	1. Physical care 2. Supportive relationships 3. Mindful awareness 4. Self-compassion and purpose 5. Mindful relaxation 6. Supportive structure	33 (Cook-Cottone & Guyker, 2017)	5-point scale	Measure a set of actionable practices that promote positive embodiment and well-being in general population	448 nonclinical, primarily White adults from community	33.5 (11.7) [18–71]	Full scale $\alpha = .89$	Initial evidence for construct and divergent validity/ participant and expert review, exploratory factor analysis, confirmatory factor analysis, correlations with related measures
		24 (Horchkiss & Cook-Cottone, 2019)	5-point scale	Measure self care in hospice workers and also further validate MSCS among sample of health care professionals	858 hospice workers	54.2 (9.64) [not reported]	Subscale $\alpha s = .74-.86$	Initial evidence for concurrent, construct, and structural validity/ confirmatory factor analysis, correlations with related measures
PSCS (Dorociak, et al., 2017)	1. Professional support 2. Professional development 3. Life balance 4. Cognitive awareness 5. Daily balance	21	Not Available	Allow psychologists and other professionals to assess self-care and promote well-being in and outside work setting	374 psychologists	51.55 (not reported) [Not reported]	Subscale $\alpha s = .70-.83$	Initial evidence for concurrent and content validity/expert review, exploratory factor analysis, confirmatory factor analysis, correlations with related measures
PSEQ (Concher et al., 2013)	1. Balancing professional and personal lives 2. Seeking guidance and supervision	30	5-point scale	Measure self-care emphasis in clinical psychology graduate trainees' training experience	262 clinical psychology graduate trainees	28.30 (5.10) [21–57]	Full scale $\alpha = .947$	Initial evidence is reportedly found but no specifics is reported/principal component analysis
SCUQ (Goncher et al., 2013)	1. Positive coping 2. Personal fulfillment	30	5-point scale	Measure self-care utilization in clinical psychology graduate trainees' training experience	262 clinical psychology graduate trainees	28.30 (5.10) [21–57]	Full scale $\alpha = .89$	Initial evidence is reportedly found but no specifics is reported/principal component analysis
SCPS (Lee et al., 2016)	1. Personal self-care 2. Professional self-care	18	5-point scale	Assess frequency of personal and professional self-care practices for mental health service providers	129 undergraduate and graduate social work students and then 492 master's-level social workers	Not reported (not reported) [Not reported]	Full scale $\alpha = .932$	Initial evidence for factorial validity/confirmatory factor analysis

(table continues)

Table 2 (continued)

Instrument (author, year)	Factors	Number of items	Scaling	Intended use in target population	Sample size/participants	Age—M (SD) [age range]	Reliability	Validity evidence/key procedure
Self-care planning and preparation (O'Neill et al., 2019)	Not reported	7	Dichotomous scaling	Measure self-care practices in social workers	90 undergraduate and graduate social work students	29 (9.24) [20–55]	Not reported	Initial evidence for construct validity/procedure not reported
TTISC (Salloum et al., 2015)	1. Organizational practices 2. Utilizing organizational supports and resources 3. Personal self-care practices	14	5-point scale	Assess child welfare workers' trauma-focused self-care practices	104 child welfare workers	Not reported (not reported) [25–60]	Full scale $\alpha = .82$	Initial evidence for factorial validity/exploratory factor analysis, correlations with related measures
TTISC-revised (Salloum, et al., 2018)	1. Organizational practices 2. Utilizing organizational supports and resources 3. Personal self-care practices	10	5-point scale	Provide additional validation of TTISC for measurement of trauma-informed self-care practices among child welfare works	184 Child welfare workers	Not reported (not reported) [20 – 65 or older]	Full scale $\alpha = .84$	Further evidence for factorial, discriminant, and criterion validity/exploratory factor analysis, confirmatory factor analysis, correlations with related measures
SCBI (Santana & Fouad, 2017)	1. Cognitive-emotional-relational 2. Physical 3. Spiritual	19	Not available	Measure self-care practices among health care professionals in training	232 Clinical psychology and counseling doctoral students	28 (not reported) [Not reported]	$r = .83$	Initial evidence for construct, convergent, and discriminant validity/exploratory factor analysis, correlations with related measures

Note. MSCS = Mindful Self-Care Scale; PSCS = Professional Self-Care Scale; PSEQ = Perceived Self-Care Emphasis Questionnaire; SCUQ = Self-Care Utilization Questionnaire; SCPS = Self-Care Practices Scale; SCBI = Self-Care Behavior Inventory; TTISC = Trauma-Informed Self-Care.

workers ($N = 786$, $\text{Mean}_{\text{Age}} = 41$; Bloomquist et al., 2015). The measure consists of five domains of self-care practice—physical, professional, emotional, psychological, and spiritual. Each domain includes between eight and 12 self-care activities associated with well-being. This scale requires respondents to indicate the frequency of engagement in 45 different self-care activities during the past 30 days. Responses were rated on a 6-point scale. A summary score was used to indicate each self-care practice domain as well as overall self-care practice. Higher scores indicated a greater frequency of engagement. Internal consistency of the whole self-care practice scale was high ($\alpha = .90$) and acceptable for each subscale (α s = .69–.73). Initial evidence for predictive validity was reported, such that psychological self-care predicted less secondary traumatic stress. In addition, professional, emotional, and spiritual self-care practice predicted less burnout, and professional and emotional self-care predicted more compassion satisfaction.

Like the self-care practice scale above, a self-care perceptions scale was developed as part of a larger study to assess social workers' perceptions of the appreciation, value, and/or awareness of self-care (Bloomquist et al., 2015). The scale consists of 11 items answered on a 5-point scale. Four of the items are reversed scored, and higher scores on the scale indicate more positive self-care perceptions. Internal consistency for the total scale was acceptable ($\alpha = .76$). The author reported initial evidence for predictive validity, such that respondents reported less secondary traumatic stress and burnout and more compassion satisfaction when they held more positive perceptions of self-care.

Mindful Self-Care Scale (MSCS; Cook-Cottone et al., 2017)

The MSCS was designed to assess practices of self-care and promote positive well-being (Cook-Cottone et al., 2017). The measure consists of 33 items answered on a 5-point Likert scale. Items focus on six components of self-care: physical care, supportive relationships, mindful awareness, self-compassion and purpose, mindful relaxation, and supportive structure. Psychometric analyses were conducted with a sample of 448 participants from general population ($\text{Mean}_{\text{Age}} = 33.5$). Results provide support for the reliability ($\alpha = .89$) and construct and divergent validity of the scale via comparisons with body esteem and eating disorder symptomatology. However, further research of the original scale was needed to provide further support for the structure of the scale in more diverse samples.

Hotchkiss and Cook-Cottone (2019) provided further validation of the MSCS among hospice and health care professionals ($N = 858$, $\text{Mean}_{\text{Age}} = 54.2$). In this sample, the researchers shortened the MSCS to create a 24-item Brief MSCS via a confirmatory factor analysis. Cronbach's alpha was computed to assess the internal consistency for the MSCS and Brief MSCS, respectively, which yielded very similar results ranging from .74 to .86 across all the subscales. Construct and concurrent validity of the scales were assessed through correlations of the subscales to the MSCS total and other well-being measures, including life satisfaction and quality of life (Hotchkiss et al., 2019).

Professional Self-Care Scale (PSCS; Dorociak et al., 2017)

The PSCS was developed in response to the lack of psychometrically sound measures of self-care among professionals (Dorociak et al., 2017). The scale consists of 21 items that assess five self-care components: professional support, professional development, life balance, cognitive awareness, and daily balance. Psychometric evaluation was conducted with a sample of 374 psychologists ($\text{Mean}_{\text{Age}} = 54.2$). Content validity was supported by significant correlations in the expected direction for each PSCS subscale and validity measures that measured perceived stress, life satisfaction, and burnout, respectively. The authors also provided good support for the factorial structure and concurrent validity of the scale. In addition, Cronbach's alphas were in the range of .70–.83 for all the subscales (Dorociak et al., 2017). The reliability of the scale was further supported in Zahniser, Rupert, and Dorociak's (2017) adaptation of the scale for clinical psychology doctoral students. In their study, Cronbach's alphas for subscales were adequate (α s ranging from .70 to .80) with the exception of cognitive awareness ($\alpha = .65$). Furthermore, their results supported the structural validity of the five-factor model of the scale (Zahniser et al., 2017).

Perceived Self-Care Emphasis Questionnaire and Self-Care Utilization Questionnaire (PSEQ and SCUQ; Goncher et al., 2013)

The PSEQ is a 30-item questionnaire developed as part of a larger study of well-being among graduate students to assess the level of perceived self-care emphasis within clinical psychology programs (Goncher et al., 2013). The sample was 262 clinical psychology graduate trainees ($\text{Mean}_{\text{Age}} = 28$). Item responses were on a 5-point Likert scale, and higher scores on the questionnaire indicated increased perceived emphasis on self-care in the particular clinical program. Analysis for content validity was not reported. The questionnaire included items that focused on two components: balancing professional and personal lives and seeking guidance and supervision. Psychometric analyses revealed that the internal consistency of the questionnaire was good ($\alpha = .95$). Support for any validity evidence was not reported.

The SCUQ was developed as part of a larger study assessing the well-being of graduate students (same as the PSEQ above). Its aim was to measure the self-care modalities by students pursuing a doctoral degree in clinical psychology (Goncher et al., 2013). The measure consisted of 30 questions answered using a 5-point Likert scale. Higher scores on the scale indicated increased use of self-care strategies by graduate students. Items on the questionnaire focused on positive coping and personal fulfillment. Psychometric analyses revealed that the questionnaire has good internal consistency ($\alpha = .89$). Support for validity evidence was not reported.

Self-Care Practices Scale (SCPS; Lee et al., 2016)

The SCPS was designed to assess the frequency of personal and professional self-care practices for mental health service providers, including social workers, psychotherapists, counselors, psychologists, and psychiatrists (Lee et al., 2016). The scale consists of two domains—personal self-care and professional self-care—with nine

items for each scale, totaling 18 items. Items are answered using a 5-point scale, with higher scores indicating more frequency related to engaging in self-care practices. Results from a previous 71-item version of the scale provide support for a reliable measure (total scale: $\alpha = .93$; personal self-care: $\alpha = .87$; professional self-care: $\alpha = .91$). Further support for the internal consistency of the 18-item scale is reported in Miller, Donohue-Dioh, Niu, & Shalash's (2018) study of self-care practices among child welfare workers. For their study, measures for personal ($\alpha = .81$) and professional ($\alpha = .77$) care displayed high internal consistency. However, validity evidence of the final scale was not found.

Self-Care Planning and Participation (O'Neill et al., 2019)

O'Neill et al. (2019) developed seven dichotomous questions about self-care planning and participation as part of a larger study to assess the relation between self-care and academic stress among undergraduate and graduate social work students. The sample consisted of 90 students ($\text{Mean}_{\text{Age}} = 29$). Whereas the study is not a validation study, results provided initial support for the validity of the self-care questions as practicing self-care daily reduced academic stress in the sample. The reliability of the items was not reported.

Trauma-Informed Self-Care Scale–Original (TISC; Salloum et al., 2015) and Revised (Salloum, Choi, & Stover, 2018)

A trauma-informed self-care scale was developed for child welfare workers (Salloum et al., 2015). The measure originally consisted of 12 items answered on a 5-point scale. The items focus on three subscales: standard organizational practices, resources and supports for workers, and personal self-care practices. Internal reliability was good for the total scale ($\alpha = .82$) and all subscales ($\alpha = .73-.79$). Although initial support for the factor structure was reported (Salloum et al., 2015), Salloum et al. (2018) revised and further validated the scale. The revised scale consists of a 10-item measure with the same factors as the original version. Analysis reveal acceptable to good internal consistency for the total scale ($\alpha = .84$) and subscales ($\alpha = .75-.88$) except one subscale (organizational practices, $\alpha = .68$). Adequate support for structural validity via exploratory and confirmatory factor analyses was reported. Discriminant validity was examined based on the correlations among the three factors, which were less than 0.85, suggesting the constructs measured by different subscales were discriminant. Criterion validity was supported through significant correlations between the TISC and other measures, including psychological health, burnout, secondary trauma, and compassion satisfaction.

Self-Care Behavior Inventory (SCBI; Santana et al., 2017)

The SCBI was developed to measure self-care practices of psychology doctoral students (Santana et al., 2017). The measure consists of a total of 19 items and assesses three aspects of self-care: cognitive-emotional-relational, physical, and spiritual. A psychometric evaluation was conducted in a sample of 232 stu-

dents enrolled in clinical and counseling doctoral programs ($\text{Mean}_{\text{Age}} = 28$). Analysis for content validity was not reported. Results revealed that the instrument is reliable ($r = .83$) and established preliminary convergent and divergent validity for the instrument. Convergent and divergent validity were assessed through the correlations between the SCBI and criterion measures, which yielded small but significant correlations with burnout ($r = -.13$ to $.25$) and self-perceived competence ($r = -.12$), and two trivial and nonsignificant correlations with well-being ($r = .02$) and distress ($r = .08$). Continued research to further improve the structure of the scale is needed (Santana et al., 2017).

Discussion

Since the late 20th century, the necessity of self-care for caregivers has become increasingly clear, especially professionals in mental health service fields. Overall, only a handful of professional self-care measurements have been developed, and further validations of the measures or empirical investigations based on these measures have been sparse. To promote self-care for professionals in both research and practice, it is crucial to have proper measurement tools to assess self-care. This systematic review identified 10 instruments assessing self-care practices among mental health care professionals.

Current Stage of Self-Care Measurement Development

All of the scales reviewed have been developed within the past decade. Two measures have two validation studies (including both an original version and a revised version of the scale), MSCS (Cook-Cottone et al., 2017) and Brief MSCS (Hotchkiss et al., 2019), TISC (Salloum et al., 2015) and TISC-Revised (Salloum, et al., 2018); all other measures have only one peer-reviewed study reporting the development and initial validation for each, which suggests that measurement development in the field of professional self-care is still in its infancy. The target populations in these measurement studies were professionals or trainees in mental health-related fields, and the actual samples included social workers, child welfare workers, practicing psychologists, hospice professionals, and undergraduate and graduate trainees. Within these studies, three measures were designed specifically for psychology graduate trainees (PSEQ and SCUQ, Goncher et al., 2013; and SCBI, Santana et al., 2017), suggesting that self-care among graduate students has gained attention from as an important issue to address to better prepare future psychologists.

Psychometric Properties of the Self-Care Measurements

Five of the scales were found as part of hypothesis testing studies and do not have solid measurement development or validation studies. Although foundational literature anchored the development of these measures, there are missing steps in confirming content validity (self-care practice and self-care perceptions, Bloomquist et al., 2015; PSEQ and SCUQ, Goncher et al., 2013; SCPS, Lee et al., 2016). Among the rest of the scales, one reported some format of expert review to modify the content of the scale (Salloum et al., 2018) and two others (PSCS, Dorociak et al., 2017; SCBI, Santana et al., 2017) had adequate procedures to generate

the items, obtain expert feedback, and modify the content, all of which secured high content validity. In most studies, the structural validity was evaluated through an exploratory factorial analysis (EFA) or both an exploratory factorial analysis and confirmatory factor analysis (PSCS, Dorociak et al., 2017), but the measures reported by Bloomquist et al. (2015) and O'Neill et al. (2019) did not have any structural validity analysis. The criterion validity was reported for half of the measures through correlational analysis or hypothesis testing, although only concurrent or predictive validity was assessed. All the measures reported acceptable to good internal consistency, but none of the studies reported other types of reliabilities (e.g., test-retest). We could not find any study testing the cross-cultural validity (e.g., multigroup invariance) of the instruments, which was not surprising, given the early stage of self-care research. Overall, more support for content, structural, criterion, and cross-cultural validity of the self-care measures is needed.

The Conceptualization of Self-Care and Its Corresponding Measurement

The conceptualization of self-care for professionals in the reviewed scales is heavily influenced by literature that indicate what behaviors contribute to reduced stress and enhance wellness. To date, there is a lack of specific theoretical basis that guides the development of self-care measurement, such as its structure and the selection of components within self-care. Personal care, especially the balance between work and personal well-being, appeared to be a central theme in most scales. Professional support and development were apparent in some scales. Several themes emerged from the review of these scales, as discussed below.

First, self-care has been conceptualized as an overarching construct with broad domains following unclear and inconsistent categorization rules. For example, in Bloomquist et al.'s (2015) study, the scale was based on the areas that self-care practice focuses on, or what self-care is for, including physical, professional, emotional, psychological, and spiritual self-care, suggested by earlier research (Saakvitne, Pearlman, & Abrahamson, 1996). Without evidence for content and structural validity, however, it was not convincing how these domains, such as emotional, psychological, and spiritual self-care, distinguish from each other. Derived from the same foundational literature (Saakvitne et al., 1996), Santana et al.'s (2017) scale has a three-factor structure supported by factor analysis, suggesting three domains of self-care: cognitive-emotional-relational, physical, and spiritual, which are at the same conceptual level. In contrast, other scales centered around the broad categories of self-care behaviors, or what people do. However, the initial items selected by the researchers, the factor analysis results, and the final factors varied greatly (e.g., balancing professional and personal lives, and seeking guidance and supervision, in PSEQ, Goncher et al., 2013; professional support, professional development, life balance, cognitive awareness, and daily balance, in PSCS, Dorociak et al., 2017).

Second, self-care practices for professionals can be differentiated, depending on the focus on professional self or personal self, although boundaries are not always clear. In the scale designed for social workers (SCPS), Lee et al. (2016) separated the items into two subscales, one for personal self-care and the other for professional self-care. In this case, professional behaviors and personal

behaviors are separated by in which the behaviors occur (workplace vs. outside workplace), not what the behaviors are for (e.g., for personal or professional self). This structure has a clear distinction and is supported by factor analysis. In another scale developed for psychologists, Dorociak et al. (2017) accepted a five-factor structure model, and within these factors, two clearly indicated professional self-care, including professional support and professional development; and three others indicated self-care behaviors applied to both professional and personal contexts, including life balance, cognitive strategies, and daily balance. One scale for graduate trainees (SCUQ, Goncher et al., 2013) has two dimensions, positive coping and personal fulfillment, which includes self-care behaviors applied across personal and training-related contexts. These variations in the use of professional and personal self-care echoed the points made in the literature review that the boundary between these two realms can be fuzzy (Pipes et al., 2005), and taking care of both the personal and professional self should go hand in hand for health service professionals.

Third, self-care efforts can be generated not only at the individual level but also at the program or organization levels. Although most of the scales aim only to capture individual self-care behaviors, a few researchers paid attention to the necessity of involving systems-level support for professional self-care. Specifically, Goncher et al. (2013) designed a scale (PSEQ) to measure how clinical psychology trainees perceived the self-care emphasis in their training programs. For example: "My program and/or institution emphasizes the importance of self-care in my graduate training in clinical psychology." The two-factor structure of the scale suggested that two important domains of self-care messages delivered by the training programs and perceived by the trainees are: balancing professional and personal lives and seeking guidance and supervision. Similarly, Bloomquist et al.'s (2015) Self-Care Perceptions Scale (2015) incorporated perceptions of support for self-care in social workers' social network (e.g., family, community) and training or work settings (e.g., employer, training program) along with personal value of self-care. Another scale aimed to address the importance of self-care in child welfare workers (TISC, Salloum et al., 2015; TISC-Revised, 2018), and it placed a heavier emphasis on support for self-care at the systems level. Specifically, in addition to personal self-care practices, it measures two other domains, including organizational practices and utilizing organizational supports and resources. The approaches taken by these researchers are inspiring because it suggested how an ecological perspective can be integrated into self-care conceptualization and measurement. This is especially relevant to how training programs can prepare trainees to develop self-care that may benefit them not only during training but also in their future careers. This view also can be helpful for building or strengthening systems support for both novice and experienced psychologists, especially those who have practiced years in the field but likely have less accessibility to structural support as those still in training.

Fourth, the overall findings from the validity analyses supported the positive role of self-care in professionals or trainees' functioning and well-being, although the evidence is preliminary. Some studies reported only how overall self-care correlated with validity measures. For instance, the total score of the PSEQ, which was designed for graduate trainees was found to be a positive, strong predictor of quality of life (Goncher et al., 2013). The validity

analyses of another scale for graduate trainees, the SCBI (Santana et al., 2017) revealed that overall self-care negatively correlated with burnout measures and positively correlated with self-perceived competence but did not significantly correlate with well-being measures (i.e., distress, positive feelings). In one study using the TISC for social workers, Salloum et al. (2015) found that the total score of self-care was associated with higher levels of compassion satisfaction, lower levels of burnout, and less secondary trauma. In comparison, a few studies reported how domains of self-care correlated with validity measures. For example, using the PSCS, a scale for psychologists, Dorociak et al. (2017) reported that all five self-care factor scores had significant correlations with burnout, perceived stress, and life satisfaction in the expected direction. Among the factors, strategies with a focus on personal self-care (measured by life balance, cognitive awareness, and daily balance) had stronger correlations with all validity measures compared with professional self-care strategies (measured by professional support, and professional development). In a sequel study using the revised TISC, Salloum et al. (2018) reported that each factor correlated with the validity measures differently, with personal self-care practices being associated with all three professional function indicators, including lower levels of burnout, lower levels of secondary trauma, and higher levels of compassion satisfaction, and two organizational factors correlated only one of two of the same indicators (decreased burnout and/or increased compassion satisfaction).

Because of the diverse conceptualization of self-care as well as the varying structure of the self-care scales, it is difficult to compare the results across studies. At this time, the evidence appears to be more consistent in showing the positive association between self-care and professional functioning (e.g., reduced burnout, increased perceived competence) and less consistent in terms of how self-care associates with enhanced well-being (e.g., perceived stress, positive feelings). These findings in general are aligned with the conclusions made in Colman et al.'s (2016) meta-analysis study, which supported the overall benefits of self-care practice, and the differential effect size of the relations between self-care and outcomes depended on the type of outcome. More specifically, Colman et al. (2016) found the strongest association between self-care and the areas of gains (e.g., self-compassion), followed by well-being measures (e.g., decreased psychological distress, and life satisfaction), and had a significantly smaller association with ratings of stress. In addition, Colman et al. (2016) found that such associations did not differ across the type of self-care. The studies in our review measured a wider range of self-care types, but because of the great heterogeneity within the limited evidence, it is premature to conclude which types of self-care contribute more to professional or training outcomes. Clearly, more research is needed to investigate what self-care contains and how it works.

Strengths, Limitations, and Future Directions

To the best of our knowledge, this is the first systematic examination of how self-care is defined and measured for professional populations. The strengths of the study include providing a comprehensive review of the self-care concept from a mental health care providers' perspective, following a systematic review guideline (i.e., COSMIN checklist) to ensure the appropriateness and

comprehensiveness of the search and the evaluation of the search results, applying a multidisciplinary approach and using three major databases to yield optimal results. Despite these strengths, the limitations should also be noted. Although three main electronic databases were searched, papers published in other databases might have been overlooked. Also, only articles published in English were selected; therefore, instruments developed and evaluated in other languages and cultures might have been missed.

Several of these measures from well-designed studies are efficient tools to continue research in this area, especially when the target population and the social-cultural context are the same. However, more validation and continuous development of self-care measures are needed to capture the breadth and the variations of this complicated construct. We recommend further research be conducted on existing self-care measures to validate their use across different subgroups (e.g., professions, types of programs) or across different career stages (e.g., trainee, early, middle, and late career). This will help further solidify self-care as a construct worthy of measurement and focus by professional communities.

Furthermore, we suggest researchers think broadly about the definition and scope of self-care to assess the efficacy of self-care before narrowing the self-care concept to individual behaviors. For example, it is possible that the key factors to determine how self-care works are not specific behaviors, which likely associate with widespread individual differences and are heavily influenced by social-cultural contexts. Rather, the factors that tend to be universal and determine the efficacy of self-care on a deeper level may be the core determinants. For example, we speculate that the awareness of self-care importance and perceived effectiveness of self-care (according to one's own standards) may be better predictors of the efficacy of self-care. We concurred with the suggestion made in Colman et al. (2016, p. 195) that "future studies are needed that allow students to tailor their self-care practices to their individual likes and needs, rather than simply testing a standard self-care protocol." Beyond the behavioral factors at the individual level, we encourage researchers to consider the cognitive-motivational factors that typically precede behaviors and social-cultural/systems-level factors when conceptualizing and assessing self-care. This research area is atheoretical to this date, but more conceptual and empirical work should pave the way to formulate a theory of professional self-care, which will further guide future research.

Conclusion and Training Implications

Defining and operationalizing self-care through the creation of a measurement instrument represents a critical step in advancing research aimed at understanding and promoting effective self-care for professionals. For this reason, we conducted this systematic review to identify the most valid and reliable self-care instrument(s) that health service professionals can use in research and clinical practice. Several scales had adequate measurement properties evidenced by high-quality studies; we recommend them for future use, especially for psychologists and psychology trainees. Taken together, the scales identified in the current systematic review provide a picture of current tools to promote self-care research and practice in professional settings. Professional self-care research is in its infancy, and continuous development of

professional self-care at both conceptual and empirical levels are needed.

The practical significance of this review is derived from technical information (e.g., measurement properties) that can be used in professional practice. Because some scholars proposed that the ongoing use of self-care and self-awareness of one's professional and personal functioning should be incorporated into the training and the assessment of competence in professional psychology (e.g., Boellinghaus et al., 2013; Goncher et al., 2013; Zahniser et al., 2017), it is important to know whether developing a culture of self-care as a graduate student does indeed carry over into one's professional career and whether it positively predicts continuing self-care after graduation to maintain lifelong competence and ethical practice. How training programs can facilitate and promote self-care has been summarized elsewhere, and we direct the readers to these references (e.g., Bamonti et al., 2014; Colman et al., 2016). We hope this review increases the awareness of the importance of self-care in training programs and the accessibility of available tools for both research consumers and producers. Training program faculty is in the best position to promote self-care in graduate trainees and conduct applied studies to contribute to this new research area.

Having a reliable and valid self-care measure for these professionals is the first step to analyzing the long-term implications of self-care. We suggest researchers fully utilize the existing measures or information and continue to assess and improve the psychometric properties of these scales. Based on the results of our review, we identified several self-care instruments for psychologists or psychology trainees with moderate to strong evidence for most of the measurement properties. Specifically, if the focus is on self-care behaviors at the individual level, we recommend the use of PSCS (designed for psychologists, Dorociak et al., 2017) and SCBI (designed for graduate trainees, Santana et al., 2017). If systems-level factors are considered, suggested measures include the PSEQ (designed for graduate trainees, Goncher et al., 2013) and TISC-Revised (designed for child welfare workers, Salloum et al., 2018). Researchers should keep in mind that further evidence to support the use of these scales is needed. We also recommend the inclusion of a variety of validity measures (e.g., competence, professional functioning, and well-being) in assessment. Moreover, training program faculty may consider tracking self-care development and its relations to professional outcomes longitudinally, both within the course of training and beyond. The professional organization may also consider incorporating self-care assessment into continuous education or professional development programs for independent and experienced professionals.

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