Research

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Development and Validation of a New Self-Care Scale: Self-Care Assessment for Employees (SAFE)

Çalışanlar İçin Öz-Bakım Değerlendirme Ölçeğinin (SAFE) Geliştirilmesi ve Geçerlik-Güvenirlik Çalışması

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ABSTRACT

Objective: This study aimed to develop and psychometrically validate the Self-Care Assessment for Employees (SAFE), a multidimensional instrument assessing physical, psychosocial, occupational, and mental self-care.

Method: A total of 979 healthcare professionals completed an online survey. After excluding 11 responses due to random response patterns, 968 participants were included in the analyses and randomly divided into two subsamples for exploratory factor analysis (EFA; n =484) and confirmatory factor analysis (CFA; n =484).

Results: The Kaiser–Meyer–Olkin value was .927, and Bartlett's test of sphericity was significant, indicating sampling adequacy. EFA revealed a four-factor structure explaining 51.52% of the total variance. During CFA, one item with a standardized loading below .40 was removed, resulting in a final 23-item scale. The four-factor model demonstrated acceptable fit (χ^2/df = 2.86, CFI = .918, TLI = .906, RMSEA = .062). Standardized factor loadings ranged from .51 to .79. Composite reliability values exceeded .70 for all factors, and convergent and discriminant validity were generally supported.

Conclusion: The SAFE demonstrated satisfactory psychometric properties and provides a comprehensive framework for assessing multidimensional self-care and motivational readiness among employees.

Keywords: Self-care, scale development, employees, mental health, occupational health, public health

ÖZ

Amaç: Bu çalışma, fiziksel, psikososyal, mesleki ve zihinsel öz bakımı değerlendiren çok boyutlu bir araç olan Çalışanlar için Öz Bakım Değerlendirmesi'ni (SAFE) geliştirmeyi ve psikometrik olarak doğrulamayı amaçlamıştır.

Yöntem: Toplam 979 sağlık uzmanı çevrimiçi bir anketi tamamladı. Rastgele yanıt kalıpları nedeniyle 11 yanıt hariç tutulduktan sonra, 968 katılımcı analizlere dahil edildi ve açıklayıcı faktör analizi (EFA; n = 484) ve doğrulayıcı faktör analizi (CFA; n = 484) için rastgele iki alt örneğe ayrıldı. Bu yönde değerlendirmeler yapıldı.

Bulgular: Kaiser-Meyer-Olkin değeri .927 idi ve Bartlett'in küresellik testi anlamlıydı, bu da örnekleme yeterliliğini göstermiştir. EFA, toplam varyansın %51,52'sini açıklayan dört faktörlü bir yapı ortaya çıkardı. CFA sırasında, standartlaştırılmış yüklemesi ,40'ın altında olan bir öğe kaldırıldı ve bu da son 23 maddelik bir ölçekle sonuçlandı. Dört faktörlü model kabul edilebilir bir uyum gösterdi (χ^2/df=2,86, CFI=,918, TLI=,906, RMSEA=,062). Standartlaştırılmış faktör yüklemeleri ,51 ile ,79 arasında değişmektedir. Bileşik güvenilirlik değerleri tüm faktörler için .-,70'i aştı ve yakınsak ve ayırt edici geçerlilik genel olarak desteklendi.

Sonuç: SAFE tatmin edici psikometrik özellikler göstermişir ve çalışanlar arasında çok boyutlu öz bakım ve motivasyonel hazırlığı değerlendirmek için kapsamlı bir çerçeve sağlamaktadır.

Anahtar sözcükler: Öz bakım, ölçek geliştirme, çalışanlar, ruh sağlığı, iş sağlığı, halk sağlığı

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Introduction

The term self-care was first introduced into the National Library of Medicine's Medical Subject Headings (MeSH) in 1981 and referred to an individual's deliberate efforts to maintain, protect, and improve personal well-being (Riegel et al. 2021). Although the concept gained particular attention in the late twentieth century, especially with the rise of chronic and lifestyle-related diseases, practices aimed at preserving health have existed throughout human history (Martínez et al. 2021).

Self-care provides a foundation for coping with daily stressors and achieving long-term health goals (Levin and Idler 1983). It is commonly described as encompassing four primary domains: physical, psychological, social, and occupational well-being. Physical self-care includes behaviors such as regular exercise, balanced nutrition, and adequate sleep. Psychological self-care involves stress management, emotional regulation, and mindfulness practices. Social self-care refers to building and maintaining supportive relationships and effectively using social support networks. Occupational self-care focuses on work–life balance, job satisfaction, and professional development (Clark et al. 1991, Smith 2017).

The theoretical foundations of self-care are grounded in several conceptual models, most notably Orem's Self-Care Deficit Theory and Riegel's Middle-Range Theory of Self-Care of Chronic Illness. Orem conceptualized self-care as intentional and learned behaviors that individuals perform to sustain life, health, and well-being. When individuals are unable to meet their self-care needs, a "self-care deficit" arises, requiring external support or professional intervention (Orem et al. 1995).

Building on these principles, Riegel described self-care as a dynamic and cyclical process consisting of self-maintenance, self-monitoring, and self-management. Self-maintenance involves engaging in health-promoting behaviors, self-monitoring refers to observing one's condition, and self-management includes responding appropriately to changes in health status (Riegel et al. 2012). These theoretical perspectives emphasize that self-care is not a static behavior but an ongoing and context-dependent process.

The importance of self-care for health and quality of life has been widely documented. Engaging in self-care behaviors contributes to disease prevention, improved emotional well-being, and better management of existing health conditions (Riegel et al. 2012). Empirical evidence indicates that regular physical activity and healthy dietary habits are associated with reduced risk of chronic conditions such as obesity, diabetes, and cardiovascular disease (WHO 2014). Similarly, strong social connections and perceived social support have been linked to lower levels of psychological distress and anxiety (Taylor 2011). At the same time, self-care is shaped by cultural norms, values, and health beliefs. Its meaning, expression, and prioritization may vary across cultural contexts (Gallant et al. 2010). Therefore, cultural sensitivity and contextual relevance should be considered when developing instruments designed to assess self-care behaviors.

Despite the growing interest in self-care research, validated and comprehensive measurement tools remain limited. Many existing instruments were developed for specific clinical populations, such as individuals with chronic illness, or focus on a single domain, such as physical or mental health (Figley 2013). Although the number of publications on self-care has increased substantially over the decades, relatively few instruments have been designed to assess self-care comprehensively within occupational settings (Riegel et al. 2021). This limitation highlights the need for broader and contextually appropriate measurement tools. Employees working in healthcare and social service sectors are often exposed to high levels of occupational stress and emotional demands, which may compromise their ability to engage in consistent self-care practices. For these populations, assessing not only self-care behaviors but also motivational readiness may be particularly important.

Although self-care is increasingly conceptualized as a multidimensional construct, most available instruments do not adequately integrate behavioral practices with motivational aspects of change. In occupational contexts, comprehensive tools that address both dimensions remain scarce. This gap restricts a deeper understanding of how employees initiate, maintain, and sustain self-care behaviors over time. Accordingly, the present study aimed to develop and validate the Self-Care Assessment for Employees (SAFE), a multidimensional instrument designed to assess physical, psychosocial, occupational, and mental aspects of self-care. Drawing on established theoretical frameworks and

motivational models of behavioral change, we hypothesized that SAFE would demonstrate a coherent four-factor structure, satisfactory internal consistency, and acceptable construct validity across exploratory and confirmatory factor analyses. By integrating behavioral and motivational dimensions, this study seeks to contribute a more comprehensive framework for assessing employee self-care.

Method

Sample and Procedure

A total of 979 healthcare professionals completed the online survey. After data screening, 11 responses were excluded due to incomplete questionnaires or response patterns indicating random or inattentive answering. The final sample consisted of 968 participants whose data were included in the analyses.

Data were collected through an online survey administered via the SurveyMonkey platform. Recruitment was conducted exclusively through institutional communication channels. The survey link was distributed via e-mail and professional WhatsApp groups to healthcare professionals who had previously participated in training programs organized by the Department of Mental Health under the General Directorate of Public Health. The study was not advertised on public social media platforms and no paid promotional strategies were used. The invitation message briefly described the purpose of the study, emphasized voluntary participation, and assured confidentiality and anonymity. Participants accessed the online informed consent form before proceeding to the questionnaire. No financial or material incentives were provided. The electronic survey form was pilot tested with a small group of healthcare professionals prior to the main data collection to evaluate clarity, comprehensibility, and technical functionality. Minor wording adjustments were made based on feedback; however, no structural changes were introduced. The survey was configured to ensure appropriate item sequencing and accurate response recording across commonly used devices, including smartphones and desktop computers. All items were set as mandatory to prevent missing data. Responses were securely stored within the SurveyMonkey database and were accessible only to the research team.

To examine construct validity, the sample was randomly divided into two independent subsamples. The first subsample (n = 484) was used for exploratory factor analysis (EFA), and the second subsample (n = 484) was used for confirmatory factor analysis (CFA). The mean age of participants in the EFA group was 34.54 ± 8.35 years, and in the CFA group 35.25 ± 8.42 years; the mean years of education were 16.57 ± 2.96 and 16.60 ± 2.53, respectively. No statistically significant differences were observed between the groups in terms of age or education ($p = .192$ and $p = .853$). Gender distribution was also comparable between the two groups ($p = .379$).

The study was planned and coordinated by the Department of Mental Health within the General Directorate of Public Health. Survey dissemination was conducted through official professional networks to ensure appropriate access to the target population, including family physicians, psychologists, nurses, and social workers. Data collection and monitoring procedures were carried out by the research team, all of whom are mental health professionals trained in research ethics and data protection principles. Ethical approval was obtained from the Scientific Research Evaluation and Ethics Committee of Ankara Etlik City Hospital (AEŞH-BADEK-2024-385; July 10, 2024).

Inclusion criteria were: (1) being 18 years of age or older, (2) currently working as a healthcare professional (family physician, psychologist, nurse, or social worker), (3) having sufficient literacy to complete the survey, and (4) providing voluntary informed consent. Exclusion criteria included incomplete survey responses and response patterns suggesting random or inattentive answering (e.g., identical responses across items).

Sample size was determined based on commonly accepted methodological recommendations for scale development and factor analysis. Guidelines generally recommend a participant-to-item ratio of at least 10:1 to obtain stable factor solutions. Given the initial item pool and the final 24-item structure, the total sample (n = 968) substantially exceeded these recommendations. Methodological literature also suggests

that samples above 300 are adequate for exploratory factor analysis, while samples approaching or exceeding 500 provide stable solutions for both exploratory and confirmatory factor analyses. In the present study, both the EFA (n = 484) and CFA (n = 484) subsamples met these recommended thresholds.

Measures

Sociodemographic Form

A sociodemographic data form was developed by the research team to obtain information regarding participants' age, gender, educational level, and professional role.

Self-Care Assesment for Employees (SAFE)

The Self-Care Assessment for Employees (SAFE) was developed by the research team based on relevant theoretical frameworks and existing literature. The initial item pool was generated through a structured expert consensus process. Three subject-matter experts independently drafted items grounded in conceptual definitions of self-care and motivational readiness. In a subsequent stage, the experts jointly reviewed all items to evaluate clarity, content relevance, and representativeness of the construct. Items that were considered redundant or insufficiently representative were removed through consensus. Following this review process, potential employee-specific self-care domains were categorized into four areas: physical, psychosocial, occupational, and mental self-care. The preliminary version of the scale was then prepared for factor analytic evaluation.

In addition to behavioral content, the scale was designed to capture individuals' motivational readiness. Assessing self-care solely at the behavioral level was considered insufficient; therefore, response options for the physical, psychosocial, and occupational domains were structured according to stages of change derived from motivational models (pre-contemplation, contemplation, preparation, action, and maintenance). Accordingly, participants selected from five ordered statements reflecting increasing levels of awareness and behavioral engagement (e.g., from not considering the issue to regularly maintaining improvements).

For the mental self-care subdimension, response options followed a frequency-based Likert format (never, rarely, sometimes, often, always), as these items assessed ongoing internal experiences rather than stage-based behaviors. All items were presented under the following instruction: "Below are statements related to self-care across different areas of life. Please select the response that best reflects your current situation." The suitability of the dataset for factor analysis was evaluated prior to conducting exploratory and confirmatory analyses. The primary objective was to examine the factor structure of the scale and determine whether items loaded onto the theoretically expected dimensions.

Statistical Analysis

All statistical analyses were conducted using IBM SPSS 15.0 for Windows and AMOS 18.0. Descriptive statistics were calculated for demographic variables and scale scores. Continuous variables were presented as means and standard deviations, and categorical variables as frequencies and percentages. Normality assumptions were assessed using the Kolmogorov–Smirnov test. A p-value of $< .05$ was considered statistically significant. Exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) procedures are described in detail in the Statistical Analysis section.

Exploratory factor analysis was conducted to investigate the underlying structure of the SAFE. Given the theoretical expectation that the dimensions of self-care would be interrelated, principal components extraction with direct oblimin rotation was applied. The adequacy of the data for factor analysis was evaluated using the Kaiser–Meyer–Olkin (KMO) measure and Bartlett's test of sphericity. Decisions regarding the number of factors to retain were based on multiple criteria, including eigenvalues greater than 1, inspection of the scree plot, the proportion of explained variance, and conceptual interpretability of the factor solution. Items with factor loadings below .32 or with substantial cross-loadings were excluded from further analyses. Internal consistency of the total scale and subscales was assessed using

Cronbach's alpha coefficients. Following the exploratory phase, confirmatory factor analysis was performed using maximum likelihood estimation in AMOS 18.0 to test the four-factor model identified through EFA. Model fit was evaluated using several commonly reported fit indices, including the chi-square to degrees of freedom ratio (χ^2/df), Comparative Fit Index (CFI), Tucker–Lewis Index (TLI), and Root Mean Square Error of Approximation (RMSEA).

Modification indices were reviewed to identify areas of localized strain within the model. Where theoretically justified, correlated error terms were added between items belonging to the same latent factor. No modifications were made across different latent constructs. Convergent validity was examined through standardized factor loadings, Average Variance Extracted (AVE), and Composite Reliability (CR). Discriminant validity was evaluated by comparing the square root of AVE values with the corresponding inter-factor correlations.

Results

The sociodemographic characteristics of the participants are presented in Table 1. The sample consisted of 968 participants, of whom 71.3 % were female and 28.0 % were male. The mean age of the participants was 34.89 years (SD = 8.39). Occupational distribution is also summarized in Table 1.

Table 1. Demographic data of the participants

Variable	Categories	AFA (n = 484)	DFA (n= 484)	All Group (n = 968)
Age mean (±SD)		34.54 (±8.35)	35.25 (±8.42)	34.89 (±8.39)
Gender n (%)	Female	354 (73.3 %)	336 (69.3 %)	690 (71.3%)
	Male	126 (26.1%)	145 (29.9%)	271 (28.0%)
	Not Declared	3 (0.6%)	4 (0.8%)	7 (0.7%)
Academic Year mean (±SD)		16.57 (±2.96)	16.60 (±2.53)	16.59 (±2.75)
Occupation n (%)	Doctor	32 (6.6%)	34 (7.0%)	66 (6.8%)
	Psychologist	132 (27.3%)	109 (22.5%)	241 (24.9%)
	Nurse	88 (18.2%)	76 (15.7%)	164 (16.9%)
	Social Worker	74 (15.3%)	78 (16.1%)	152 (15.7%)
	Midwife	50 (10.4%)	47 (9.7%)	97 (10.0%)
	Child Development Specialist	20 (4.1%)	20 (4.1%)	40 (4.1%)
	Other	87 (18.0%)	121 (24.9%)	208 (21.5%)
Marital Status n (%)	Single	180 (37.3%)	173 (35.8%)	353 (36.6%)
	Married	293 (60.8%)	297 (61.5%)	590 (61.1%)
	Other	9 (1.9%)	13 (2.7%)	22 (2.3%)

SD: Standard deviation

The Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity were conducted to determine the suitability of the data for EFA (Kienfie Liau et al. 2011). In addition, the scree plot test, the amount of explained variance, and the interpretability of the factors were taken into consideration in deciding the number of factors to be extracted.

Exploratory Factor Analysis (EFA)

To determine the construct validity of the scale and to reveal its factor structure, EFA was conducted. For this purpose, principal components extraction, one of the most commonly used methods in practice, was employed as the exploratory factor analytic approach. During the rotation phase, the direct oblimin method, which is an oblique rotation technique, was selected given the presumed relationships among the factors. Another reason for selecting direct oblimin rotation was its practical convenience in data handling (Büyüköztürk 2018). Items were expected to load onto the relevant factor (pattern and structure matrix) at or above an absolute value of 0.32 (Tabachnick and Fidell 2013). Cronbach's alpha coefficients were calculated to assess the reliability of each subscale represented by the identified factors. EFA was conducted for the SAFE scale.

During the analyses, the items "spending time away from technology," "being stressed," "being able to express negative emotions appropriately," and "spending quality time with your partner" were removed because they did not load onto any factor. Additionally, the items "being aware of thoughts, judgments, beliefs, emotions, and attitudes" and "spending time with your close circle" were excluded due to cross-loadings. With the revised item set, the KMO value was found to be 0.927, indicating excellent sampling adequacy. Values above 0.50 are considered acceptable (Field 2013). Bartlett's test of sphericity was significant ($\chi^2(276) = 561.617$, $p < 0.01$), indicating that the correlations among the items were sufficient for factor analysis.

Table 2. SAFE exploratory factor analysis summary

Factor	Eigenvalue	% Variance	% Cumulative
F1	6.66	35.35	35.35
F2	5.10	7.64	42.99
F3	5.47	4.88	47.87
F4	5.65	3.65	51.52

F1: Factor 1; F2: Factor 2; F3: Factor 3; F4: Factor 4

Table 3. SAFE item factor loadings

Items	Factor 1	Factor 2	Factor 3	Factor 4
Generally paying attention to health			.799	
Getting regular and adequate sleep			.554	
Exercising			.536	
Eating healthy			.767	
Avoiding harmful habits (smoking, alcohol etc)			.478	
Getting regular medical check-ups			.503	
Paying attention to appearance (personal grooming, clothing, hair, etc.)			.360	
Having hobbies				.618
Participating in activities with others				.791
Participating in recreational activities				.802
Making new acquaintances				.470
Making time for personel development (outside of work)				.430
Having a job that suits your personal/professional characteristics	.567			
Managing professional boundaries (subordinate-superior and co-worker relationships)	.634			
Evaluating opportunities for professional development	.583			
Taking breaks at work to rest and for other needs	.812			
Making the workspace comfortable (such as personalization)	.752			
Taking a leave. taking a vacation	.588			
Managing work stress	.583			
Self-approval and self-appreciation		.479		
Having hope		.844		
Having dreams		.790		
Setting goals		.794		
Feeling the meaning of life		.846		
Initial eigenvalues	6.66	5.10	5.47	5.65
% of Variance	35.35	7.64	4.88	3.65
% of total variance				51.52
Items	Factor 1	Factor 2	Factor 3	Factor 4

The EFA results demonstrated that the 24-item SAFE had a four-factor structure explaining 51.52% of the total variance. The first factor explained 35.35% of the variance, the second 7.64%, the third 4.88%, and the fourth 3.65%. Table 2 presents the distribution of items across factors and their corresponding factor loadings. As shown in Table 2, each subdimension consisted of seven items. Factor loadings ranged down to .360, meeting the recommended minimum threshold of 0.32 (Tabachnick and Fidell 2013). The four

factors were labeled as "physical," "psychosocial," "occupational," and "mental." The overall Cronbach's alpha coefficient of the scale was 0.92 (physical = .79, psychosocial = .86, occupational = .86, mental = .86).

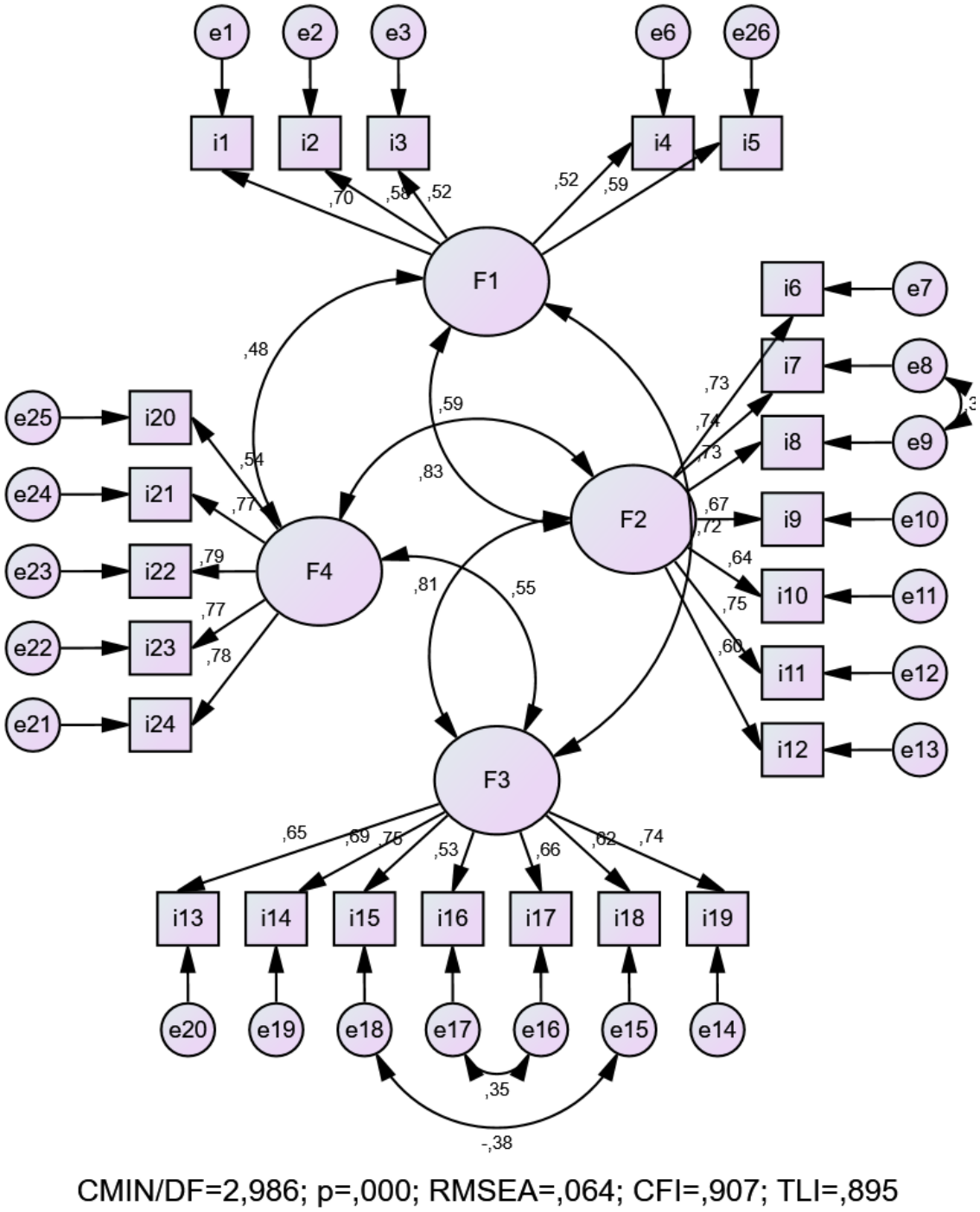


Figure 1. Unstandardized values

Confirmatory Factor Analysis (CFA)

The purpose of CFA was to test the factor structure of the SAFE identified through EFA using an independent sample. Following the EFA results, maximum likelihood estimation was performed in AMOS 18.0. The objectives were to evaluate the model fit and to test the hypothesized four-factor model while considering alternative or competing models (Kienfie Liau et al. 2011).

Following the results of the EFA, a series of maximum likelihood estimations of CFA were performed using AMOS 18.0. This process is known as CFA. The objectives of the study were twofold: firstly, to ascertain the degree of fit of the model; and secondly, to concentrate on the final four-factor model hypothesised, whilst taking into consideration other comparable or competing models (Kienfie Liau et al. 2011). A model is considered to demonstrate adequate fit when the following criteria are met: with a sample size greater than 250, χ^2/df < 5, Tucker–Lewis Index (TLI) > 0.90, Comparative Fit Index (CFI) > 0.92, and Root Mean Square Error of Approximation (RMSEA) < 0.07 (Byrne 2013).

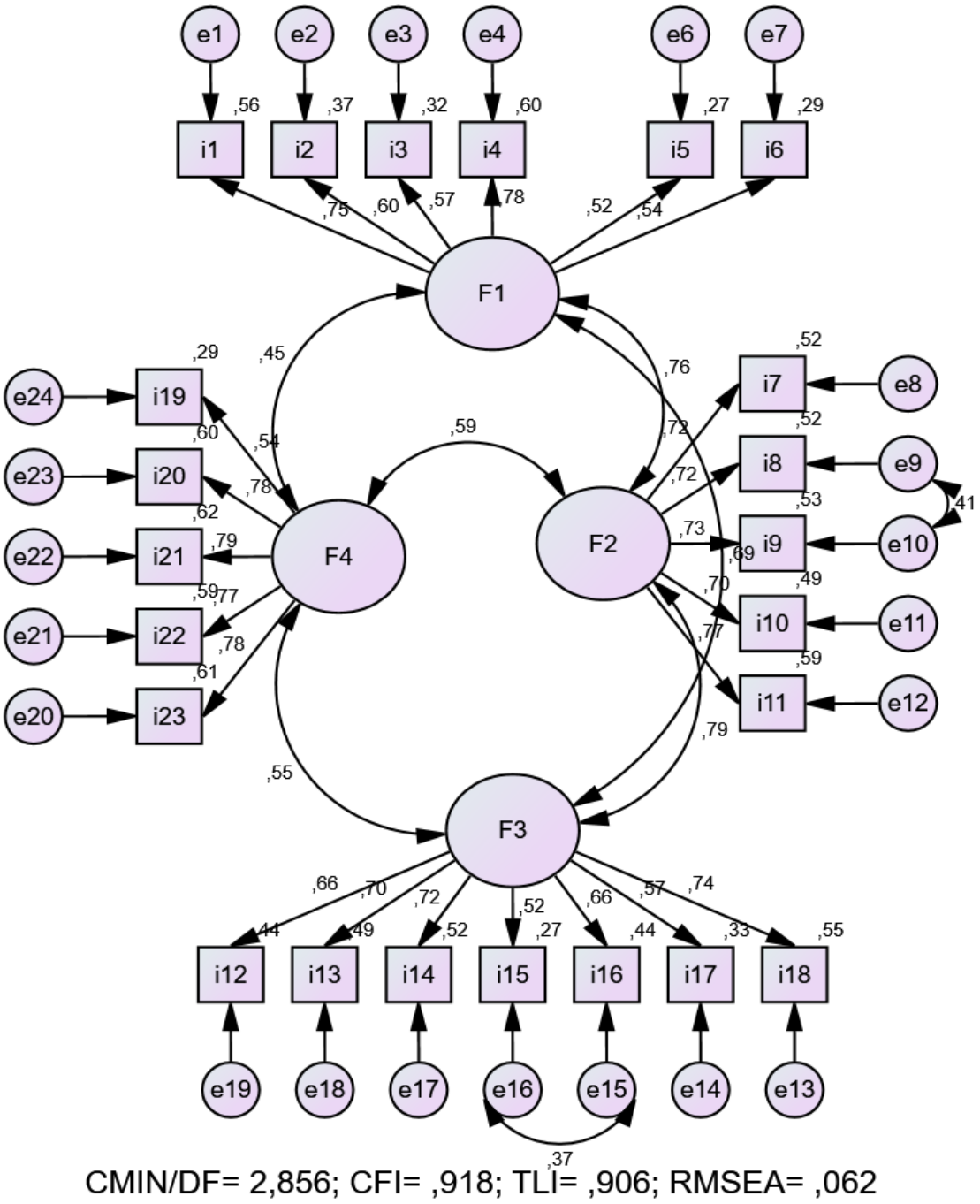


Figure 2. Standardized values

During CFA, one item ("Avoiding harmful habits") with a standardized factor loading below .40 was removed due to weak representation. Thus, the final scale consisted of 23 items. The estimated path diagrams,

including unstandardized and standardized path coefficients as well as correlations among latent variables, are presented in Figures 1 and 2.

Model fit was assessed using multiple fit indices. Based on modification indices, correlated error terms were added between two pairs of items within the same latent factor. These modifications were theoretically justified because the paired items contained highly similar wording and reflected closely related aspects of the same construct. Allowing correlated error terms accounted for shared variance without altering the underlying factor structure. No modifications were made between different latent factors. The results indicated that the model demonstrated acceptable fit. The chi-square/degrees of freedom ratio was 2.86 (χ^2/df ≤ 3), indicating good fit. The Comparative Fit Index (CFI = .918) and Tucker–Lewis Index (TLI = .906) exceeded the .90 threshold. The Root Mean Square Error of Approximation (RMSEA = .062) was below .08, indicating adequate fit. Overall, these findings support the four-factor measurement model.

Convergent and Discriminant Validity

Convergent validity was evaluated using standardized factor loadings, Average Variance Extracted (AVE), and Composite Reliability (CR). Standardized loadings ranged from .51 to .79 and were statistically significant. Although the AVE values for two factors were below .50, the CR values for all factors exceeded .70, indicating acceptable convergent validity according to the Fornell and Larcker criteria (Fornell and Larcker 1981). Discriminant validity was examined by comparing the square root of AVE values with inter-factor correlations, and the results generally supported discriminant validity.

Discussion

The present study aimed to develop and validate the Self-Care Assessment for Employees (SAFE), a multidimensional instrument designed to assess self-care behaviors and attitudes among employees, particularly those working in health and social service sectors. The findings from both EFA and CFA supported a four-factor, 23-item structure with satisfactory validity and reliability.

The psychometric results indicate that SAFE is a valid and reliable instrument for assessing self-care among employees. The four-factor model—Physical, Psychosocial, Occupational, and Mental Self-Care—reflects the complex and multidimensional nature of the self-care construct. The theoretical frameworks proposed by Orem (Orem et al. 1995) and Riegel (Riegel et al. 2012), align with this structure, as both conceptualize self-care as a dynamic process involving behavioral, emotional, and cognitive regulation. The results demonstrate that self-care is multidimensional; although the dimensions are conceptually distinct, they are also interrelated. The four-dimensional structure of SAFE provides a comprehensive framework for assessing the fundamental components of self-care, each of which plays a significant role in physical and psychological well-being.

Physical self-care encompasses efforts to maintain and improve physical health, including regular exercise, balanced nutrition, and adequate sleep. The literature consistently emphasizes the importance of physical activity in preventing chronic diseases and enhancing quality of life (Warburton et al. 2006, Lee et al. 2012). Psychosocial self-care refers to the role of social relationships and support networks in promoting well-being. It includes participating in social activities and spending time with family and friends. Social support has been shown to enhance individuals' ability to cope with stress and to increase overall life satisfaction (Thoits 2011). Occupational self-care involves efforts to maintain satisfaction and balance in professional life. This dimension includes managing work-related stress, setting boundaries, allocating personal time within the workplace, and engaging in professional development. The literature highlights the importance of occupational self-care in preventing burnout and enhancing job satisfaction (Maslach and Leiter 2016). Mental self-care includes activities aimed at maintaining and promoting psychological well-being. Consistent with previous studies, mental self-care practices contribute to reducing symptoms of anxiety and depression, strengthening psychological resilience, and improving stress management (Grossman et al. 2004). Taken together, these four dimensions suggest that self-care represents a comprehensive pattern of adaptive functioning rather than a single behavior. One of the

notable contributions of SAFE is the integration of motivational stages (from pre-contemplation to maintenance) into the assessment framework. This feature enables the scale to evaluate not only the presence of self-care behaviors but also individuals' readiness and motivation to engage in them.

Previous self-care instruments have generally focused on specific populations or limited behavioral domains. For example, the Self-Care of Chronic Illness Inventory (Riegel et al. 2012) primarily assesses self-care behaviors in individuals with chronic conditions, while the Professional Self-Care Scale (Smith 2017) focuses on coping and boundary management among clinical professionals. In contrast, SAFE offers a broader and multidimensional framework applicable to employees across various professions and incorporates motivational readiness as a core assessment component.

Unlike earlier tools that conceptualize self-care primarily as a set of observable behaviors, SAFE approaches self-care as both a behavioral and cognitive-motivational process. This perspective is consistent with self-regulation theory and helps explain how individuals move from awareness to sustained behavioral change, a process particularly relevant in occupational environments characterized by chronic stress and emotional demands.

The findings also provide empirical support for expanding upon the theoretical models proposed by Orem and Riegel by demonstrating that self-care operates across multiple interrelated domains at both behavioral (what individuals do) and motivational (why they do it) levels. From a practical perspective, SAFE may serve as both a diagnostic and evaluative tool in occupational health and organizational psychology. It can help identify areas in which employees may require support in self-care practices and guide the development of well-being interventions. Furthermore, it may be useful for evaluating the effectiveness of counseling programs and training initiatives aimed at promoting self-care.

This study has several limitations. First, data were collected using an online self-report survey, which may be subject to response biases such as social desirability and recall bias. Although data screening procedures were applied to identify random or inconsistent responding, subjective reporting remains an inherent limitation. Future research may complement self-reported data with behavioral or objective psychological indicators of self-care. Second, the sample consisted primarily of healthcare and social service professionals who participated in training programs organized by the General Directorate of Public Health. Therefore, the generalizability of the findings to other occupational groups may be limited. Replication studies involving larger and more diverse employee populations are recommended. Third, the cross-sectional design prevents conclusions regarding causal relationships and temporal stability. Longitudinal studies, intervention-based research, and test–retest reliability analyses would provide stronger evidence for the predictive validity and stability of the SAFE over time. In addition, self-care behaviors are influenced by cultural norms, work environments, and healthcare systems. Future research should therefore examine the cross-cultural applicability of the instrument. Translation and validation studies in different languages and cultural contexts would enhance the global utility of the SAFE. Despite these limitations, the supported factor structure, satisfactory reliability coefficients, and evidence of convergent and discriminant validity provide strong preliminary support for the psychometric soundness of the scale.

Conclusion

This study developed and psychometrically validated the Self-Care Assessment for Employees (SAFE), a multidimensional instrument designed to assess self-care behaviors and motivational readiness among employees. The SAFE comprises 23 items across four domains—physical, psychosocial, occupational, and mental self-care. By integrating behavioral practices with motivational stages of change, the instrument offers a comprehensive framework that captures both what employees do to maintain their well-being and how prepared they are to engage in such behaviors. This dual-structure approach provides added value for understanding self-care within the context of occupational stress and employee well-being. Conceptually, SAFE aligns with and extends Riegel's Middle-Range Theory of Self-Care of Chronic Illness and Orem's Self-Care Deficit Theory by emphasizing the multidimensional and dynamic nature of self-care and the role of motivational and contextual factors. The findings suggest that SAFE may serve as a useful

assessment tool in workplace mental health initiatives, resilience programs, and organizational well-being research.

Future studies should examine the temporal stability of the instrument through test–retest reliability analyses and evaluate its predictive validity in relation to burnout, job satisfaction, and mental health outcomes. Further validation across different occupational groups and cultural contexts is recommended to enhance generalizability. Additionally, intervention-based research may determine whether SAFE scores are sensitive to change following workplace well-being programs, thereby strengthening its practical and theoretical utility.

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Addendum 1. Self-Care Assessment for Employees (SAFE)

Instructions

Below are statements related to self-care across different areas of life. Please select the response that best reflects your current situation."

1- I have never thought about this issue.
2- I have started to think that this issue might be important, but I have not taken any action yet.
3- I think this issue is important and I have started to explore what I can do about it.
4- I have started to make some improvements regarding this issue.
5- I regularly continue the improvements I have made regarding this issue.

Items	**1**	**2**	**3**	**4**	**5**
Physical					
1- Generally paying attetion to health					
2- Getting regular and adequate sleep					
3- Exercising					
4- Eating healthy					
5- Getting regular medical check-ups					
6- Paying attention to appearance (personal grooming, clothing, hair, etc.)					
Psychosocial					
7- Having hobbies					
8- Participating in activities with others					
9- Participating in recreational activities					
10- Making new acquaintances					
11- Making time for personel development (outside of work)					
Occupational					
12- Having a job that suits your personal/professional characteristics					
13- Managing professional boundaries (subordinate-superior and co-worker relationships)					
14- Evaluating opportunities for professional development					
15- Taking breaks at work to rest and for other needs					
16- Making the workspace comfortable (such as personalization)					
17- Taking a leave. taking a vacation					
18- Managing work stress					
For the following items, please indicate how often each statement reflects your current experience.	never	rarely	sometimes	often	always
Mental					
19- Self-approval and self-appreciation					
20- Having hope					
21- Having dreams					
22- Setting goals					
23- Feeling the meaning of life					

Scoring

There is no cutoff score for the scale. High scores indicate high self-care processes.