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Summary
The Effect of Self-Care Intervention Programme on Psychological Health Problems of Professionals Working with Displaced People

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Displacement is defined as the mobility of people who have been forced to leave their homes across an international border or within a country, in particular to escape armed conflict, violence, human rights violations, natural or man-made disasters, or their effects (Perruchoud, 2004). It is a phenomenon that affects the physical and mental health of individuals, as well as its legal, political, and socio-economic consequences (Kurban et al., 2008). Not only those who are directly exposed to the traumatic experience but also the professionals with whom these people interact and communicate can be negatively affected by this process. These individuals may be one of the person's family members or friends, or they may be case managers, support workers, or institutional staff who listen to the person's story (Kahil and Palabıyıkoğlu, 2018). Professionals who provide psychosocial support to displaced persons are one of the groups that are frequently exposed to the traumatic experiences of these individuals and are likely to be emotionally affected (Çırakoğlu, 2018).

Although working in any job is protective for mental health, it is known that a negative work environment can cause physical and mental health problems. Risk factors include tasks that are not appropriate for the individual's skills or excessive workloads. Some occupational groups have more risk factors than others—such as first responders or humanitarian workers. This situation can affect the mental health of professionals working in this field and cause some symptoms to occur (WHO, 2022).

For mental health professionals working in the field of traumatic stress, the importance of self-care practices to ensure physical, mental, and emotional stability has been mentioned (Chaksfield, 2002, as cited in Alptekin, 2014).

Depression, burnout, and secondary traumatic stress are characterized by a decrease in self-care behaviours (e.g., changes in sleep and appetite, withdrawal from others, lack of communication, deterioration in relationships) or a decrease in interest in such behaviours (American Psychological Association, 2017; Çakır et al., 2012; Figley, 1995; Kahil & Palabıyıkoğlu, 2018). Among the interventions offered for depression, the effectiveness of psychosocial interventions as well as pharmacological treatment is mentioned (Sütçigil & Özmenler, 2007). The 2009 guideline from the National Institute for Health and Care Excellence (NICE) presented a stepped care model with a series of recommendations, including psychoeducation as the first step. In the second step, psychosocial interventions such as a structured group exercise programme and a group-based peer support (self-help) programme were included in the recommendations. Some recommendations on sleep hygiene were also made. As stated by Çakır et al. (2012), the neglect of self-care by carers may place this group in the risk group in terms of burnout and secondary trauma. As a suggestion, the authors mention the positive effect of attending support sessions to gain awareness. A review of the literature suggests that practices including self-care skills are recommended for depression, secondary trauma, and burnout.

It is noted that the studies carried out are limited to research and the intervention programmes developed for professionals working with displaced groups are quite limited (Ebren et al., 2022). For this reason, it is assessed that the self-care intervention program developed by the researcher for professionals providing psychosocial support to displaced people will not only fill the gap in this area but will also lead to organizational benefits as it will increase the quality of services provided, as stated by Ludick and Figley (2017).

The aim of this study is to examine the effective-

ness of a self-care intervention programme on self-care, burnout, secondary traumatic stress, and depressive symptoms among professionals actively providing psychosocial support to displaced people

Research Design

A 6-week intervention programme was designed and implemented with 16 participants (8 in the intervention group and 8 in the waiting/control group) on an online platform. The study used an experimental design with a pretest-posttest control group.

Initially, baseline measurements were taken in both groups, which showed no significant differences in the variables studied. The intervention group received a weekly self-care programme for six weeks. The waiting/control group received no treatment during this period. After the six-week self-care intervention for the intervention group, post-intervention measures were taken from both groups to assess differences. A 6-week self-care intervention programme was then delivered to the waiting/control group. On completion of the intervention for the waiting/control group, post-intervention measures were taken from both groups to assess differences.

Method

Participants

The sample consisted of 16 people actively providing psychosocial support to displaced people. In the intervention group, there were 8 participants, 4 psychologists (*50%*), and 4 social workers (*50%*). The mean age of the participants was 28.87 years. The duration of working in the field of migration ranged from 11 months to 75 months, with an average duration of 35.37 months. The participants' weekly working hours varied between 8 and 50 hours ($M = 36.50$). The number of trauma victims encountered per week ranged from a minimum of 2 to a maximum of 250 ($M = 48$). In the waiting/control group, there were 8 participants, 6 psychologists (*75%*), and 2 social workers (*25%*). The mean age of the participants was 27.62 years. The duration of working in the field of migration varied between 1 month and 60 months, with an average duration of 29.62 months. The participants' weekly working hours varied between 35 and 45 hours ($M = 41.87$). The number of trauma victims encountered per week ranged from a minimum of 2 to a maximum of 40 ($M = 11.62$).

Materials

Demographic Form: The demographic form includes gender, age, marital status, level of education, occupation, length of time working in the field of migration, weekly working hours, the approximate number of trauma victims they have one-on-one contact with per week due to their duties, level of identification, and participation in a similar intervention programme.

Pre-interview Form: This is a form developed by the researcher to inform the participants about the details of the intervention programme, information about the training of the leader, the group rules and ethical rules, and what is expected/required from the participant. It is also used to obtain the participants' expectations about the intervention programme.

The Self-care Behaviour Questionnaire: This is an 18-item behavioural assessment questionnaire created by the researcher to assess participants' self-care behaviours. This questionnaire was developed by the researcher within the framework of the Transtheoretical Model of Change (Prochaska et al., 1994), as there was no measurement tool in the literature that was appropriate for the purpose and related to the behavioural repertoire of interest. In this questionnaire, which contains items related to each self-care dimension, the pre-thinking stage - I do not plan to use this method; thinking stage - I plan to use this method in the next six months; preparation stage - I plan to use it in the next month; action stage - I have been using it for the last six months; maintenance stage - I have been using it for more than six months. Participants were asked to respond to the questionnaire by rating where they were in each self-care dimension (e.g., paying attention to sleep patterns, exercising, etc. for the physical self-care dimension; being aware of supportive relationships, trying to develop a social support network, etc. for the relational self-care dimension; feeling grateful for what they have in life for the spiritual self-care dimension, etc.). This questionnaire was designed by the researcher to understand whether there was a change in the self-care behaviour of the participants after the self-care intervention programme, and no validity and reliability study was conducted.

The Beck Depression Inventory: The scale developed by Beck (1961) was revised and finalized in 1978 and adapted into Turkish by Hisli (1989). It is a 21-item scale. It can be evaluated according to the total score, and higher scores indicate an increase in depressive symptoms. In the original study conducted by Beck (1961), the test-retest reliability coefficient of the scale was .65, and the internal consistency coefficient was .78. In the adaptation study conducted by Hisli (1989), the split-half reliability of the scale was .74, and the Cronbach's Alpha coefficient was .80. In this study, the Cronbach's Alpha coefficient for the pre-test was calculated to be .87.

The Maslach Burnout Scale: The Maslach Bur-

nout Scale was developed by Maslach and Jackson (1986) to measure the burnout levels of caregivers, service and treatment providers. In the reliability studies of the scale, Cronbach's Alpha coefficient was found to be .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment (Maslach et al., 1996). It was adapted into Turkish by Ergin (1993). The 5-point Likert-type scale consists of 22 items and has emotional exhaustion, depersonalization, and personal accomplishment subscales. Each subscale is used separately, and no total score can be obtained from the scale. A high score on the emotional exhaustion subscale indicates high emotional exhaustion, a high score on the depersonalization subscale indicates high depersonalization and a high score on the personal accomplishment subscale indicates a high sense of personal accomplishment. In the adaptation study conducted by Ergin (1993), Cronbach's Alpha internal consistency coefficients were .83 for the emotional exhaustion subscale, .65 for the depersonalization subscale, and .72 for the personal accomplishment subscale. The test-retest reliability coefficients for these subscales are .83, .72, and .67, respectively. For this study, Cronbach's Alpha internal consistency coefficients were calculated as .84 for the emotional exhaustion subscale, .55 for the depersonalization subscale, and .56 for the personal accomplishment subscale for the pre-test.

The Secondary Traumatic Stress Scale: It was developed by Bride et al. (2004) for people who have been directly exposed to traumatic events through a professional helping relationship with the person or persons who directly experienced the traumatic events. As a result of the analyses conducted in the original study, the Cronbach's Alpha coefficient of the scale was calculated as .93. The scale was adapted into Turkish by Yıldırım et al. (2018). It is a 5-point Likert-type scale with 17 items. The scale has three sub-dimensions: avoidance, emotional violation, and arousal. In the adaptation study conducted by Yıldırım et al. (2018), the Cronbach's Alpha internal consistency coefficient of the scale was calculated as .91 for the total scale, .78 for the avoidance subscale, .82 for the arousal subscale and .84 for the emotional violation subscale. In this study, the total score of the scale was used, and Cronbach's Alpha coefficient was calculated as .89 for the pre-test.

The Self-care Intervention Programme

The aim of the self-care intervention programme is to improve the self-care skills of professionals actively providing psychosocial support to displaced people. In this context, a 6-week self-care intervention program of 90-120 minutes per week was created within the framework of the multidimensional structure of self-care, which includes physical, cognitive/emotional, relational, spiritual, professional self-care, and balance and awareness dimensions proposed by Güler (2018). The programme basically envisages the acquisition of behaviours related to self-care skills. For this reason, it has been designed taking into account the "transtheoretical model". This model emphasises that individuals go through similar stages of change and that change has a five-stage structure that includes precontemplation, reflection, preparation, action, and maintenance (Prochaska et al., 1994). In addition, homework was added to the programme to ensure that behavioural change could occur and be sustained. Each homework assignment was completed at the beginning of the next session. In order to keep the attention on the programme, the sessions were enriched with different exercises each week. The programme was designed as closed sessions on an online platform. No new group participants were accepted after the intervention programme started. The group rules are as follows: attend the sessions regularly, cameras must be on, microphones must be open when necessary, no camera or audio recording, no sharing on social media accounts, no sharing of what is discussed in the group with third parties. In addition, in line with the scientific approach, participants were informed that they would be randomly assigned to a group.

Results

To measure the effectiveness of the self-care intervention programme, group comparisons (intervention group vs. waiting/control group) were made using the Mann-Whitney U test, a non-parametric test, while within-group changes were analysed using the Friedman test. Multiple comparisons were performed using the Wilcoxon Signed Ranks Test. According to the results, there was no significant difference between the first and second depression scores of the waiting/control group ($z = -.76, p > .05$), whereas there was a significant difference between the second and last depression scores ($z = -2.52, p < .05$) and between the first and last depression scores ($z = -2.21, p < .05$). Depression scores in the waiting/control group were significantly lower after the intervention programme ($Mdn = 1.00, n = 8$) than before the intervention programme ($Mdn = 10.00, n = 8$) ($z = -2.52, p < .05$). Similarly, post-measurement depression scores for the waiting/control group ($Mdn = 1.00, n = 8$) were significantly lower than pre-measurement scores ($Mdn = 3.50, n = 8$) ($z = -2.21, p < .05$).

There were no significant between or within group differences in any of the other variables assessed.

Discussion

It is suggested that the reason for the lack of differ-

ence between groups in self-care scores is that self-care concepts became more understandable with the intervention programme. It is suggested that the reason for the lack of difference between groups in burnout scores can be explained by the effort-reward imbalance model. It is suggested that the fact that the self-care intervention programme does not focus directly on traumatic experiences may be the reason for the lack of difference between groups in secondary traumatic stress scores.

Only the depression score at the last measurement showed a significant decrease compared to the waiting/control group before the intervention programme. However, the same cannot be said for the intervention group. There was no significant decrease in depression scores in the intervention group after the intervention programme. This could be due to group-related factors. Yalom (2012), in his book The Theory and Ethics of Group Psychotherapy, mentions eleven factors that express the important points of the therapeutic change process related to group psychotherapy. Although the self-care intervention programme was not structured as a therapeutic programme, it is believed that the factors mentioned by Yalom, such as instilling hope, universality, interpersonal learning, and group cohesiveness, may have influenced the outcomes of the intervention programme. Yalom (2012) also states that although these factors work in any type of therapy group, their importance varies from group to group. At this point, it can be said that the extent to which each group is affected by these factors also varies. The fact that there was no significant decrease in the level of depressive symptoms in the intervention group after the implementation of the self-care intervention programme, while there was a significant decrease in the waiting/control group, may be due to the differentiating factors related to the groups.

The main drawback of the research is that it was conducted under epidemic conditions and online. Although this situation allowed professionals working in all provinces to participate in the intervention programme, it limited the interaction between participants and the maximum effectiveness of the programme.

Another limitation of the study is the high loss of subjects. Attrition is an issue that is particularly prevalent in longitudinal studies where data are collected multiple times over time (Maruyama and Ryan, 2014). Although the duration of this research is shorter than that of longitudinal studies, it is likely to be susceptible to attrition effects as it requires regular participation and is a skills development programme.