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The prospective role of defeat and entrapment in caregiver burden and depression amongst formal caregivers

Alys Wyn Griffiths[a,*], Alex M. Wood[b,c], Sara Tai[b]

[a] School of Health and Community Studies, Faculty of Health and Social Sciences Leeds Beckett University, City Campus, Leeds LS1 3HE, United Kingdom
[b] School of Psychological Sciences, University of Manchester, Oxford Road, Manchester M13 9PL, United Kingdom
[c] Behavioural Science Centre, Stirling Management School, University of Stirling, Stirling FK9 4LA, United Kingdom

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ABSTRACT

The mental and physical demands of working in a care home are known to lead to elevated risk for staff of work and stress related illnesses such as depression. However, little is known about how these develop. Recent developments in defeat and entrapment research have demonstrated that they are best conceptualised as a single factor. Our aim was to establish whether combined defeat and entrapment influences the development of depression and caregiver burden amongst health care staff. Formal care staff (N = 195) were recruited from a care organisation and completed self-report measures of caregiver burden, depression, defeat and entrapment at two time points approximately 12 months apart. Regression analyses demonstrated that changes in caregiver burden and depression between Time 1 and Time 2 were predicted from baseline levels of combined defeat and entrapment. This research provided the first evidence of a link between defeat, entrapment and caregiver burden and depression in care staff. There are implications for improving education and training within care organisations about caregiver burden to help identify individuals at risk of developing illnesses.

As the proportion of adults within the population aged 65 and over continues to rise and more individuals become susceptible to age-related disorders, the demand for family and formal (employed) caregivers to provide care is also increasing (Pitfield, Shahriyarmolki, & Livingston, 2011). Whilst the burden of caring for family members is well established (see Adelman, Tmanova, Delgado, Dion, & Lachs, 2014 for a review), much less is known about the burden for formal caregivers (Cocco, Gatti, de Mendonca, & Camus, 2003; Duffy, Oyebode, & Allen, 2009) and how this affects well-being. This paper provides an exploration of the role of a psychological factor, combined defeat and entrapment (Gilbert & Allan, 1998), in the experience of caregiver burden and depression amongst formal caregivers.

Working in care homes is mentally and physically demanding, with staff experiencing elevated risk of depression (Maslach & Jackson, 1986; Testad, Mikkelsen, Ballard, & Aarsland, 2010). Formal caregivers prioritize the well-being of their residents over their own (Crout, Chang, & Cioffi, 2005), however many appear physically and emotionally exhausted in work (e.g. 68.6%, Duffy et al., 2009). Subsequently, these individuals experience caregiver burden, defined as poor physical and emotional health resulting from excessive caregiving demands (Given et al., 1992), or feelings of emotional exhaustion, depersonalized treatment of clients and reduced sense of personal accomplishment within the workplace (Maslach & Jackson, 1986). As burnout and caregiver burden are associated with negative experiences for both the staff and residents in care homes (Moniz-Cook, Millington, & Silver, 1997), targeting and reducing caregiver burden should be a priority (Åström, Nilsson, Norberg, Sandman, & Winblad, 1991). However, the prevalence of burden is yet to be established (Albers, Van den Block, & Vander Stichele, 2014). This is particularly relevant as high levels of caregiver burden may have an impact on staff turnover, which in turn has a negative impact on the quality of care provided (Castle & Engberg, 2005). As increasing numbers of individuals live in care homes, understanding the support care staff require to optimally carry out their role is vital (Adelman et al., 2014).

A systematic review of care staff demonstrated that the risk for developing caregiver burden or burnout ranged from 5% to 36% (Pitfield et al., 2011). However, this review only included cross-sectional studies and individuals with enduring psychological stress may terminate their employment (Pitfield et al., 2011). Supporting this, individuals with high stress levels felt less committed to their job and were more likely to terminate their employment (Duffy et al., 2009). Conversely, almost 65% of nurses and psychologists working in dementia care reported moderate to high levels of burnout (Todd & Watts, 2005). Amongst these individuals, almost 70% also reported

* Corresponding author.
E-mail address: alys.griffiths@leedsbeckett.ac.uk (A.W. Griffiths).

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experiencing emotional exhaustion due to their role (Duffy et al., 2009) and almost 37% of nursing home staff reported impaired mental well-being (Pélissier, Fontana, Fort, et al., 2015). Due to conflicting research evidence, prospective research to establish levels of psychological distress amongst individuals working in the care sector has been recommended (Pitfield et al., 2011).

The role of stress, defined as a "relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her well-being" (Lazarus & Folkman, 1984, pp.21), has been well established for individuals working in care homes. Such individuals often experience stress (Hazelhof, Schoonhoven, & van Gaal., B. G.I., Koopmans, R. T. C. M., & Gerritsen, D. L., 2016), which may result from challenging behaviours and interactions with residents they work with (McVicar, 2003). Recently, it has been identified that antecedents such as communication problems, arguing with residents and limited experience in the role have a direct influence on stress, which in turn impact on job dissatisfaction, experience of burnout and absence from work (Hazelhof et al., 2016), supporting theories that stress associated with professional caring roles may have health consequences (Chappell & Novak, 1994).

Two factors specifically associated with stress and psychological distress that may be particularly relevant to care staff, are defeat and entrapment. Defeat has been defined as failing to achieve important goals and experiencing a loss in social rank, and entrapment has been defined as a lack of available options for escape from an aversive situation (Gilbert & Allan, 1998). Entrapment, in particular, is associated with situations of chronic stress (Brown, Harris, & Hepworth, 1995). Defeat and entrapment are thought to represent low social rank and therefore may lead to increased feelings of anxiety and lower positive affect (Gilbert, Allan, Brough, Melley, & Miles, 2002). Defeat and entrapment are associated with the development and maintenance of mental health problems amongst clinical and non-clinical populations (see Taylor, Gooding, Wood, & Tarrier, 2011 for a review) and may operate transdiagnostically. This coincides with a shift in mental health practice and research from the diagnosis and treatment of individual disorders to using treatments to enhance overall well-being (Kinderman, Schwannauer, Pontin, & Tai, 2013).

Within defeat and entrapment research, there has been discussion over whether they are best defined as a single construct. This was first identified as definitions of defeat include suggestions of a lack of available solutions, which is strongly associated with entrapment (Rooke & Birchwood, 1998). Although initially viewed as separate concepts, recent theory and research has conceptualised defeat and entrapment as a single construct encompassing feelings of failure without any escape routes (e.g., Taylor, Wood, Gooding, Johnson, & Tarrier, 2009), or as subfacets within a higher order construct termed involuntary subordination (Sturman, 2011). Within this construct, it is thought that the acceptance of defeating and entrapping situations is crucial in whether they become prolonged and manifest in depressive symptoms (Sturman, Rose, McKeighan, Burch, & Evanico, 2015). Taylor et al. (2011) suggested that following an aversive event, defeat and entrapment form a self-reinforcing mechanism whereby the experience of one influences the other continuously, leading them to co-occur to such an extent that they cannot be separated. Additionally, Johnson, Gooding, and Tarrier (2008) suggested that defeat and entrapment involve identical themes representing a biased appraisal of an aversive situation and a lack of escape options. Furthermore, Sturman (2011) proposed that defeat and entrapment are overlapping subfacets of the perception of involuntary subordination. Furthermore, factor analysis on the *Defeat Scale* and *Entrapment Scale* (Gilbert & Allan, 1998) has consistently shown that a single structure underlies the items (e.g. Griffiths et al., 2015; Griffiths, Wood, Maltby, Taylor, & Tai, 2014; Taylor et al., 2009). Defeat and entrapment also consistently correlate at above 0.80, considered too high to be included in analyses as independent variables (Tabachnick & Fidell, 2007).

Although the link between defeat, entrapment and mental health is well established, limited research has considered this amongst caregivers. In a study of informal caregivers of individuals with dementia, entrapment was highly related to symptoms of depression, thought to result from caregiving stress (Martin, Gilbert, McEwan, & Irons, 2006). However, no relationship was found between stress and depression when controlling for defeat and entrapment. The constant demands of caring, combined with inescapable stressors, were key factors in depression (Martin et al., 2006). Research should now consider formal caregiving settings, where individuals may feel trapped in situations of chronic high stress. Despite evidence that caregiver morale may increase over time (Gilhooly, 1984), for some, the burden of caring may become increasingly entrapping and depressing (Martin et al., 2006). Prospective research with large samples that could indicate risk factors that predict the experience of caregiver burden is a priority (Martin et al., 2006; Pitfield et al., 2011) to develop strategies to address these risk factors.

Studies considering risk factors for mental health problems have shown that defeat and entrapment are a "generative mechanism", suggesting that whilst risk factors may appear to predict mental health problems, the "active" part of the risk factor is the variance shared with defeat and entrapment. Whilst both a risk factor and defeat and entrapment may individually predict a psychopathological outcome, when outcomes are simultaneously regressed on both risk factor and defeat and entrapment, only defeat and entrapment remains significant. For example, the relationship between stress and depression was mediated by defeat and entrapment for individuals providing care for individuals with learning disabilities (Willner & Goldstein, 2001). We expect that, longitudinally, both depression and combined defeat and entrapment will be predictors of caregiver burden, but that only defeat and entrapment will be a significant predictor when controlling for overlapping variance between the constructs.

In the current study, we provided the first exploration of the influence of defeat and entrapment on caregiver burden and depression for formal caregivers across twelve months. We predicted that participants who experience high levels of defeat and entrapment would report higher levels of caregiver burden and depression twelve months later. We also predicted that depression and caregiver burden would correlate, however that the relationship would operate through shared variance between depression and combined defeat and entrapment. This is a test of defeat and entrapment confounding the relationship between depression and caregiver burden; were mediation predicted, the same test would be used, but with the additional assumption that a causal relationship exists between the factors, which is not claimed here (MacKinnon, Krull, & Lockwood, 2000).

1. Method

1.1. Participants and procedure

One hundred and ninety five formal caregivers (age range 18–71 years; $M = 38.4$ years, $SD = 12.20$; see Table 1 for demographic characteristics) were recruited through advertisements placed in seven care homes forming a care organisation in North Wales, recruited on an opportunistic basis, through postal invitations to participate in research. Formal caregivers in this organisation provide care for individuals with dementia, neurological problems, and older adults who require nursing or residential care. Individuals rotate their shifts around the seven care homes, working with residents with different levels of need and severity of symptoms. Average hourly rate for a care assistant within the organisation was £6.30 and average rate for a senior care assistant was £7.50. The average weekly earnings for care assistants (£226.80) and senior care assistants (£270) was considerably lower than the average earnings for full time employees (£528), placing them within the lowest 10% of earners (Office for National Statistics, 2015). At Time 1, participants had been employed by the organisation for