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The paradox of compassionate work: a mixed-methods study of satisfying and fatiguing experiences of animal health care providers

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ABSTRACT

Background and objectives: Compassionate work appears paradoxical as it may provide great rewards, but may also come at great costs to care providers. This paper explores the paradox of compassionate work by examining what interactions contribute to compassion satisfaction and what interactions contribute to compassion fatigue.

Design: This mixed-methods, cross-sectional study uses qualitative interview data from animal health care providers (N = 20) to identify work interactions that they find satisfying or stressful. Quantitative survey data (N = 572) are used to test hypotheses generated from the interviews regarding predictors of compassion satisfaction and compassion fatigue.

Methods: Interview transcripts were analyzed using a directed content analysis approach. Survey data were analyzed using ordinary least squares regression.

Results: The results highlight the complex nature of compassionate work. As hypothesized, making a difference to animals and building relationships with animal patients and human clients relate to greater compassion satisfaction. Human client barriers to animal care and witnessing client grief relate to greater compassion fatigue, as predicted. None of the predictors relate to less compassion fatigue, but forming relationships with animal patients relates to both greater compassion satisfaction and compassion fatigue.

Conclusions: This paper enhances our understanding of provider-client-patient interactions and highlights the paradox of compassionate work.

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Compassionate work; compassion satisfaction; compassion fatigue; provider-client-patient interactions; veterinary medicine; mixed-methods research

Helping a family with children by saving their pet or euthanizing animals that are suffering gives me satisfaction.

… the euths [sic], the financial constraints of pet owners, and the cases of neglect, take its toll when you are trying to be the voice for their pet. Who knew caring so much could be so exhausting?

These quotes from animal health care providers (AHCPs) illustrate the complex and paradoxical experience of compassionate work in veterinary medicine. On one hand, these workers often experience great joy, fulfillment, and satisfaction from caring for helpless animals and distressed pet owners (Bartram, Yadegarfar, & Baldwin, 2009; Cake, Bell, Bickley, & Bartram, 2015). Yet, at the same time, AHCPs must care for and respond to animals and pet owners in empathetic ways (Figley & Roop, 2006). While human care workers may face a similar experience in caring for their patients, some researchers suggest that AHCPs may experience higher costs associated with caring compared to
their human care counterparts since AHCPs care not only for animals, but also for humans (Rank, Zaparanich, & Gentry, 2009).

Individuals who enter compassionate work often do so with the motivation to help others and make a difference in their lives. Compassion is characterized as holding “a deep awareness of the suffering of another coupled with the wish to relieve it” (Figley & Roop, 2006, p. 10). Compassionate work may be highly rewarding and contribute to positive feelings of fulfillment as care providers meet the needs of those who are suffering (Radey & Figley, 2007). Such workers may experience compassion satisfaction, which refers to the sense of joy, pleasure, or fulfillment that care providers receive from helping others, such that they are satisfied, gratified, or invigorated by their work (Figley & Roop, 2006; Radey & Figley, 2007; Stamm, 2005, 2010). At the same time, however, care providers may be emotionally distressed by helping others as their hearts go out to those in need (Radey & Figley, 2007). This means that compassionate work may come at a cost, since care providers may be exposed to others’ pain, suffering, and trauma on a daily basis. This continuous exposure to the traumatic events of others may contribute to compassion fatigue (Figley, 1995), which refers to a worker’s reduced ability to be empathetic to clients’ suffering due to the prolonged demands of caring for others (Figley, 1995, 2002; Figley & Roop, 2006).

Compassionate work, therefore, appears paradoxical as it may provide great rewards, but it may also come at great costs to care providers. The aim of this paper is to explore the paradox of compassionate work by examining what interactions with patients or clients may contribute to compassion satisfaction and what interactions may contribute to compassion fatigue. This research expands the scope of inquiry regarding compassionate work in two important ways. One is that compassion satisfaction has been excluded from many studies of compassion fatigue and compassionate work. The growing awareness of workplace stress has lead to an emphasis on the negative outcomes of one’s job (Mastenbroek et al., 2014) and focuses more on compassion fatigue, without considering how compassionate work may enable providers to thrive and flourish. It is also important to consider the other side of performing caring work, namely compassion satisfaction, and to examine what may enable compassionate care providers to enjoy and feel rewarded by their work (Cake et al., 2015; Wendt, Tuckey, & Prosser, 2011). While attention to compassion satisfaction has become more prevalent in recent years, research has not sufficiently considered what specific interactions may contribute to compassion satisfaction and whether the same interactions may relate to both compassion satisfaction and compassion fatigue. This study explores both of these questions.

Second, much of the research focuses on validating measures of compassion fatigue, demonstrating the conceptual distinction between compassion fatigue and other concepts, such as compassion satisfaction, burnout, or secondary trauma (e.g., Adams, Boscarno, & Figley, 2006; Craig & Sprang, 2010) and documenting groups at risk based on their standardized scores (e.g., Alkema, Linton, & Davies, 2008; Craig & Sprang, 2010; Sprang, Clark, & Whitt-Woosley, 2007). This research is vital for understanding these concepts in relation to one another and their prevalence across different occupational groups. It has been useful in showing that compassion satisfaction and compassion fatigue are distinct factors, rather than opposite ends of the same continuum, as evidenced by psychometric assessments of the Professional Quality of Life Scale (ProQOL) (Stamm, 2002, 2005, 2010). While some studies have moved beyond reporting psychometric assessments or descriptive frequencies, they tend to focus on employee demographics (e.g., age, gender, years of experience, type of license, or practice affiliation) or employing organization descriptors (e.g., type of agency, unit, or clients) as potential correlates of compassion fatigue and compassion satisfaction (Ledoux, 2015). Relatively few studies have examined employees’ work experiences as predictors of these outcomes and whether particular types of service provider interactions relate to compassion satisfaction and compassion fatigue in different ways. From the literature, it appears that helping and interacting with those in distress is key to understanding what may be satisfying and fatiguing about compassionate work. What is unclear, however, are the specific types of interactions and relationships that care providers have with those they are helping and how they are associated with compassion satisfaction or compassion fatigue.
This paper examines the following research question:

What provider–client–patient interactions relate to compassion satisfaction and compassion fatigue?

In order to address this question, data from an exploratory sequential mixed-methods study of veterinarians and animal health technologists (AHTs) is utilized. Specifically, this paper focuses on AHCPs’ interactions with human clients and animal patients because compassion satisfaction and fatigue are inherently shaped by emotional interactions with others. That is, the literature suggests that the rewards or costs of helping others stem from empathizing and working closely with clients and patients in distress (Black, Winefield, & Chur-Hansen, 2011; Cake et al., 2015; Figley & Roop, 2006; Rohlf & Bennett, 2005). Much of the available literature focuses on health care providers in human medicine, such as nurses, physicians, social workers, first responders, counselors, and mental health professionals who deal directly with vulnerable, suffering, or traumatized populations, such as patients in intensive care, emergency care, or domestic violence treatment centers (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017; Sprang et al., 2007). Regardless of the occupation, individuals suffering from compassion fatigue develop similar symptoms that arise from similar interactions and experiences in helping others (Brannick et al., 2015). The specific nuances of AHCPs’ provider–client–patient interactions are explored using qualitative interview data that describes satisfying and stressful parts of these interactions. Based on the themes described in these interviews, four hypotheses were formulated. Quantitative survey data from a larger, more representative sample of AHCPs was then used to operationalize the satisfying and stressful interactions identified in the interview data. Analyzing the survey data enables testing of the hypotheses regarding which specific provider–client–patient interactions are significantly related to compassion satisfaction or compassion fatigue among AHCPs.

This sample of AHCPs is well suited for addressing the research question examined here. There have been important changes in veterinary practice over recent decades, particularly in the relationships that AHCPs have with both their human clients and animal patients. The bond between humans and animals has evolved, such that animals are no longer seen as merely having instrumental value, but rather are often considered members of the family. For example, in 2011, 85% of pet owners considered their pets to be family members (Shaw, Adams, Bonnett, Larson, & Roter, 2012), and in viewing their pets as their children, expect veterinarians to take on the role of a pediatrician in providing their care (Figley & Roop, 2006).

This evolution of the human–animal bond has resulted in AHCPs providing not only physical care to their animal patients, but also empathetic care to the emotional needs of human clients. This dual caring role for AHCPs may contribute to a greater likelihood of experiencing compassion satisfaction and compassion fatigue. Being empathetic is necessary for veterinary practice, but it may also put AHCPs at risk for compassion fatigue, particularly since many enter the occupation because of their love for and desire to care for animals (Black et al., 2011; Figley & Roop, 2006; Rohlf & Bennett, 2005). At the same time, however, while provider–client–patient interactions may be emotionally demanding, AHCPs may find many of these interactions highly rewarding. As a result, they may also derive great satisfaction from caring for and helping animal patients and their owners (Figley & Roop, 2006).

Methods: qualitative phase

Participants and procedures

In the spring of 2013, structured, asynchronous electronic interviews were conducted with a purposive sample of 7 veterinarians and 13 AHTs in Alberta, Canada. Participants were selected from various career stages and practice settings (e.g., small, mixed, and large animal practices in urban and rural areas). Participants were informed that their participation was completely voluntary and completion and submission of the electronic interview would be accepted as evidence of their consent to
participate. The Conjoint Faculty Research Ethics Board at the University of Calgary approved this research.

Participants had practiced for an average of 16.5 years (range = 4–35 years) and 70% were female. Each participant was emailed a document containing open-ended questions and asked to return their typed responses to the authors via email. This approach was meant to facilitate honest reflection and thoughtful responses by giving participants time to think about their answers before responding.

**Analyses**

Interview transcripts were analyzed using a directed content analysis approach (Hsieh & Shannon, 2005) focusing specifically on provider–client–patient interactions that AHCPs described as satisfying or stressful. The goal of a directed approach to qualitative content analysis is to support and extend existing theory and research. More specifically for this paper, the goal was to identify in greater detail the fine distinctions and nuances associated with satisfying and stressful provider–client–patient interactions. In line with the directed content analysis approach, analysis proceeded in two stages. First, the authors read through the interview transcripts to identify all passages pertaining to provider–client–patient interactions. Using an inductive approach, rather than predetermined codes, the authors then assigned codes to each of these passages. In the second stage of the analysis, the authors focused their attention on work elements that participants felt were satisfying or stressful, by grouping similar codes into increasingly abstract themes in order to identify key themes that emerged across the questions.

While the authors coded and analyzed all data about satisfying and stressful aspects of provider–client–patient interactions, regardless of where it was discussed in the interview, relevant comments were primarily discussed in response to four interview questions: (1) What parts of your work do you like or enjoy the most, that give you the greatest sense of satisfaction? (2) At the end of the day, what do you consider to have been a “good day” and how do you feel emotionally when you get home from work after a good day? (3) What do you find to be the most stressful aspects of your job? and (4) At the end of the day, what do you consider to have been a “bad day” and how do you feel after having a bad day?

All interview responses were reviewed and analyzed by both authors to reduce bias and increase confirmability of the results by including multiple researcher perspectives (Jensen, 2012). Any discrepancies in coding were discussed between the authors to ensure agreement and to refine the themes. All codes pertaining to satisfying and stressful aspects of provider–client–patient interactions were included in this analytic abstraction, regardless of how often each code was raised in the data, and all themes that emerged are presented here. These themes were identified across numerous questions and across participants. Broad categories were further refined into more detailed subcodes. For example, building relationships was distinguished by relationships with animal patients versus those with human clients. Prior research on compassion fatigue, compassion satisfaction, and the stresses and rewards of veterinary medicine was used to aid in interpreting the findings and developing hypotheses. The selected examples and quotes also offer a complementary set of results to provide a more complete understanding of AHCPs’ day-to-day interactions and experiences of compassion satisfaction and compassion fatigue.

**Results: qualitative phase**

The qualitative interview results were used to identify provider–client–patient interactions that AHCPs perceive as particularly satisfying or stressful. Many of these experiences and interactions are similar to those linked to compassion satisfaction and compassion fatigue among human health care providers. It is hypothesized below that these types of interactions may be important predictors of compassion satisfaction and compassion fatigue. AHCPs often reported that they find it satisfying to interact with, help, and build relationships with animals and human clients. In contrast,
they indicated that they find it stressful to face various barriers to providing animal care and to witness animal suffering or euthanasia or human client grief.

**Satisfying interactions**

Participants described different ways in which provider–client–patient interactions are the most satisfying parts of their jobs. Many reported that they enjoy interacting with and helping animals and making a difference to animals that they cared for. As one AHT explained, “my favorite part of the job was always bonding… Making them [animal patients] feel comfortable and safe, but showing love and affections.” Other participants described the best parts of their job as follows: “I enjoy helping others and helping animals;” “helping a patient’s medical status improve;” and “Animal nursing. Providing the animals with the care they need in a safe, clean environment.” This notion of “making a difference” to those in need and providing good patient care has been cited in the literature as a key predictor of compassion satisfaction among other caring occupations such as hospice care professionals, emergency physicians, social workers, and teachers (Alkema et al., 2008; Dasan, Gohil, Cornelius, & Taylor, 2015; Figley & Roop, 2006; Wendt et al., 2011). In the study reported here, AHCPs felt that their work is fulfilling because it revolves around working with and caring for animals. For example:

A good day is a super busy day with lots of critical cases and then some other cases going home … I like the intensity of the complex cases … and that I know I make a difference with my patients.

**Hypothesis 1:** Making a difference to animals will be positively associated with compassion satisfaction.

Participants also recognized that helping animal patients is often intertwined with, and inseparable from, helping their owners. For example, they described a good day as being “able to successfully help an animal improve their mobility and quality of life and their owners have more time to spend with them,” and another stated: “Getting to work on the animals I enjoy (cats and cows) and helping clients that are grateful.” While helping animals appears to be fundamental to AHCPs’ job satisfaction, working with animal owners is also recognized as an important source of satisfaction by many, which is consistent with the literature (Figley & Roop, 2006). By helping animals, AHCPs also helped human clients, and many participants described the rewards of building relationships with animals as well as building relationships with human clients as extremely satisfying. For example: “I get a great deal of satisfaction when I see happy clients, happy animals and happy staff.” Within this theme, participants also described the satisfaction of being able to educate clients so that they better understood the care being offered to their pet, their expectations were more realistic, and they trusted the veterinary staff to care for their animal. Some referred to “talking with clients after surgery,” “client communication/education,” “people thanking me for helping them,” or “when the clients have been polite and appreciate your work” as the most satisfying part of their work. Another described a good day as, “Animals treated, clients educated and comfortable with their animal’s care. Exhausted but so happy as to be euphoric about supporting the human-animal bond.” It was not just helping animals that is fulfilling for these care providers, but also building relationships with pet owners.

While AHCPs often enter this line of work in order to help and care for animals, animal patients are non-verbal and relatively powerless (Figley & Roop, 2006; Sanders, 1994). AHCPs must, therefore, communicate with human clients to care for their animals (Adams et al., 2006; Cohen, 2007; Figley & Roop, 2006). During communication with clients, AHCPs not only exchange data, but also build rapport, relationships, and partnerships (Shaw, Adams, Bonnett, Larson, & Roter, 2008). Positive reactions may result when animal or human care workers feel they are able to offer care and connect with their clients (Stamm, 2002). This relationship-based approach to veterinary care requires AHCPs to recognize the human–animal bond and to collaborate with clients (Shaw, Adams, & Bonnett, 2004). One veterinarian described the most satisfying part of the job as, “Working with the patients
and their owners to improve their pet’s quality of life. Building rapport with the owners.” Building these relationships takes effort and time, but can be satisfying in the long run. As one AHCP described, “I enjoy my client interactions and the relationships I have built with my clients over the years.”

**Hypothesis 2**: Building relationships with animals and human clients will be positively associated with compassion satisfaction.

**Stressful interactions**

Participants also described several provider–client–patient interactions that were seen as the most stressful parts of their work. One common stressor they described in various ways was an inability to help animals, as noted in other studies (Sanders, 1994). Participants explained how they felt clinical, human client, and communication barriers sometimes prevented them from providing the best care they could to their animal patients and how this was extremely stressful. Participants described clinical barriers to care such as complex medical cases where they were unable to save animals or “extremely busy days filled with unexpected occurrences.” According to one AHT, a bad day is:

Patients dead in their kennel, not knowing if it had been one hour or two since they died, and feeling that if there had been a way to manage things differently I could have prevented it. Worst is if that patient had been a routine surgery and woke up from anesthetic fine and then left to “warm up” and gone shocky [sic] while no one had been able to notice. A critical patient that dies after showing marked improvement is another example. After these shifts I’m depressed.

As this passage shows, it was particularly stressful when a patient took an unexpected turn for the worse. Similarly, community nurses caring for human patients have identified situations where they feel the care they provide is futile or the patient is facing imminent death as a situation that triggers compassion fatigue (Yoder, 2010).

Participants also described stressful client barriers such as clients’ inability or unwillingness to pay for proper treatments for their animals. For example, they described “clients that want us to help the pet for free and blame us for the costs of healthcare” and “frustrating clients that can’t treat due to lack of money or just not caring about their pet” as particularly stressful aspects of their work. Had it not been for clients’ inability or unwillingness to pay for treatment, many AHCPs believed they could have helped their animal patients, and this experience was described as highly stressful, in line with other studies (Morris, 2012).

AHCPs also described clients’ unrealistic expectations as a substantial stressor. According to an AHT, one of the most stressful aspects of the job is “the increasing demands of the public for instant service while they challenge you with Dr Google,” while a veterinarian stated that one of the most stressful aspects was “simply feeling the need to live up to their [clients] expectations.” Furthermore, as a veterinarian explained, “people have an unrealistic perception about the economics of veterinary medicine and try to hold their veterinarians responsible when we fail to live up to their (often misguided) expectations.” As medicine evolves, clients may hold unrealistic expectations for extraordinary treatments or cures, especially if clients view their animals as family members (Cohen, 2007). Clients often have exceptionally high standards for care, such that every effort should be made to keep their animal healthy for as long as possible (Lue, Pantenburg, & Crawford, 2008), reflecting the strong human–animal bond. However, AHCPs may experience moral conflict between advocating for animals and honouring clients’ wishes when client and animal interests do not align (Morris, 2012).

Participants also described stressful communication barriers such as clients who complained about services or costs, did not follow recommendations (Figley & Roop, 2006), and were rude or verbally abusive, as described in other studies (Antelyes, 1990). Studies of hospital and home care nurses also report that demanding, angry, or difficult patients may contribute to compassion fatigue (Yoder, 2010). As one AHT commented, “a bad day is getting yelled at by a client who is
unhappy ... I feel useless, so unconfident, want to crawl into bed and cry.” Several participants also suggested that if they could change their job it would involve “less dealing with the public, especially high maintenance pet owners,” being able to “fire the obnoxious clients,” and having “more compliant owners.” Difficult client communications may be compounded when clients have a strong emotional connection to their animals, particularly in times of stress and uncertainty (Sanders, 1994).

Hypothesis 3: Barriers to animal care will be positively associated with compassion fatigue.

Lastly, participants described animal suffering, euthanasia, and human client grief as highly stressful, in line with previous research on AHCPs (Morris, 2012; Rohlf & Bennett, 2005). Similarly, in human health care, “endless suffering, grief, or despair of patients and families” (Sheppard, 2015, p. 58) has been identified as a predictor of compassion fatigue among registered nurses. In the study presented here, one ACHP wrote that, “dealing with euthanasia ... is an important stress factor.” Euthanizing animals can be physically, emotionally, and morally stressful, particularly since AHCPs may face conflict between their ideals of animal care and the reality of having to kill healthy, unwanted animals (Morris, 2012; Rohlf & Bennett, 2005). For one participant, “The event that defines a ‘bad day’ has to be an anesthetic death on a healthy patient. If I caused it or didn’t pick up on the impending death I feel terrible and very personally responsible.” Put simply, a “bad day is if something died...[which is] very rare, thank goodness.” Furthermore, while many comments referred to the stress of animal deaths, animal suffering due to prolonged life was also stressful and upsetting, as noted in the literature (Morris, 2012). A veterinarian described how it is stressful “where we do not know what is going on and treatments are not successful.” An AHT explained that it is “really hard to see pets who should be put down and are suffering but the owners keep them alive.” Nursing research has also demonstrated an association between compassion fatigue and the inability to rescue or save a patient, particularly those who are in extreme pain or trauma (Hinderer et al., 2014; Yoder, 2010).

The stress of animal suffering and euthanasia was further compounded by the presence of family members, particularly children, as noted by others (Morris, 2012). According to one AHT, a bad day involved “taking pets from children to euthanize them, doing the perfect euthanasia every time with the family watching, always being ‘on.’” And for another, the “Loss of an animal (only happened once). I was] depressed at the death, questioning my skill, very sad for the owner.” AHCPs undertake extensive work to ensure that the death of an animal is seen as peaceful and painless to avoid further upsetting clients who are present during euthanasia (Morris, 2012). Furthermore, as the above quote suggests, witnessing human client grief is a major stressor. Individuals working with bereaved clients may prioritize clients’ emotional needs over their own as they provide empathy and try to help clients feel better, yet many AHCPs feel ill-equipped to deal with, and overwhelmed by, clients’ emotional responses to the death of a beloved animal companion (Toray, 2004).

Hypothesis 4: Witnessing suffering and death will be positively associated with compassion fatigue.

Methods: quantitative phase

Participants and procedures

During April and May 2013, electronic newsletters were distributed to all 1401 veterinarians and 1234 AHTs registered with the Alberta Veterinary Medical Association (ABVMA). These newsletters described the study and invited all registered members to participate in an online questionnaire. Respondents were informed that their participation was completely voluntary and that completion and submission of the online survey would be accepted as evidence of their consent to participate. The Conjoint Faculty Research Ethics Board of the University of Calgary approved this research.

Questionnaires were completed by 537 veterinarians and 453 AHTs, which equates to response rates of 38% and 37%, respectively. The distribution of our sample in terms of gender, years of experience, and work setting was similar to provincial data available from the ABVMA regarding all
registered veterinarians and AHTs (available from authors). The sample was restricted to include only those AHCPs engaged in clinical work and without missing data on the included variables \((N = 572)\). Descriptive statistics and correlations are presented in Table 1.

### Measures

Responses to most questions ranged from never (coded 1) to most of the time (coded 5), such that higher values indicated a greater frequency of that variable. Scales were calculated as mean scores. In order to retain as much of the sample as possible, scores were computed for respondents who answered a majority of the items in each scale. All scales were examined using principal components analysis to ensure that the included items represented a single factor.

### Dependent variables

Compassion satisfaction and compassion fatigue were assessed by adapting Stamm’s (2009) ProQOL compassion satisfaction and compassion fatigue sub-scales. The original ProQOL is widely used to

#### Table 1. Descriptive statistics, correlations, and reliabilities of all variables included in the analyses.

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Compassion satisfaction</td>
<td>3.73</td>
<td>0.73</td>
<td>.78</td>
<td>.78</td>
<td>.78</td>
<td>.78</td>
<td>.78</td>
<td>.78</td>
<td>.78</td>
</tr>
<tr>
<td>2. Compassion fatigue</td>
<td>2.60</td>
<td>0.67</td>
<td>-.06</td>
<td>(.82)</td>
<td>.82</td>
<td>.82</td>
<td>.82</td>
<td>.82</td>
<td>.82</td>
</tr>
<tr>
<td>3. Making a difference to animals</td>
<td>4.42</td>
<td>0.59</td>
<td>.56*</td>
<td>-.04</td>
<td>.85</td>
<td>.85</td>
<td>.85</td>
<td>.85</td>
<td>.85</td>
</tr>
<tr>
<td>4. Relationships with animals</td>
<td>4.17</td>
<td>0.91</td>
<td>.42*</td>
<td>.12*</td>
<td>.54*</td>
<td>.54*</td>
<td>.54*</td>
<td>.54*</td>
<td>.54*</td>
</tr>
<tr>
<td>5. Relationships with human clients</td>
<td>3.96</td>
<td>0.82</td>
<td>.42*</td>
<td>.02</td>
<td>.35*</td>
<td>.29*</td>
<td>.29*</td>
<td>.29*</td>
<td>.29*</td>
</tr>
<tr>
<td>6. Clinical barriers</td>
<td>2.64</td>
<td>0.69</td>
<td>-.04</td>
<td>.27*</td>
<td>-.05</td>
<td>-.09*</td>
<td>-.09*</td>
<td>-.09*</td>
<td>-.09*</td>
</tr>
<tr>
<td>7. Human client barriers</td>
<td>3.20</td>
<td>0.64</td>
<td>-.34*</td>
<td>.41*</td>
<td>-.17*</td>
<td>-.11*</td>
<td>-.19*</td>
<td>.31*</td>
<td>(.72)</td>
</tr>
<tr>
<td>8. Communication barriers</td>
<td>2.71</td>
<td>0.75</td>
<td>-.22*</td>
<td>.22*</td>
<td>-.16*</td>
<td>-.09*</td>
<td>-.19*</td>
<td>.22*</td>
<td>.40*</td>
</tr>
<tr>
<td>9. Animal suffering</td>
<td>2.95</td>
<td>0.76</td>
<td>-.08</td>
<td>.26*</td>
<td>-.07</td>
<td>-.06</td>
<td>-.11*</td>
<td>.33*</td>
<td>.39*</td>
</tr>
<tr>
<td>10. Animal euthanasia</td>
<td>3.87</td>
<td>0.79</td>
<td>-.05</td>
<td>.14*</td>
<td>.04</td>
<td>.02</td>
<td>-.01</td>
<td>.13*</td>
<td>.20*</td>
</tr>
<tr>
<td>11. Human client grief</td>
<td>3.36</td>
<td>0.84</td>
<td>.07</td>
<td>.33*</td>
<td>.09*</td>
<td>.12*</td>
<td>.15*</td>
<td>.31*</td>
<td>.31*</td>
</tr>
<tr>
<td>12. Sex(^a)</td>
<td>0.18</td>
<td>0.39</td>
<td>.02</td>
<td>.00</td>
<td>-.06</td>
<td>-.13*</td>
<td>-.08*</td>
<td>.06</td>
<td>-.11*</td>
</tr>
<tr>
<td>13. Occupation(^b)</td>
<td>0.60</td>
<td>0.49</td>
<td>.06</td>
<td>.22*</td>
<td>-.11*</td>
<td>-.17*</td>
<td>-.23*</td>
<td>.06</td>
<td>.23*</td>
</tr>
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<td>14. Practice setting(^c)</td>
<td>0.67</td>
<td>0.47</td>
<td>-.07</td>
<td>-.04</td>
<td>.08</td>
<td>.11*</td>
<td>.00</td>
<td>-.07</td>
<td>.10*</td>
</tr>
<tr>
<td>15. Employment status(^d)</td>
<td>0.79</td>
<td>0.41</td>
<td>-.03</td>
<td>.10*</td>
<td>.03</td>
<td>.08*</td>
<td>-.07</td>
<td>.04</td>
<td>.06</td>
</tr>
<tr>
<td>16. Supervisor status(^e)</td>
<td>0.56</td>
<td>0.50</td>
<td>.01</td>
<td>.03</td>
<td>.02</td>
<td>-.06</td>
<td>-.04</td>
<td>.09*</td>
<td>.03</td>
</tr>
<tr>
<td>17. Years since graduation</td>
<td>12.73</td>
<td>10.19</td>
<td>.17*</td>
<td>-.06</td>
<td>.02</td>
<td>.07</td>
<td>.11*</td>
<td>-.10*</td>
<td>-.27*</td>
</tr>
</tbody>
</table>

Note: \(N = 572\). Cronbach’s alpha is in parentheses on diagonal.

\(^a\) = male.
\(^b\) = veterinarian.
\(^c\) = small animal practice.
\(^d\) = full time.
\(^e\) = supervisor.
\(p < .05\).
measure positive and negative aspects of helping others (Stamm, 2005, 2010) using 30 items where respondents report how frequently they experienced each within the last 30 days. In order to maximize the response rate, the survey needed to be brief, so some constructs, such as the ProQOL, were operationalized using a reduced set of items.

The following three items are used to assess compassion satisfaction: (1) “I get satisfaction from being able to help my clients,” (2) “I feel invigorated after working with my clients,” and (3) “I feel I can make a difference to the lives of others through my work” ($\alpha = .78$). The following six items are used to assess compassion fatigue: (1) “I am preoccupied with the concerns of my clients,” (2) “I find it difficult to separate my personal life from my life as a veterinarian/AHT,” (3) “I feel depressed because of the stressful experiences of my clients,” (4) “I feel as though I experience the emotional pain of my clients,” (5) “I feel I may be affected by the traumatic stress of those I help in my work,” and (6) “I am affected by the stress of those I help in my work” ($\alpha = .82$).

Exploratory factor analysis indicated that compassion satisfaction and compassion fatigue are distinct constructs. The three items for compassion satisfaction load on one factor, while the six items for compassion fatigue load on a second factor with no cross loadings above .40 in the un-rotated factor analysis. Furthermore, as shown in the correlation matrix in Table 1, compassion satisfaction and compassion fatigue are unrelated to one another, as indicated by the non-significant zero-order correlation of $-0.06$. AHCPs who experience more of one of these compassion outcomes (i.e., high compassion satisfaction) do not necessarily experience less of the other (i.e., low compassion fatigue). Table 1 also shows that few of the predictors are significantly related to both compassion outcomes. Taken together, these results suggest that compassion satisfaction and compassion fatigue are conceptually distinct and do not reflect opposite dimensions of the same underlying concept.

**Satisfying interactions**

Satisfying interactions for AHCPs include making a difference to animals and building relationships with both animals and human clients. Making a difference to animals is assessed using four items adapted from Ilgen et al. (2003) that tap respondents’ sense of contributing to animal wellness. Respondents were asked how often they experienced the following: (1) “My work allows me to make a significant contribution to the health and well being of animals,” (2) “My work allows me to do good things for animals,” (3) “My job allows me to be involved with the human-animal bond in a positive way,” and (4) “I find caring for animals very rewarding” ($\alpha = .85$). Relationships with animals reflect the extent to which AHCPs feel connected to their animal patients. This is assessed using a single item the authors developed from the interview results that asked respondents to report how often “I feel a strong personal connection with the animals I work with.” Relationships with human clients reflect the extent to which providers feel appreciated by animals’ caretakers. This is tapped using a single item the authors developed for this study that asked respondents how frequently “My clients thank me for caring for their animals.”

**Stressful interactions**

Stressful interactions for AHCPs include clinical, human client, and communication barriers to animal care, as well as witnessing suffering and death such as animal suffering, animal euthanasia, and human client grief. Items from Bartram et al.’s (2009) veterinarian work stress scale are used to measure these variables. Clinical barriers refer to complicated medical cases where providers were unable to help animal patients. This is assessed using a single item that asked respondents how frequently they experienced “unexpected clinical outcomes.” Human client barriers refer to the challenges related to animals’ caretakers that inhibit care of animal patients. This is assessed by asking respondents how frequently they experienced the following: (1) “conflict between client and animal interests,” (2) “clients’ financial barriers to best care,” (3) “I feel frustrated when clients can’t pay for necessary animal care,” and (4) “unrealistic client expectations” ($\alpha = .72$). Communication barriers is assessed using a single item that asked respondents how frequently they experienced,
“difficult communications with clients” in order to tap the challenges that AHCPs face when exchanging information with human clients.

Animal suffering assesses providers’ exposure to the pain and anguish of animal patients, using a single item that asked respondents how often they experienced “animal suffering.” Animal euthanasia refers to providers’ exposure to the intentional ending of an animal’s life. This is assessed using a single item that asked respondents how frequently they experienced the “euthanasia of animals.” Finally, human client grief indicates AHCPs’ exposure to the sorrow and heartache of animals’ caretakers, using a single item that asked respondents how frequently they experienced “dealing with client grief.”

**Control variables**

Sex indicates whether the respondent is male (coded 1) or female (coded 0). Occupation refers to whether the respondent is a veterinarian (coded 1) or an AHT (coded 0). Practice setting is dichotomized into small animal practice (coded 1) and other (e.g., mixed or large animal practice) (coded 0). Employment status refers to whether the respondent works full-time (coded 1) or part-time (coded 0). Supervisor status refers to whether the respondent supervises and manages others (coded 1) or not (coded 0). Finally, years since graduation is the number of years since respondents received their DVM degree or became an accredited AHT.

**Analyses**

The hypotheses set out above were tested using ordinary least squares regression analyses reported in Table 2. The satisfying and stressful interactions were entered simultaneously for both compassion outcomes. This allows us to determine each interaction’s unique contributions net of the other

<table>
<thead>
<tr>
<th>Table 2. Unstandardized (b) and standardized (β) regression results for compassion satisfaction and compassion fatigue.</th>
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</thead>
<tbody>
<tr>
<td><strong>Compassion satisfaction</strong></td>
</tr>
<tr>
<td>b</td>
</tr>
<tr>
<td><strong>Satisfying work interactions</strong></td>
</tr>
<tr>
<td>Making a difference to animals</td>
</tr>
<tr>
<td>Building relationships</td>
</tr>
<tr>
<td>Relationships with animals</td>
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<tr>
<td>Relationships with human clients</td>
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<tr>
<td><strong>Stressful work interactions</strong></td>
</tr>
<tr>
<td>Barriers to animal care</td>
</tr>
<tr>
<td>Clinical barriers</td>
</tr>
<tr>
<td>Human client barriers</td>
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<tr>
<td>Communication barriers</td>
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<tr>
<td>Witnessing suffering and death</td>
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<tr>
<td>Animal suffering</td>
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<tr>
<td>Animal euthanasia</td>
</tr>
<tr>
<td>Human client grief</td>
</tr>
<tr>
<td><strong>Control variables</strong></td>
</tr>
<tr>
<td>Sex (1 = male)</td>
</tr>
<tr>
<td>Occupation (1 = veterinarian)</td>
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<tr>
<td>Practice setting (1 = small animal practice)</td>
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<td>Employment status (1 = full time)</td>
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<td>Supervisor status (1 = supervisor)</td>
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<td>Years since graduation</td>
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<tr>
<td>Constant</td>
</tr>
<tr>
<td>R²</td>
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<tr>
<td>Adjusted R²</td>
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</tbody>
</table>

Note: N = 572.

*p < .05.
**p < .01.
***p < .001 (two-tailed).
provider–client–patient interactions. It also allows us to explore whether the satisfying interactions (hypothesized to related to compassion satisfaction in H1 and H2) also relate to compassion fatigue, and whether the stressful interactions (hypothesized to relate to compassion fatigue in H3 and H4) also relate to compassion satisfaction. Multicollinearity is not a problem as the highest zero-order correlation among the predictor variables is .56 and the highest VIF is 1.65 (see Allison, 1999).

**Results: quantitative phase**

Looking first at compassion satisfaction, the results presented in Table 2 demonstrate that, as predicted in H1, making a difference to animals \((b = .50, \beta = .40, p < .001)\) is related to greater compassion satisfaction. As hypothesized in H2, building relationships with animals \((b = .11, \beta = .14, p < .001)\) and human clients \((b = .17, \beta = .19, p < .001)\) are also related to greater compassion satisfaction. Turning to compassion fatigue, the results show that, as predicted in H3 and H4, respectively, human client barriers \((b = .33, \beta = .32, p < .001)\) and human client grief \((b = .11, \beta = .13, p < .01)\) are related to greater compassion fatigue.

Two of the variables were related with compassion outcomes that were not predicted. Building relationships with animals, which is positively related to compassion satisfaction as hypothesized (H2), is also positively related to greater compassion fatigue \((b = .16, \beta = .22, p < .001)\). The more AHCPs foster relationships with their animal patients, the more compassion satisfaction and compassion fatigue they experience. In addition, human client barriers, which are positively related to compassion fatigue as predicted (H3), are also negatively related to compassion satisfaction \((b = −.24, \beta = −.21, p < .001)\). Struggling with clients who make it difficult to provide proper care to animal patients is related to less compassion satisfaction and more compassion fatigue for AHCPs. It is interesting to note that the pattern of results suggests that the satisfying work-related interactions ACHPs experience are not related to lessening compassion fatigue, but that both stressful and satisfying interactions may be related to greater compassion fatigue.

**Discussion**

This paper considered the paradox of compassionate work by exploring how provider–client–patient interactions can be both satisfying and stressful and by identifying specific interactions arising from compassionate work that contribute to compassion satisfaction and compassion fatigue. Provider–client–patient interactions are complex, and these interactions are not simply either completely satisfying or completely stressful. Instead, it is important to consider specific types of interactions when identifying potential correlates of compassion satisfaction and compassion fatigue. Specifically, the qualitative results suggest that interacting with, helping, and building relationships with patients or clients are highly satisfying parts of their work. On the other hand, having complex medical cases with unexpected outcomes, clients who are unable or unwilling to pay for proper treatments, clients with unrealistic expectations, difficult communication, and exposure to suffering, death, and grief are stressful elements of these interactions.

These satisfying and stressful interactions were then used as predictors of compassion satisfaction and compassion fatigue in the statistical models. The results indicate that “making a difference” and building relationships with patients and/or clients are related to greater compassion satisfaction, while barriers to care are related to less compassion satisfaction. The results also show that building relationships, barriers to care, and client grief are related to greater compassion fatigue.

The qualitative and quantitative findings of this study are consistent with those reported among other helping professions that involve caring for human patients or clients. For example, observing extreme pain and suffering in patients, the inability to alleviate suffering, exposure to death and dying, and grieving family members are considered relevant to the compassion fatigue experienced by many different types of health care providers (Alkema et al., 2008; Dasan et al., 2015; Yoder, 2010).
Udipi et al. (2008) also reported that challenging or difficult patients who are demanding or uncooperative are risk factors related to compassion fatigue. On the other hand, making a positive impact on the lives of others, seeing clients improve and participating in that process, getting to know patients and genuinely caring for them, engaging the patient as a person with individualized needs, and feeling that despite a negative outcome they had made the situation more bearable have been identified as essential to compassionate care (Stamm, 2002; Yoder, 2010). Future research might explore further the similarities of AHCPs to care situations involving human patients who cannot speak for themselves to further understand the challenges and rewards of forming compassionate relationships with patients and their advocates.

The quantitative analyses highlight several interesting findings that merit further discussion. First, none of the predictors significantly related to less compassion fatigue. While the results help in understanding what provider–client–patient interactions relate to greater compassion fatigue, they do little to identify what characteristics related to less compassion fatigue. This is consistent with much of the literature where the focus is on work-related factors that contribute to “what’s wrong” (Mastenbroek et al., 2014), emphasizing the costs of compassionate work rather than the benefits. Future research should examine other factors related to provider–client–patient interactions and compassionate work more broadly that may be associated with less compassion fatigue.

A variety of interventions have been proposed to prevent and manage compassion fatigue among care providers. For example, Dobbs (2014) suggests that veterinary medicine should adopt a four-pronged approach where the profession recognizes the issue of compassion fatigue amongst its members, employing organizations care for their staff, colleagues support one another, and individual caregivers care for himself or herself. Dobbs further identifies specific practices to creating a healthy workplace such as taking a break, taking advantage of self-care benefits, creating and maintaining relationships, and acknowledging and expressing grief. Other studies have explored potential interventions to prevent or reduce compassion fatigue among human health care providers (e.g., social workers, palliative care workers, nurses, trauma therapists, and emergency responders) that are also relevant to AHCPs. These include offering training and education programs to raise awareness about compassion fatigue and how to cope with it, offering employee assistance or wellness programs, employer sponsored activities that promote self-care, and support groups for managing work-related stress (Alkema et al., 2008; Campbell, 2007; Coetzee & Klopper, 2010; Sinclair et al., 2017). Recent meta-analyses on stress management interventions suggest that cognitive-behavioral interventions initiated by the employing organization appear to be most effective where employees are taught how to modify negative thoughts or emotions in order to facilitate an adaptive and rational approach to coping (Richardson & Rothstein, 2008; ver der Klink, Blonk, Schene, & van Dijk, 2001). While it is not possible to eliminate the sources of stress, it is possible to teach workers how to manage it and reduce the negative outcomes of being exposed to these stressors (Ivancevich, Matteson, Freedman, & Phillips, 1990).

Professional animal care associations may also offer important resources in helping AHCPs cope with the demands and challenges of compassionate work. Stress management programs may not be easily accessible to AHCPs working in private clinical practice, but programs may be offered through professional associations as they are becoming increasingly cognizant of AHCPs’ mental health challenges. For example, the ABVMA has posted online resources to support member wellness (e.g., Wallace, 2014) and the American Veterinary Medical Association offers online resources including self-assessment tools and recommendations on how and when to seek assistance, as well as information on stress management, setting up wellness programs, and how to care for oneself (see avma.org/wellness).

It is also interesting that one of the predictors is related to both greater compassion satisfaction and greater compassion fatigue. That is, building relationships with animal patients, which was identified as a satisfying interaction in the qualitative data, is related not only to greater compassion satisfaction but also to greater compassion fatigue. This finding, in conjunction with the qualitative data, supports the assertion that AHCPs’ caring and empathy for their patients affects them in complex ways. Performing compassionate work can, paradoxically, be both satisfying and stressful such
that the same types of interactions may relate to both greater compassion satisfaction and greater compassion fatigue. As Bunderson and Thompson (2009) suggest, deeply meaningful work may be a double-edge sword. AHCPs may have many rewarding work experiences that contribute to compassion satisfaction, such as forming relationships with their animal patients, but they may also sacrifice their well-being as they continually give of themselves in caring for others and put themselves at risk for experiencing compassion fatigue.

AHCPs often develop strong bonds with their animal patients, just as clients do with their pets. While this human–animal bond may initially be satisfying, as supported by AHCPs who described experiencing the special or immense human–animal bond as some of the best parts of their work, it may become stressful when animal patients suffer or die. AHCPs may feel overwhelmed by caring deeply for suffering animals they have bonded with, putting them at risk for compassion fatigue. In line with this, one veterinarian recounted her grief, stating that, “I drove home crying tonight as I was upset about a case of mine that was euthanized.” Future research should take a more nuanced approach to examining this complex relationship in order to tease apart what elements or under what conditions having relationships with animals is related to greater compassion satisfaction or greater compassion fatigue.

Limitations

There are several limitations to this study. First, the qualitative data may not be sufficiently in-depth to understand the intricacies of why or under what conditions certain interactions within compassionate work are satisfying or stressful. For example, what is it, specifically, about relationships with animals that are satisfying in contrast to being stressful? Responses to the electronic interviews were relatively short, and more in-depth interviews should be used to explore the nuances of how AHCPs perceive provider–client–patient interactions. Second, the quantitative data do not tap all of the interactions identified by AHCPs in the qualitative data. For example, while helping human clients was described as satisfying, this was not assessed quantitatively. Similarly, while relationships with human clients encompassed several aspects in the interviews including appreciation, building long-term friendships, and playing an important role in the lives of their clients, only a single element of relationships with human clients, namely appreciation, was tapped in the quantitative data. Furthermore, several predictors are assessed using single items, which may be less reliable and more vulnerable to random measurement error than multi-item scales. As well, this study measured the frequency with which AHCPs experienced stressful or satisfying aspects of their work, which does reflect the emotional intensity of these experiences. For example, exposure to animal suffering may occur sometimes, but the degree of animal suffering may vary significantly. Future research should examine a wider range of satisfying and stressful factors, using multi-item measures that capture the intensity of these factors, to more fully understand what specific experiences in performing compassionate work may contribute to compassion satisfaction and compassion fatigue.

Fourth, the data are cross-sectional, and it is not possible to make causal claims about the satisfying and stressful interactions leading to compassion satisfaction or compassion fatigue. Rather, compassion satisfaction or compassion fatigue may change how AHCPs evaluate provider–client–patient interactions. For example, if an AHCP experiences compassion fatigue, they may report greater exposure to human client grief. Longitudinal data are, therefore, needed to examine causal processes in the relationships observed here. Finally, the data are self-reported by AHCPs, and their responses may be influenced by social desirability or response biases. Nevertheless, these data are important for understanding compassionate work and the potential impact it may have for providers.

Conclusion

These results highlight the paradox of compassionate work. Caring for patients and/or clients can offer opportunities to build rewarding, meaningful, and fulfilling relationships with others, but it
can also be painful when encountering barriers to caring for them or witnessing their suffering. It is, therefore, necessary to take a more nuanced approach to understanding the complex interactions that care providers have with their patients and clients and how these interactions may contribute to both compassion satisfaction and compassion fatigue. As found in this study, some of the same predictors relate to compassion satisfaction and compassion fatigue, though sometimes in unanticipated ways, and provider–client–patient interactions that are associated with greater compassion satisfaction may not necessarily relate to less compassion fatigue. In fact, little is known about what interactions arising from compassionate work may relate to less compassion fatigue. Instead of focusing on the costs of caring, it is important to also examine what may enhance compassion satisfaction and reduce compassion fatigue in order to better understand what enables compassionate workers to care for others and thrive at work.

Note
1. Some exceptions include Hinderer et al. (2014); Kulkarni, Bell, Hartman, and Herman-Smith (2013); and Von Reuden et al. (2010).

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