Sociological conceptualizations of compassion fatigue: Expanding our understanding

Christian Vaccaro | Melissa Swauger | Shayna Morrison | Alex Heckert

Abstract
Compassion fatigue has been primarily studied at the micro level and framed as a psychological “personal trouble” that results from one’s personality traits, demographic characteristics, or life and work stressors. In addition, compassion fatigue is used to predict other psychological outcomes such as burnout, depersonalization, and stress.

This literature on compassion fatigue has been reviewed, in order to illustrate areas where sociologists can contribute to a more nuanced understanding of the phenomenon. In this article we conceptualize compassion fatigue as a sociological concept and overview the potential ways that sociological approaches can enhance our understanding.

We draw on the literatures of emotion work, social exchange theory, and macrolevel sociological theories to facilitate the use of compassion fatigue from a sociological perspective. For example, we use concepts such as social integration and anomie to stimulate thinking about rates of compassion fatigue.

Keywords
anomie, burnout, compassion fatigue, emotional labor, social exchange, social inequality, social integration
INTRODUCTION

There are many definitions of compassion fatigue, which all include a focus on the experience of depersonalization and expression of dehumanization from distress when helping, caring for, or empathizing with someone else. Compassion fatigue has been primarily studied at the micro level and framed as a psychological "personal trouble" that results from one's personality traits, demographic characteristics, or life and work stressors. Relatedly, it is generally treated as a dependent variable; researchers focus on personal and organizational predictors of compassion fatigue. Fewer studies treat compassion fatigue as an independent variable, used to predict other social psychological outcomes. Moreover, researchers have historically studied the manifestation of compassion fatigue using psychometric measurement, leaving sociological understandings of the "compassion" in compassion fatigue understudied (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017).

Stemming from this insight we review literature on compassion fatigue in order to illustrate areas where sociologists can contribute to a more nuanced understanding of the phenomenon. We conducted our literature review by using basic search terms related to compassion fatigue to net an initial sample of 100 articles which were reviewed and then sorted according to key citations and initial thematic commonalities. Once commonalities and key citations were identified by our team, we then used an iterative comparative process of searching, integrating, and revising additional literature until our analysis reached its current form. We then situated compassion fatigue as a construct of sociological interest by illustrating how sociological concepts, theories, and lines of literature can expand and refine an understanding of compassion fatigue. Not only can sociological thinking stimulate valuable insights to understanding compassion fatigue, but also sociologists can benefit from assessing how the concept operates in organizations and social structures. Table 1 outlines our findings by showing how compassion fatigue can be conceptualized as both a psychological and a sociological construct. In this table, we illustrate how compassion fatigue can be applied at the microlevels, mesolevels, and macrolevels.

In this article, we first provide an overview of our thematic organization of the literature on compassion fatigue, with a specific emphasis on how it has been studied in the caring professions, how it has been measured psychometrically, and how organizational interventions have been designed to address compassion fatigue. We then discuss some potential ways that sociological approaches can contribute to an enhanced understanding of compassion fatigue. In particular, we show how compassion fatigue can be understood as a social fact, as a social emotion, and as an interactional outcome of social exchanges in organizations.

COMPASSION FATIGUE IN THE CARING PROFESSIONS

Compassion fatigue was first introduced as a psychological construct to specify a type of burnout defined as part of a "helper syndrome" experienced by emergency department nurses (Huggard & Huggard, 2008). The term has since been expanded throughout the caring professions (Figley, 1995). The primary focus of compassion fatigue literature has been on the impact on frontline employees who work directly with clients.

Inadvertently, this traditional approach to the study of compassion fatigue points to the contextual nature of the phenomenon. For example, measurements of compassion fatigue have tended to focus on the interplay of workers' individual characteristics with conditions of work in industries that tend to induce higher levels of compassion fatigue. For instance, Wee and Myers (2003) estimated forty percent of Critical Incident Stress Management Providers were at high risk for compassion fatigue (Wee & Myers, 2003). However, they also found when CISM workers reported high compassion satisfaction their risk for burnout was lower. Wee and Myers showed that for some workers, the rewards of work in CISM outweigh negative consequences (Wee & Myers, 2003).
Other researchers have shown the same relationship between individual characteristics and industry work. For example, disaster workers scoring high on measures of empathy scales were at risk for compassion fatigue (Nagamine et al., 2018), trauma treatment specialists with more lengthy experience in the field were less likely to report symptoms of compassion fatigue and burnout (Craig & Sprang, 2010), and therapists who feared working through trauma experience of torture survivors and had high advocacy for their patients presented higher risk for compassion fatigue (Deighton, Gurris, & Traue, 2007). Research examining compassion fatigue experiences of law enforcement professionals also showed a heightened prevalence of compassion fatigue symptoms in comparison to other mental health measures (Dabdoub, Baker, Craw, & Kernes, 2018). Additionally, genetic counselors were found to be at higher risk for compassion fatigue if they reported being burned out, used self-criticism, experienced a greater variety of distressing clinical events, had larger patient caseloads, relied on religion for coping, and had no children (Udipi, Veach, Kao, & Leroy, 2008). Uniquely, compassion fatigue and burnout were not related to military deployments in a study of military health care providers (Cragun, April, & Thaxton, 2016).

Among health-care professionals the experience of compassion fatigue is inversely related to emotional intelligence, emotion management, and adaptive coping (Zeidner, Hadar, Matthews, & Roberts, 2013). Zeidner et al. (2013) demonstrated differences in emotional intelligence, coping strategies, and negative affect between mental and medical professionals that impact the prevalence of compassion fatigue. Finally, in a study of clinical nurses, Kim et al. (2017) found that type D personality was significantly associated with job stress and compassion fatigue (Kim et al., 2017).

A review of literature within caring professions illuminates how using the sociological perspective can expand an understanding of compassion fatigue. Sociology’s extensive focus on how organizational configuration, structure, and process can shape human experience and behavior provides useful insights on the risk and rates of compassion fatigue that extend far beyond variations of individual characteristics (Kanov et al., 2004). Moreover, critical sociological theory provides understanding into the risk and prevalence of compassion fatigue in both organizations and economies. For instance, a long-lineage of critical sociology from Marx (House, 2017) onward has highlighted the important role that configuration of labor enironments have on the experience of depersonalization and dehumanization. Similarly, critical race and gender theories highlight the importance of understanding societal inequalities as they are reproduced in organizations (Kanter, 1977; Ray, 2015; Wingfield, 2019; Zimmer, 1988) and

| TABLE 1 Conceptualizing compassion fatigue |
|---------------------------------|---------------------------------|---------------------------------|
| **Level of focus** | **Conceptualization of CF** | **Contributions for sociologist** |
| Psychological | As a psychologically focused outcome that varies as an individual factor and caused by individual characteristics | Bringing sociological imagination to using ProQOL as both an independent and dependent variable; a focus on sociological outcomes |
| Microsociological | As an interactional consequence related to emotion work and emotional labor | Articulating how expectations for and processes of emotional labor/work produce compassion fatigue and how it varies by social location and structural inequalities |
| Mesosociological | As a consequence of social exchanges between social actors in the context of organizations and institutions | Examining how compassion fatigue is a consequence of social exchanges that vary by power and status expectations |
| Macrosociological | As a social fact, with rates that vary based on structural, macrolevel factors | Theorizing and researching organizational and structural factors that produce differing rates of compassion fatigue (dependent variable); examining consequences of high rates of compassion fatigue for organizations and social systems (independent variable) |
inform worker stress, burnout, and ultimately, workers’ ability to do “compassion” (Ruchti, 2012). Finally, sociology can contribute to the understanding of compassion fatigue by examining caring professions, and the accompanying problems contained within them, as products of broader social and economic forces. For example, changes in healthcare policy and rising costs of healthcare, and the corporatization of caring work, alter the contexts in which individuals can perform care work and certainly contribute to the conditions under which they can care.

3 | PSYCHOMETRIC MEASUREMENT OF COMPASSION FATIGUE

Much literature exploring the experience of compassion fatigue is premised on the idea that compassion fatigue is a result of professional burnout and secondary traumatic stress (Showalter, 2010). Both compassion satisfaction and compassion fatigue are assessed by versions of the Professional Quality of Life (ProQOL) measure developed by Stamm (2002, 2010). The ProQOL measure is a free, thirty-item inventory, with measures of internal construct validity, options of either self or other administration, and available in 28 languages.

Research using various versions of the ProQOL instrument has produced thousands of books, articles, manuscripts, reports, and dissertations with important contributions. The instrument has also been used to determine rates, prevalence, and severity of compassion fatigue among first responders (Benedek, Fullerton, & Ursano, 2007). The ProQOL measure of compassion fatigue is correlated with measures of dysfunctional coping strategies such as distraction and self-criticism (Cicognani, Pietrantoni, Palestini, & Prati, 2009) and self-focused moral injury (Papazoglou, Andersen, Farb, & Page-Gould, 2017) among emergency workers. It has also been used to demonstrate the negative spillover effects of compassion fatigue from professional work environment to marital quality (Finzi-Dottan & Kormosh, 2018). There is an abundance of literature on the links between compassion fatigue and other psychometric measures such as distress (Adams, Figley, & Boscarino, 2008), resiliency (Burnett & Wahl, 2015; Zeidner et al., 2013), dysfunctional coping and self-criticism (Cicognani et al., 2009; Jacobson, 2012; Udipi et al., 2008), and moral injury (Papazoglou Andersen, Farb, & Page-Gould, 2017) among others.

The ProQOL has also been used to demonstrate effective ways of reducing compassion fatigue including individual factors such as self-care, awareness, and coping (Sansó et al., 2015); and organizational factors such as welcoming workplace environment and team cohesiveness (Wu, Singh-Carlson, Odell, Rynolds & Yuhua, 2016). Other research has demonstrated the potential for clinical utility of the ProQOL (Sprang & Craig, 2015).

Yet in many ways, the utility of the ProQOL instrument and the abundance of findings have led to the undertheorizing of the concept of compassion fatigue. A main reason is that the measure does not directly assess any elements of compassion (Sinclair et al., 2017); instead the instrument focuses on measuring secondary trauma and burnout as latent predictors of compassion fatigue. As a result, the construct often gets tautologically conflated with predictors of compassion fatigue leaving discussions of the emotional and social interactional aspects of compassion largely ignored and unmeasured. There are very few studies designed to expand the concept beyond the scope of the instrument and a paucity of literature directly connecting the concept to broader institutional structures and changes.

Sociologists could expand the use of the ProQOL instrument in several ways. First, sociologists can contribute to understanding how distal structures can impact the experience of compassion fatigue. Sociologists have long used established measures of psychological constructs to focus attention on social determinants of mental health (Bartley, 2003; Trudel-Fitzgerald, 2016) and social structure and personality (Schnitckker, 2013), and the ProQOL instrument would fit well in this lineage. Second, sociologists have used established measures, such as the ProQOL to examine how rates in organizations, professions, and sectors are tied to broader social conditions of work. Rather than focusing on the value of the instrument for individual outcomes within organizations, the contribution of sociology would focus on how institutional changes affect the aggregate rates of this measure. Finally, this instrument could be incorporated as a common outcome measure for the stress process model (Pearlin, 1989;Thoits, 1995). The work of Adams, Boscarino, and Figley (2006) provides a reliable model that uses an alternative
compassion fatigue measure with validated scales used in stress process research, which we found to be a useful model for how these measures can be effectively used sociologically (see also Adams et al., 2008).

4 | ORGANIZATIONAL INTERVENTIONS FOR COMPASSION FATIGUE

The focus of compassion fatigue, as a concept, is within specific caring professions such as healthcare, social work, and emergency response (Day & Anderson, 2011). As such, there is an abundance of literature testing interventions intended to reduce the prevalence of compassion fatigue among frontline workers in these industries. A review of 13 intervention studies for compassion fatigue among healthcare, emergency, and community service workers showed mixed support for various types of interventions (Cocker & Joss, 2016).

Much of the intervention research is focused on piloting or testing assorted types of training intended to result in the reduction of compassion fatigue among employees. For instance, Tucker, Bouvette, Daly, and Grassau (2017) highlighted the need for integration of training programs into medical curricula to reduce the experience of burnout and compassion fatigue among medical students in their third year. Similarly, research on first responder training had mixed findings, with some evidence pointing to increases in preparedness and awareness training for trauma responses to reduce the experience of compassion fatigue (Craig & Sprang, 2010), while other research showed no effect of similar training on first responders’ experience of compassion fatigue (Atkins & Burnett, 2016). A review of the social worker training literature suggests a need for improving the quality of training and educational materials to reduce the prevalence of compassion fatigue (Newell & MacNeil, 2010).

Another line of research on interventions focuses on the efficacy of various organizational supports intended to reduce compassion fatigue. For instance, Adlerian therapy, focusing on internal factors related to the worker, might be a useful tool for compassion fatigue as reported from a case study example with firefighters (Garner, Baker, & Hagelgans, 2016). Bourassa and Clements (2010) found group support is efficacious for social workers experiencing compassion fatigue. Similarly, outcomes from a small survey of military health care providers who took part in a Care Provider Support Program (CPSP) reported improved resiliency and reduced compassion fatigue (Weidlich & Ugarriza, 2015). Conversely, an experimental pilot of group sessions on compassion fatigue education and self-care techniques among nurses did not facilitate the reduction of compassion fatigue using ProQOL measures (Kim & Park, 2016).

The intervention literature examines how industries can reduce compassion fatigue among their individual workers by individual and group therapy but is weak in its sociological understanding of social and structural change. In other words, the intervention literature fails to employ a sociological lens in both understanding the risk and prevalence of compassion fatigue and intervention strategies when workers are experiencing it. For example, sociologists understand how inequalities within organizations are experienced differently for individuals of various gender (Acker, 1990; Risman, 2004; Yancy-Martin, 2004), social class (Bettie, 2002; Lareau, 2003; MacLeod, 1987), and racial/ethnic (Bonilla-Silva, 2006; Pager, 2007; Ray, 2015) backgrounds, and how their various backgrounds may intersect to produce unique discrimination (Hill Collins & Bilge, 2016). This work can contribute to understanding variations in experiences of compassion fatigue and how individuals from different social locations may respond differently to compassion fatigue interventions. Sociologists have demonstrated that carework is structured by intersections of gender, class, and race (Ruchti, 2012).

Sociologists can also contribute to the development of more nuanced interventions based on this knowledge. Fruitful work here would parallel the successful pilot intervention of structurally embedding crisis intervention social workers within fire departments to respond to emotional needs of others in emergency response situations (Cacciatore, Carlson, Michaels, Klinek, & Steffan, 2011). Interventions would also take into account the variations in the social locations of workers in organizations being studied.

Perhaps more importantly, sociologists can focus attention on deeper changes and interventions to organizational life that can alleviate compassion fatigue (Kanov et al., 2004).
Employing the sociological perspective means moving the framing of compassion fatigue from a personal trouble to a public issue. Compassion fatigue is experienced personally and privately, but it is influenced by interpersonal dynamics and shaped by structures in which individuals are embedded. High rates of compassion fatigue also have potentially pernicious consequences for society or an organization at large (Erickson, 1978). As illustrated above, the existing compassion fatigue literature does not focus on interactions or organizational structures but on individual personalities and how individuals negotiate jobs that require they care for others in organizations that might be more prone to compassion fatigue. Unfortunately, this approach assumes a constant effect of structure and attributes variations in compassion fatigue exclusively to variations in individual factors. A sociological approach, on the other hand, would search for variations in structures that produce different rates of compassion fatigue.

Sociologists can contribute, therefore, to a broader understanding by illustrating that compassion fatigue is a social fact. Sociologists can also further explore compassion as a social emotion, which occurs in specific contexts, and requires an object for which to have compassion (Kemper, 1987). Compassion fatigue evokes emotion rules and norms in particular social contexts (Hochschild, 1979). Finally, “compassion” implies a relationship of exchange (Homans, 1946) and “fatigue” suggests the balance of exchange has been disrupted (Clark, 1987). We will elaborate on each of these potential sociological contributions to the compassion fatigue literature.

Compassion fatigue can be well explained at the intersection of biography and history (Mills, 1959). It is no surprise the concept of compassion fatigue has emerged in an era of exacerbated stress, individualism, hyper-competition, and fear, all of which run counter to the goals of the human service industry, but which are creeping into the industry as it corporatizes. Inadvertently, the literature is already pointing to the organizational and structural nature of compassion fatigue, and sociologists can push these ideas further by considering compassion fatigue as a macrolevel social fact, rather than a trait or condition of individuals. Sociology has a long tradition of using this formula for other phenomenon previously conceived as individualistic, from suicide (Durkheim, 1897) to making decisions to engage with civic society (Putnam, 2000) to developing fears about the workplace or public life (Glassner, 2010). Adopting this approach induces scholars to theorize about factors that produce higher and lower rates of compassion fatigue, as opposed to theorizing individual etiology. Doing so leads to an emphasis on structural factors that increase the percentage of individuals who experience compassion fatigue, as opposed to “psychologizing” compassion fatigue, which puts the burden to change on individuals (Mills, 1959). When particular social systems have high rates of compassion fatigue, interventions should be designed to change the prevailing structural conditions.

Current compassion fatigue literature grazes the topics of structural inequality and sociologists have the tools to make more direct contributions by adopting a macro perspective of the concept. For instance, sociologists understand how structural inequalities shape the nature of human service work, including the power and status dynamics of public interactional exchanges between clients and providers (Bonilla-Silva, 2006, Feagin, 1991, Ruchti, 2012). Similar patterns of age, gender, sexual orientation, and other social statuses are embedded in organizational and societal structures and shape our emotional and social lives, which extends to our giving and receiving of compassion (Kemper, 1987). Clearly, the burden of providing compassion to others falls more heavily on some social groups than on others, based on social location and prevailing inequalities (Fields, Copp, & Kleinman, 2006). Other structural factors pattern public interest in expressions of compassion such as the cyclical timing of holidays in western culture (Bunis, Yanick, & Snow, 1996).

It is likely that compassion fatigue was formulated and studied in the professional human services rather than the financial sector or manufacturing industry because human services work includes rules and norms around giving compassion. Moreover, human service organizations likely suffer from organizational and macrolevel failures that
cause the deficits of relational exchange that become defined as compassion fatigue. Sociologists have focused on a critical analysis of structural and organizational deficits in human service fields that include the negative impact and biases within patient/client satisfaction surveys (Lawrence & Keleher, 2004; Ray, 2018; Ruchti, 2012), structural pressure from dwindling public financial support (Bandelj, Shorette, & Sowers, 2011; Harris, 2004; Smith, 2012), and the impact of increases in clients/caseloads (Ruchti, 2012). In general, organizations, sectors, and institutions structures, define the context for compassion fatigue including the roles, rules, and processes that comprise its antecedents and sequelae. Sociologists are equipped to study these and contribute to the understanding for how context matters for the frequency of expression and experience of compassion fatigue as a social fact.

As a concrete example of a macrolevel approach to theorizing about compassion fatigue, Merton’s (1949) classic theory of anomie can be adapted. Although Merton applied his theory to American society at large, it can be applied to other social systems as well, such as organizations. Or, it can be applied differently by invoking goals, other than economic, material ones. Given this preface, social systems—including organizations—that socialize members into compassion work or emotional labor should also socialize them into the legitimate means and supports for conducting that work. If social systems over-emphasize the goals of requiring compassion work and/or under-emphasize or fail to support the appropriate ways to engage in compassion work, the disjuncture between the compassion/emotion work goals and means will increase, which will increase the rates of compassion fatigue. Also, similar to the notion of blocked opportunities, if certain social groups are not properly supported or given access to resources necessary to engage in compassion work, then the rates of compassion fatigue in those social groups will likely be higher. Conceptualized this way, compassion fatigue is a manifestation of anomie, which was defined by Merton as the degree of disjuncture between the legitimate goals and means in a social system.

As another example of macrolevel theorizing, Durkheim defined social integration as the number and strength of social ties in a social system (Durkheim, Catlin, Mueller, & Solovay, 1938). Durkheim contended that social systems that are high in social integration will have lower rates of deviance, including suicide. Similarly, following Durkheim, we hypothesize that social systems that have higher levels of social integration will have lower rates of compassion fatigue (compassion fatigue as a dependent variable). The individuals in highly integrated organizations or social systems will have shared values and norms regarding the importance and modality of providing compassion, thereby helping to buffer the stress of delivering compassion. For a specific example, academic departments that have high levels of social integration will have lower rates of depersonalization, burnout, and compassion fatigue when working with challenging students than those that are disintegrated. Another example would be a study of a range of healthcare organizations ordered by level of social integration. Importantly, these organizations include expectations that care is delivered to clients with compassion and empathy. A sociological hypothesis is that the lower the level of social integration, the higher the percentage of workers that would display compassion fatigue. In turn, high rates of compassion fatigue can have disruptive effects on an organization or social system at large, not just on the individuals within those systems (compassion fatigue as an independent variable).

7 | COMPASSION FATIGUE AS A SOCIAL EMOTION

Structural inequalities shape expression, suppression, and exchange of emotions (Fields, Copp, & Kleinman, 2006), including the production of compassion between employees and clients. Actors have to work collaboratively to produce compassion since it is a social emotion (Thoits, 1989). Sociologists have developed an extensive literature on how individuals manage and present their emotions as desired in particular social contexts (Hochschild, 1979). According to Hochschild (1979, 1983), emotional presentations are governed through “feeling rules” that dictate types of feelings that a person should have as well as the level of intensity, direction, and duration of those feelings. Sociologists’ knowledge in this domain could deepen a scholarly understanding of compassion fatigue.

Sociologists can link compassion fatigue more closely to the sociological literature on emotion work (Hochschild, 1979, 1983). Scholars have applied the concept of emotional labor to describe the required
interactional work of employees in service occupations such as nurses (Bolton, 2001; Ruchti, 2012; Cottingham, Erickson, & Diefendorff, 2015), mid-wives (Hunter, 2005), sex workers (Vanwesenbeeck, 2005), and call center employers (Deery, Iverson, & Walsh, 2002). Organizational researchers have also used the concept of emotion work in their analyses of professional occupations such as magistrates (Anleu & Mack, 2005), actors (Orzechowicz, 2008), lawyers (Pierce, 1996), and counselors (Yanay and Shahar, 1998) to show emotional labor is an aspect of the job that can lead to negative effects such as job attrition and burnout. This literature is closely connected to the compassion fatigue literature (see Wharton, 1993 for a full analysis).

Family studies researchers have employed the concept of emotion work in explaining the role of the family caregiver (Mac, 1998), in the study of marital relationships and the division of household labor (Erickson, 2005), marital quality (Erickson, 2005), links between family and work (Wharton & Erickson, 1995), and family decision making (Adams, 2004). These studies illuminate the importance of emotion work in the maintenance of power structures within family systems. This research could be extended to show how power dynamics contribute to compassion fatigue in work environments as well.

Other literature includes a focus on the types of emotion work strategies such as cognitive, physical, or spiritual (Albas & Albas, 1988), managing the emotions of others (Cahill & Eggleston, 1994; Thoits, 1996), emotion work in dyads (Smith, 2008), and in groups (Wolkomir, 2001). Studies like these suggest, as Fields, Copp, and Kleinman (2006) have, that emotion work can reproduce inequality through interactions. From these studies we can infer that emotion work is a factor for those in weaker positions in organizational hierarchies. Studies of how frontline human service workers experience compassion fatigue because of their interactions with higher level employers and clients who need care can illuminate how power dynamics contribute to compassion fatigue in certain work contexts.

Compassion fatigue, as a concept, is prevalent within specific industries and professions such as health-care, social-work, and emergency response (Day & Anderson, 2011) whereby expressions of compassion are guided by formal emotion rules and norms (Hochschild, 1979; Wolkomir, 2001). Sociologists have already contributed extensively to understanding the emotion work of compassion. For instance, Dutton, Workman, and Harding (2014) focus attention on the processes of experience and expression of compassion in work organizations. Much like Smith and Klienman’s (1989) work highlighting the absence of emotional socialization in medical school curriculum, compassion fatigue is linked to organizational gaps in socializing employees to the emotional nature of human service work. There is also a recognition that the difficult emotional labor of compassion is built directly into much of human service labor without recognition or renumeration (Kolb 2011, 2014). A research agenda using compassion fatigue sociologically should encompass questions that examine how compassion fatigue is a social process, byproduct of, or outcome from emotional work and emotional labor.

8 | SOCIAL EXCHANGE AND COMPASSION FATIGUE

Because compassion happens in social exchanges, compassion fatigue can also be theorized as a potential component of worker/client interactions. For example, in one study, researchers found therapists were affected on an emotional level by their work. Specifically, they experienced counter-transference, which can occur when the intensive emotional work of a therapist helping a client through pain can cause an emotional drain on the therapist (Marriage & Marriage, 2005).

Compassion fatigue is similar to countertransference and manifests in both short and long-term relationships in human service work. However, rather than focus on the individual experience, as literature on countertransference does, social exchange theories (Cook & Rice, 2003) can help explain what happens when human service workers and their clients enter into relationships that require exchange and how compassion fatigue develops within and because of these exchanges (Lawler, 2001).

There is a cost of caring for professional human service workers because there is an imbalanced emotional exchange between provider and recipient. As Clark (1987) showed, exchange of sympathy and compassion in
everyday social interaction are reciprocal, but in human services, compassion exchanges are not. Instead, the burden of compassion falls on the provider and can potentially lead to a strain in exchange relations (Cook & Rice, 2003; Kolb, 2014). The national opioid crisis illuminates the unbalanced emotional exchange between human service providers and clients. For frontline workers especially, emotional exchanges are often not only asymmetric but have also been confrontational as clients resist services, arrest, and even life-saving care. Not only are providers not receiving reciprocation from clients, they are also expected to carry the emotional burden of caring for clients and patients with a high level of needs. Likely, the providers often become frustrated with clients who resist behavior change, which can also lead to mistreatment and degradation of clients overtly and, in the backstage (Goffman, 1959). The nature of human service work can include the provision of services under conflicting moral, social, legal, and medical obligations. Likewise, human service providers may also experience conflicting emotion norms and rules for their responses (Lawler, 2001). For example, recent journalism on the frontline response work of the opioid crisis illustrates limitations in organizationally defined practices, policy, or structures to meet the emotional demands of the human service work (Hailer, 2018).

The cost of caring imbues an imbalance in the exchange between provider and recipient. The burden of this exchange falls on the provider. “Power inequality creates strains in exchange relations and provides an impetus toward structural changes...” (Cook & Rice, 2003, p. 68). In a provider/recipient relationship, power is most definitely unequal. The recipient is in need of a service from the provider. The provider is in a position of power to meet this need. The expectation of the exchange is that it will be unbalanced. A natural cause of compassion fatigue is the work itself, which involves a nonreciprocal exchange in a context where providers also do not seem to have their emotional needs met by the organizations. In general, organizational processes are important in understanding compassion fatigue, and they go beyond the direct client/practitioner exchanges to more indirect forms of exchange. For example, we would predict that imbalances in direct and indirect exchange of emotion would lead to a higher likelihood of compassion fatigue in individuals or groups with lower levels of power within the exchange relationships. Specifically, we would predict that regardless of gender and race, nurses will have higher rates of compassion fatigue than physicians because of their lower status within healthcare organizations. Moreover, we would predict that women physicians will have higher rates of compassion fatigue than male physicians because of gendered expectations regarding carework. Another example would be in academic institutions, women professors perceive a higher obligation to display compassion and engage in emotional exchanges with their students than male professors because of gender expectations (Ridgeway, 2009). Therefore, we would hypothesize that women faculty will have higher levels of compassion fatigue than male faculty because of these structural inequalities and power imbalances. Importantly, sociologists have ways of formalizing exchanges, focusing on the process of organizational interactional exchanges, and using a lens of intersectionality, which enable us to see how compassion fatigue happens both in interactions with providers and clients and in the providers’ interactions within their organizations.

9 | CONCLUSIONS

Compassion fatigue, studied extensively in caring occupations, has primarily been studied and framed as a "personal trouble" rather than an issue that transcends the individual. Using sociological insights to enhance the psychological understanding of compassion fatigue helps to illustrate compassion fatigue as a social fact, a social emotion, and as occurring in subtle ways in a variety of social contexts and exchanges. As Table 1 presented in the introduction shows, compassion fatigue can be conceptualized as both a psychological and a sociological construct and can be applied at the microlevels, mesolevels, and macrolevels.

At the psychological level of focus, compassion fatigue can be conceptualized as an outcome that varies across individuals and is caused by individual characteristics such as levels of burnout and unresolved secondary trauma. Sociologists can contribute here by bringing our understanding of the sociological imagination to provide insight
into how distal structures impact rates of individual level compassion fatigue. At the microsociological level, compassion fatigue can be conceptualized as an outcome of patterned interactional processes. Sociologists can contribute here by articulating how compassion fatigue is produced through processes such as emotional labor and how inequalities and social locations vary these processes. At the mesosociological level, compassion fatigue can be conceptualized as resulting from exchanges between social actors in organizations and institutions. Sociologists can contribute by examining how compassion fatigue is a consequence of certain types of social exchanges that vary by power and status expectations. Finally, at the macrosociological level of focus, compassion fatigue can be conceptualized as a social fact, with rates that vary based on structural, macrolevel factors. Contributions here can be made by sociologists through research on organizational factors that produce differing rates of compassion fatigue and examine consequences of high rates of compassion fatigue for organizations and social systems.

Sociology has a long tradition of theorizing about social interaction and social structures beyond an exclusive focus on individuals. For example, poverty is understood by many as a consequence of individual choice and behavior, whereas sociology locates the genesis of poverty in social inequality and social structures. Using the sociological conceptualization of compassion fatigue is compassionate because it enables individuals to understand they are not the cause of their own fatigue; rather the genesis of fatigue is located in the social inequalities and structures of organizations and social systems. A sociological approach can follow different avenues—micro, meso, and macro—the exploration of the compassion fatigue in any of these ways is what is important.

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