Compassion towards clients: Providing conceptual clarity and a test on its damaging effect on frontline workers

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Abstract

Despite its argued importance for the quality of public service, compassion is not yet an integrated research topic in public administration. The main purpose of this study was to gain more understanding on what frontline workers' compassion towards client entails. It did so by first providing conceptual clarity on frontline workers' compassion towards clients, and, second, by testing the damaging effects of experiencing compassion towards clients on the wellbeing of frontline workers. Using a factor analysis with data collected on social workers through a survey (n = 849), this study showed that compassion is a distinct emotion from emphatic distress, and that compassion has two underlying dimensions: emphatic concern and compassionate motivation. Second, the study points out that the dimensions of compassion have opposite effects on a frontline worker's wellbeing: while compassionate motivation is negatively related to emotional exhaustion, emphatic concern is positively related to emotional exhaustion and mediated by working overtime to help clients. Altogether, this study showed that compassion is a more complex construct and potentially damaging emotion than is often proposed and hopes to encourage fellow researchers to continue to gain more understanding on compassion and its essential role for the public service and for the effect it can have on the wellbeing of frontline workers.

Introduction

Frontline workers such as police officers, social workers and physicians are confronted with clients who often reach out in a time of need and distress (Lipsky 2010) and are assigned to deliver the adequate service needed (Zacka 2017). During this public service delivery, scholars emphasize the importance of frontline workers experiencing compassion towards their clients (e.g. Eldor 2018; Strauss et al 2016) as compassion is believed to contribute substantially to the quality of public service (e.g. Hsieh, Yang and Fu 2011). Compassion is understood as the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help and alleviate suffering (Goetz, Keltner, and Simon-Thomas 2010). Compassion is treated as one of the public service values (Kernaghan 2003) and it is argued that it should be emphasized as such in the public service ethos (Hsieh Yang Fu 2011). Compassion would, for example, bring frontline workers closer to their clients and allow them to establish a connection with them (Cassel 2002).

Despite its argued importance for the quality of public service, public administration scholars have rarely pursued the concept of compassion as a research end itself (Eldor 2018), although it has been gradually incorporating emotive aspects such as emotional labor (e.g. Guy and Newman 2013) or emotional intelligence (e.g. Vigoda-Gadot and Meisler 2010) into its theorizing. Public administration scholars that do make use of the concept of compassion often relegate it to a mere supporting role in which the concept remains undefined and unexplored (Eldor 2018). An illustrative example of this can be found in the literature on public service motivation (PSM), in which compassion is treated as one of the dimensions underlying it (Perry 1996). When going through the PSM literature, it becomes apparent that scholars use compassion as one of the underlying dimensions to measure PSM, but do not go into what compassion entails or how it should be measured. The limited role of compassion in the public

administration literature is quite surprising given that values as sensibility, respect and responsiveness are becoming more of a priority to public service organizations (Kernaghan 2011; Vigoda-Gadot and Meiri 2008; Hsieh 2014), together with an increased focus on ethical guidelines including values as caring, tolerance and humanity (Kernaghan 2003; Christensen and Lægreid 2011) – all values that are inherently embedded in compassion (Eldor 2018). Gaining more understanding on what frontline workers' compassion towards their clients entails, is thus an important research path to follow – and this is where this study comes in.

The first goal of this study is to provide conceptual clarity on the concept of compassion, which is needed because of the current lack of consensus on its conceptualization and operationalization (Klimecki and Singer 2011). A large source of this unclarity stems from the often-overlooked distinction between compassion and emphatic distress. Both are understood to be types of an individual's emotional response to anticipated or observed suffering (Lamothe et al. 2014). Compassion entails a cognitive differentiation between the other and yourself and a feeling of emphatic concern, which subsequently leads to the motivation to help alleviate the suffering of others (Klimecki and Singer 2011). Emphatic distress on the other hand entails a process whereby the self-other distinction becomes blurred as the observer is overwhelmed by the experience of negative emotions (Gilbert et al. 2017; Goetz et al. 2010), leading to feelings of personal distress and attempts to withdrawal from helping the sufferer (Klimecki and Singer 2011). Confusing compassion and emphatic distress could have problematic consequences for a frontline worker and the quality of the service s/he provides, as the first leads to the desired behavior of wanting to help and the second to the non-desired and even troubling behavior of wanting to withdrawal from helping. Another reason for why it is important to distinguish between compassion and emphatic distress is to prevent future research on compassion from having distorted outcomes when emphatic distress and compassion are confused. While some

scholars are starting to recognize the difference between compassion and emphatic distress (Goetz et al 2010; Atkins and Parker 2012), many do not differentiate between them, or seem to confuse the terms. Therefore, as stated above, the first goal of this study is to provide conceptual clarity on compassion and its difference with emphatic distress. It will do so by using an explanatory (n1 = 427) and confirmatory (n2 = 422) factor analysis, which allow for the investigation and comparison of the psychometric properties of both concepts.

The second goal of this study concerns the effect of compassion on the wellbeing of frontline workers. As described earlier, compassion is believed to contribute to the quality of public service. Based on this, it would be logical for public service organizations to be recruiting frontline workers with high levels of compassion and should stimulate it in employed frontline workers. However, it is also plausible to believe that compassion has a negative effect on the wellbeing of frontline workers. The reason for this is that the possibility of being able to help clients is not always present during public service delivery, which can lead to discouragement, frustration and burnout (Kjeldsen and Jacobsen 2012; Van Loon et al. 2015). The difficulty of helping clients is especially apparent in public service context. Due to red tape (Kjeldsen and Jacobsen 2012) and extensive workloads (Tummers et al. 2015) frontline workers may not always have the resources to help clients (Zacka 2017). In addition, many frontline workers are employed at people-changing organizations, which are known for their difficulty in regard to indicators of change and their difficulty in seeing any real signs of success (Carlson 1979; Hasenfeld 1983). The painful reality of experiencing compassion and the associated motivation to help clients, but not being able to do so or failing to see results, can take its toll (Kjeldsen and Jacobsen 2012) and lead to emotional exhaustion. In addition, frontline workers might believe that by investing more time in helping clients, they can provide them with the adequate support to see signs of success. This can result in working overtime to help clients; a behavioral

coping mechanism in which frontline workers cope with stress by using their own time to benefit clients (Tummers and Musheno 2015). However, this coping strategy could lead to even more emotional exhaustion as it might lead to an overreaching of mental and physical resources (Van Loon 2015) and to additional frustration, as the efforts made by working overtime to help clients will not necessarily be rewarded.

It is important to focus on these potential damaging aspects of compassion, as prior studies almost solely focus on the beneficial effects of compassion. Those studies link compassion towards clients to beneficial wellbeing outcomes such as improved well-being and mental health (e.g. Frederickson et al. 2008; Singer and Klimecki 2014). However, as argued above, compassion can be psychologically damaging when the goal of helping a client cannot be achieved. Protecting public servants from these potential costs of compassion is be especially important given the high level of burnout of many public servants in the public service workplace (Eldor 2018). The second goal of this study is thus to answer the following research question: 'What is the effect of compassion on emotional exhaustion for social workers, and how does working overtime to help clients mediate this relationship?' It will do so by using structural equation modelling (SEM) (n = 828).

The structure of this study is as follows: first, the state of the art of compassion research will be discussed together with the potential damaging effects of compassion for frontline workers' wellbeing. After that, the method will be presented, followed by the results section. The paper concludes with a discussion of the findings, limitations and suggestions for possible future research directions.

Theoretical framework

Compassion literature: Main findings and limitations

Compassion is conceived as of a set of subprocesses that lead to an individual having certain emotions towards a person who is suffering. In turn, these emotions motivate the individual to act and help the person suffering. This is similar to the way that other scholars see compassion. For example, Lazarus states that "The core relational theme for compassion is being moved by another's suffering and wanting to help" (1991, p. 289). Similarly, in a major systematic review of compassion, Goetz et al. (2010) describe compassion as an emotion and define it as "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" (p. 351).

Despite this conceptualization there is lack of consensus on its exact definition and on its operationalization (Strauss et al. 2016). A large source of unclarity comes from the often-overlooked distinction between compassion and emphatic distress. Both are types of an individual's emotional response to anticipated or observed suffering (Lamothe et al. 2014; Penner et al. 2008). The commonality between compassion and emphatic distress is that they refer to processes in which an individual emotionally responses to another's emotional or physical state (Batson 2017). However, they are distinct emotions towards another's suffering and are based on different cognitive, affective and behavioral components. Table 1 provides an overview of their differences.

Table 1. Emphatic distress versus compassion

	Emphatic distress	**Compassion**
Cognitive component	Self-perspective • Self-other merging • Poor emotional regulation (no or low distress tolerance)	Other-perspective • Self-other distinctiveness • Emotional regulation (distress tolerance)
Affective component	Personal distress • Self-related emotion • Feelings of discomfort, tension, anxiety	Emphatic concern • Other-related emotion • Feelings of warmth
Behavioral component	Feelings of wanting to withdrawal from helping	Motivation to engage in the suffering and help to alleviate it

The cognitive component involves the perspective a person takes towards another person's suffering. Emphatic distress starts from a self-perspective as one is overwhelmed by the vicariously induced negative emotions that are threatening the self (Klimecki and Singer 2011). One thus more or less identifies with the suffering of others by adopting another's emotional state (Klimecki and Singer 2011). Emphatic distress and the lessened self-other distinction are linked to poor emotion regulation, where one is not able to regulate the distress of another (Decety and Lamm 2009; Eisenberg et al. 1994). When experiencing compassion, an individual is aware that it is the other person who is suffering, and thus involves an 'other-oriented focus' (Eisenberg et al. 2015). The other-oriented focus of the compassionate response is said to prevent the social worker from identifying with the sufferer (Klimecki and Singer 2011). The realization of being different from the suffering person without being indifferent towards him or her enables in turn the development of prosocial behavior (i.e. intent to benefit others) (Klimecki and Singer 2011).

The affective component concerns the distinct emotional states belonging to compassion and emphatic distress. Emphatic distress involves personal distress accompanied by feelings of discomfort, tension and anxiety as one is overwhelmed by the vicariously induced negative

emotions threatening the self (Klimecki and Singer 2011; Davis 1994). Emphatic distress is a rather self-related emotion. Compassion involves emphatic concern accompanied by feelings of warmth towards another's suffering (Klimecki and Singer 2011) and thus involves an other-related emotion. For example, Sarah would experience personal distress if she shares the grief of her friend, Helen, whose husband had recently died. Sarah would experience emphatic concern if she, instead of sharing Helen's grief, feels concerned for Helen's well-being (Omdahl and O'Donell 1999). In short, it can be said that compassion entails feeling *for*, and emphatic distress entails feeling *with* the other (Singer and Klimecki 2014).

The behavioral component concerns the difference in the behaviors related to emphatic distress and compassion. The perspective that emotions lead to behaviors aligns with contemporary functional views of emotions; "emotions not only make us feel something, they make us feel like *doing* something" (Gross and Thompson 2007, p. 5). Several studies have pointed out that people who experience compassion show more helping behavior than those who experience emphatic distress (Eisenberg 2000; Batson 2009; Lamm et al. 2007). When one experiences emphatic distress, s/he will most likely try to reduce these damaging feelings and attempt to withdraw from the difficult emotional situation - even if that means losing the opportunity to provide help (Klimecki and Singer 2011). Therefore, emphatic distress is accompanied by the desire to withdraw from a situation in order to protect oneself from excessive negative feelings (Singer and Klimecki 2014). Compassion, on the other hand, involves feelings of motivation to help the sufferer (Kanov et al. 2004; Goetz, Keltner and Simon-Thomas 2010). The feeling of being concerned for a suffering person is thus accompanied by the motivation to relieve this suffering.

Despite the different cognitive, affective and behavioral components underlying compassion and emphatic distress, many authors do not make an explicit distinction between them or seem to confuse the terms. An example of this confusion can be found in the literature on compassion fatigue. This term is used to describe emotional, physical and social exhaustion overtaking a person and causing a decline in his or her desire and ability to feel and care for others (McHolm 2006). The term compassion fatigue was first used by Joinson (1992) in a nursing journal to describe situations where nurses had either turned off their own feelings or experienced helplessness and anger in response to the stress they felt watching patients go through devastating illnesses or trauma. Compassion fatigue is said to occur when one closely identifies with another and absorbs the person's trauma or pain (McHolm 2006). This indicates that compassion fatigue involves the adoption of another's emotional state. This is part of the cognitive component underlying emphatic distress, and not compassion. The term compassion fatigue is thus quite misleading since it suggests that caregivers are tired of too much compassion, when it seems like they are actually referring to caregivers being affected by emphatic distress. One could even say that the term compassion fatigue describes a state of reduced capacity for compassion as a consequence of being exhausted from absorbing the suffering of others (Sabo 2006). For this reason, authors have started to suggest a change in terminology to emphatic distress fatigue rather than compassion fatigue (Klimecki and Singer 2011; Dowling 2018).

Another stream of literature where emphatic distress and compassion seem to be confused is that of public service motivation (PSM). Together with attraction to public policy, commitment to the public, and self-sacrifice, compassion makes up the multidimensional construct of PSM (Perry 1996). Many authors writing on PSM build on the definition and operationalization of Perry (1996), who views compassion as an emotional response and identification with others

that acts as a driver and motivates individuals to help others (e.g. van Loon 2016). However, as argued above, the identification with others belongs to the cognitive component underlying emphatic distress. Subsequently, the identification with others will not act as driver to help others but will lead to a feeling of wanting to withdrawal from helping. Furthermore, the original PSM scale developed by Perry (1996) contains the item on compassion "It is difficult for me to contain my feelings when I see people in distress", which seems to be more of a measure on emphatic stress than of compassion, as compassion is accompanied by a certain distress tolerance. It is therefore seems like many scholars writing on PSM confuse compassion with emphatic distress.

Following the argument given above, it seems clear that there is conceptual unclarity between emphatic distress and compassion as they are often seen as the same construct or are mixed. This study argues that they are distinct emotions towards another's suffering, with different underlying cognitive, affective and behavioral aspects. For frontline workers, it is thus expected that experiencing compassion and emphatic distress are distinct emotions of a frontline worker towards a client's suffering. This leads to the following hypothesis.

> **H1**: Compassion and emphatic distress are distinct emotions towards the suffering of clients.

Potential damaging effects of compassion

Because of the defining characteristic of frontline work of direct contact with citizens (Zacka 2017), frontline workers do not only have the opportunity to have immediate impact on citizens lives (Lipsky 2010) but are also able to witness firsthand the impact of their actions (Zacka 2017). Their impact may be of several kinds, such as determining eligibility of citizens for

government benefits and sanctions or overseeing the treatment citizens receive in service programs (Lipsky 2010). In this context, experiencing compassion can have beneficial outcomes on the wellbeing of frontline workers as it can be fulfilling when the motivation or goal to alleviate one's suffering can be achieved. This feeling is also described as compassion satisfaction (Stamm 2010). However, it is also plausible to believe that compassion has a damaging effect on the wellbeing of frontline workers because the chance to help clients is not always present during public service delivery, which in turn might lead to discouragement and frustration (Kjeldsen and Jacobsen 2012).

The difficulty of helping clients is especially apparent in public service context, as frontline workers may not always have the resources to help clients due to red tape (Kjeldsen and Jacobsen 2012) and extensive workloads (Tummers et al. 2015). In addition, many frontline workers are employed at people-changing organizations, which are known for their difficulty in regard to indicators of change and their difficulty in seeing any real signs of success (Carlson 1979; Hasenfeld 1983). The term people-changing organizations was first coined by Hasenfeld (1983) and is used to describe human service organizations with the aim to change the behavior of citizens (e.g. schools, hospitals and prisons). In addition, actual alleviation of suffering is not always possible in people-changing organizations. This could be due to the unwillingness of the client or when change is dependent on factors outside the control of the social worker or the client (Hasenfeld 1983). Not being able to know, with any certainty, if and when you are succeeding can lead to anxiety, stress and frustration (Carlson 1979). The painful reality of being motivated to help clients but failing to see results can take its toll and lead to emotional exhaustion.

Altogether, frontline workers' compassion and its strong motivation to help clients but failing to see results, can result in stress. The existing literature focusing on how frontline workers deal with the stress related public service work has introduced several coping strategies. Building on work of Lazarus (1966), Lipsky (2010; 1980) invoked the concept of 'coping' to understand how frontline workers deal with the stress related to their public service work. Since then, many scholars have studies coping during public service delivery (e.g. Maynard-Moody & Musheno 2003; May and Wood 2003). Coping during public service delivery is defined as the "behavioral efforts frontline workers employ when interacting with clients, in order to master, tolerate or reduce external and internal demands and conflicts they face on an everyday basis" (Tummers et al. 2015, p. 5). Examples of coping mechanisms are routinizing, cynicism towards work or gaining social support from colleagues (Tummers et al 2015).

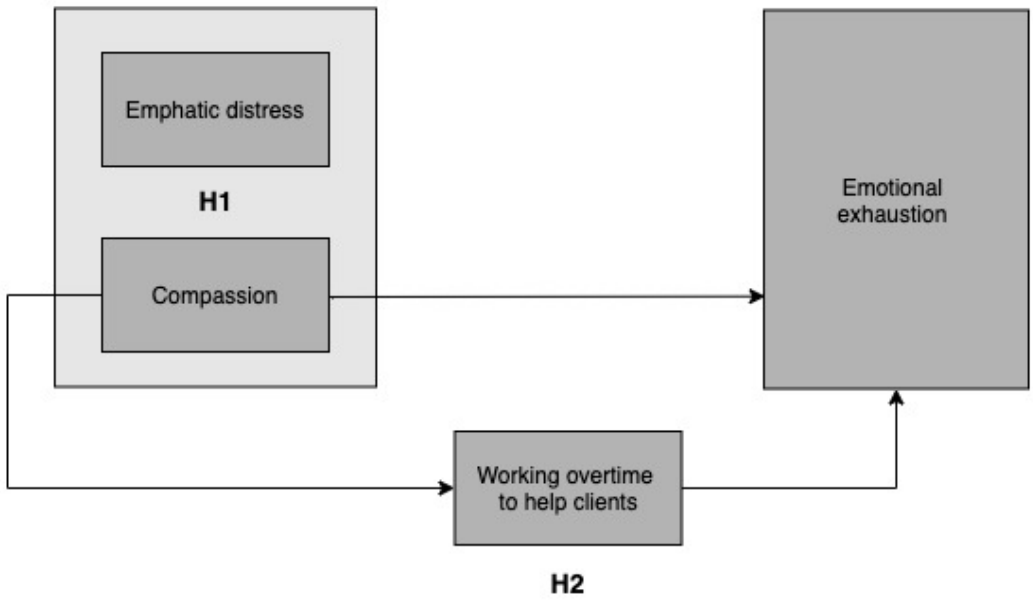
One type of coping mechanism for dealing with the stress resulting from the strong motivation to help clients but failing to see results, could be working overtime to help clients. Working overtime is described as a coping-strategy whereby workers cope with work stress by using their own time to benefit clients (Tummers and Musheno 2015). Frontline workers might believe that by investing more time in helping clients, they can provide them with the adequate support and see signs of success. However, it is expected that working overtime to help clients might not be an effective coping strategy as it leads to 1) an overreaching of mental and physical resources (Van Loon 2015) and 2) more frustration as the efforts made by working overtime to help clients will not pay off. In this way, working overtime might partly explain the positive relationship between compassion and emotional exhaustion.

This leads to the following hypothesis:

> **H2:** Working overtime to help clients mediates the positive relationship between a frontline worker's compassion towards clients and emotional exhaustion.

The hypotheses are graphically represented in the conceptual model of Figure 1.

Figure 1. Conceptual model



Methods

Research setting

To test the hypotheses, social workers were studied at a large (> 7000 employees) nonprofit social work organization in The Netherlands. The social workers employed at this organization provide direct care to clients and hold functions such as doctors, youth workers, psychiatrists, nurses and mental health counselors. The core task of the organization is to provide help to all those who call on them for it. Care is thus provided to clients with a variety of needs (e.g. those that are struggling with psychiatric problems, drug addiction, or poverty). Furthermore, the

organization has a Christian identity and each social worker identifies themselves as Christian. Their work methods are based on the Christian faith and adhere to values as justice and solidarity.

The social work organization is an appropriate context for testing the hypotheses for three main reasons. Firstly, social workers are understood as classic frontline workers (Lipsky 2010; Maynard-Moody and Musheno 2003; Zacka 2017) because of the structure of their everyday work at the frontline of public service, such as their direct interaction with clients and margin of discretion (Zacka 2017). Second, despite it being a nonprofit organization, the social work organization is almost exclusively funded by public money, and their work resembles the practice of many social workers in public social work organizations. A nonprofit organization providing a public task like this is currently very common (Zacka 2017). The reason behind this is that due to public sector reforms like New Public Management (NPM), privatization, decentralization and outsourcing, public tasks are not only performed by public organizations, but lie at the intersection between public and private, for-profit and nonprofit sectors (Thomann, Hype, and Sager 2016). Thirdly, the social workers within this organization are part of a people-changing context, as the nature of the needs of the clients reflect a difficulty in measuring indicators of change or success.

Data Collection Strategy

Data was collected through a survey. Together with an HR-manager of the organization, all social workers who have direct contact with clients were identified. The organization consequently offered the opportunity to survey each social worker that has direct client contact (N = 4128). A survey was distributed in May 2020 through the internal e-mail of the social work organization, and a reminder was sent after a week. In the introductory text, the purpose

of the study was stated, the researcher was introduced, and it was explained that participation is voluntary. Also, it was stated that anonymity of responses will be secured. This was done to assure valid responses to the questions (Singer 1978) and to adhere to the current privacy law (GDPR). The e-mail address of the researcher of this study was provided for questions and comments on the survey.

A total response rate of 26.6% was achieved (n = 1099). 17 respondents did not give consent for participating on the survey after clicking on the survey link, and a total of 233 respondents were excluded from analysis because they filled in less than 50% of the questionnaire. After these considerations, the total sample consisted of 849 respondents. Of these 25.6 percent were male and 74.4 percent female. Of the respondents, 7.2 percent were younger than 24, 35.7 percent were between 24 and 34 21.9 percent were between 34 and 44, 16.6 percent between 45 and 54, 17.5 percent between 55 and 65, and 1.1 percent is above 65. For 1.8 percent of the respondents, high school or lower were their highest education level. 24.8 percent had an intermediate vocational education degree (MBO in Dutch), 64.7 percent had a higher vocational education degree (HBO in Dutch) and 8.7 percent had a university degree. Respondents' total number of years as a social worker ranged between a quarter of years to 48 years (M = 11.39, SE = 9.59). Their number of hours of client contact in a week ranged from 1.5 hour to 40 hours in a week (M = 24.2, SE = 7.3). Table 2 gives an overview of the characteristics of the sample and of the population. This shows that, for gender and age, the sample is representative. No data was available for the population's education level, number of years as a social worker and number of hours of client contact in a week, and its representability can thus not be checked.

Table 2. Sample and population characteristics

	Sample (n = 849)	**Population**[i]
Gender		
Male	25.6%	26%
Female	74.4%	74%
Age		
<24	7,2%	9%
24-34	35,7%	34%
34 – 44	21,9%	22%
45 – 54	16,6%	18%
55-64	17,5%	20%[ii]
>65	1.1%	
Education level		
High school or lower	1.8%	NA
MBO	24.8%	
HBO	64.7%	
WO	8.7%	
Number of years as social worker	11.4	NA
Number of hours of client contact in a week	24.2	NA

Note: No data was available on the population's education level, number of years as social worker and number of hours of client contact in a week

[i] Population data includes all employed social workers with direct client contact working for the studied social work organization

[ii] Includes >65

Measures

The four key variables in this study are compassion, emphatic distress, emotional exhaustion and working overtime to help clients. Before distributing the survey, it was tested on its fit with the context. This was be done by going over the survey with five social workers from the organization studied. This led to the adjustment of two items, which will be discussed when the scales that they are part of are described below. An overview of all the measures can be found in the Appendix I[1].

[1] The reliability of the scale of emotional exhaustion is high with ω = 0.9. The reliability of the compassion and emphatic distress scales will be assessed after the psychometric properties of these scales are tested and will be discussed accordingly.

Compassion. Compassion was measured by using two scales. First, the scale of Gilbert et al. (2017) was selected. This scale focuses mostly on the motivational aspect of compassion and includes just one item that measures emphatic concern. As emphatic concern is understood as an essential aspect of compassion, a scale that focuses on emphatic concern was also included. This allowed for a more accurate investigation and comparison of the psychometric properties of compassion and empathic distress.

The compassion scale developed by Gilbert et al. (2017) consists of two subscales, namely compassionate engagement and compassionate action. Compassionate engagement was measured using six items, which includes an item on emphatic concern ("I am emotionally moved by expressions of distress in clients") and an item on personal distress tolerance ("I tolerate the various feelings that are part of clients' distress"). Compassionate action was measured using four items. A sample item of compassionate action was "I take the actions and do the things that will be helpful to clients". For both subscales, the social workers had to indicate to what extent they experience compassion towards clients on a 1-5 Likert scale (ranging from always to never). The original scale focused on compassion to others *in general*, while this study focuses on frontline worker's compassion towards clients. The items were thus made more specific by changing 'others' to 'clients'. In addition, one item of the scale was adjusted based on the test phase with social workers. The item was "I am accepting, non-critical and non-judgmental of clients' distress" and was adjusted to "I am non-judgmental of clients' distress". The reason behind this was that social workers indicated that being accepting, non-critical and non-judgmental are three different things. For example, one can be critical about a client's choices in life but can be non-judgmental about it. Non-judgmental was selected as this connects to goal of this item, which is to measure whether social workers can be non-

condemning, or with other words, non-judgmental, of someone else's suffering (Gilbert et al. 2017).

The second scale selected to measure compassion is emphatic concern was developed by Davis (1988) and consists of seven items. A sample item was "I am often quite touched by things that I see happen". The social workers had to indicate to what extent they experience emphatic concern towards clients on a 1-5 Likert scale (ranging from strongly agree to fully disagree). Again, the items were made more specific by changing 'others' to 'clients', as the original scale focuses on emphatic distress to others in general. In addition, one item of the scale was adjusted based on the test phase with social workers. This item was "I often have tender, concerned feelings for people less fortunate than me" and was adjusted to "I often have concerned feelings for people less fortunate than me". The reason for this was that social workers indicated that tender feelings are not part of their professional role towards clients but are feelings that describe a family or love relationship. Concerned feelings, on the other hand, were recognized as part of their professional role. To prevent social workers from filling in 'not at all' if they do not experience tender feelings but do experience concerned feelings for clients, the wording of 'tender feelings' was removed.

Emphatic distress. To measure emphatic distress, the scale on personal distress by Davis (1988) was selected. Using seven items, this scale focuses on feelings of anxiety and wanting to withdrawal from helping when confronted with the suffering. A sample item is "Being in a tense, emotional situation scares me". The social workers had to indicate to what extent they experience emphatic distress towards clients on a 1-5 Likert scale (ranging from strongly agree to fully disagree).

Emotional exhaustion. Emotional exhaustion was measured by using the emotional exhaustion dimension of the Maslach Burnout Inventory scale (Maslach and Jackson 1981). The social workers had to indicate to what extent they experience emotional exhaustion on a 1-5 Likert scale (ranging from always to never). A sample item was "I feel emotionally drained from my work".

Working overtime to help clients. Working overtime to help clients was measured by asking respondents how many hours they, in an average workweek, work overtime to help clients.

Alongside the variables described above, gender, age[2], level of education, years of experience as a social worker, and the number of hours of client contact in a week were added as control variables. The last two control variables were added because prior research has shown that social workers with more client contact (independent from their working hours) and more years of experience as a social worker have a higher risk of emotional exhaustion (Schauben and Frazier 1995; Yu, Jiang and Shen 2016).

Common Source Bias

The use of several survey design remedies minimized the risk of potential common source bias (Podsakoff, MacKenzie, and Podsakoff 2012). First, working overtime to help clients was measured by asking respondents to report the actual hours they worked overtime. This measure was designed as such because it taps into more factual rather than perceptual data and thus decreases the chance of common source bias. Second, the questionnaire was tested among social workers of the studied social work organization, which increases face validity. Third, the

[2] Age was measured in categories instead of years because this was requested by the social work organization due to privacy matters.

dependent and independent variables were all presented on separate pages of the questionnaire. Fourth, the respondents were incentivized to participate by informing them that a short report would be shared with them, and that the results would be translated in an advisory report to the management of the social work organization. Finally, organizational support ensured that social workers were informed through different channels and by different people (the researcher, their supervisors, and management) about the importance of participating in this research (George and Pandey 2017; Lee, Benoit-Bryan, and Johnson 2012; Podsakoff, MacKenzie, and Podsakoff 2012; Podsakoff and Organ 1986).

Post hoc statistical remedies indicated that common source bias did not substantially impact the findings of this study. This was tested by carrying out a confirmatory factor analysis (Podsakoff et al. 2003) and loading all variables of the conceptual model on one factor. The model fit ($\chi 2$ = 4257.518, df = 495, p = 0.000) was very poor, with CFI = 0.468, TLI = 0.433, RSMEA = 0.095 and SRMR = 0.118[3]. This poor fit showed that a single factor cannot account for all variance in the data, indicating that common source bias did not substantially impacted the findings of this study (Podsakoff et al. 2003).

Analysis

To test the first hypothesis, the psychometric properties of the selected scales were tested using a factor analysis. The factor structure was tested in two ways. First by performing an explanatory factor analysis (EFA) and second by performing a confirmatory factor analysis (CFA). Following Osborne and Fitzpatrick (2012), internal replication was used to ensure the findings to be robust. For this reason, the sample was randomly split in half. The first half was

[3] Cut-off criteria are between ≥ 0.95 (good fit) and ≥ 0.90 (moderate fit) for CFI and TLI, between ≤ 0.06 (good fit) and ≤ 0.08 (moderate fit) for RMSEA and, finally, ≤ 0.08 (good fit) for SRMR (Hu and Bentler 1999).

used for explanatory factor analysis (1n = 427) and the second half for confirmatory factor analysis (2n = 422). After the psychometric properties of the scales were tested, a SEM analysis was conducted (n= 828[4]) to examine how compassion impacts social workers emotional exhaustion as well as whether this is mediated by working overtime to help clients.

To perform the factor- and SEM analysis and to check for their associated assumptions, the statistical program R and packages "lavaan" (Rosseel 2011), "psych" (Revelle 2014), "GPArotation" (Bernaards and Jennrich 2014), "moments" (Komsta and Novomestky 2015) and "ggpubr" (Kassambara 2017) were used. The data slightly diverges from multivariate normality. This was accounted for by using the Satorra-Bentler correction for the maximum likelihood estimation to calculate parameters (Satorra and Bentler 1994).

Results

Psychometric properties

The first half of the data (1n = 427) was used to conduct the explanatory factor analysis. Oblique rotation was used so that the factors were allowed to correlate (Field 2013). Based on the scree plot and theoretical interpretations of factors, the EFA resulted in a three-factor model. Seven items were omitted because they had factor loadings below 0.3, and no items were omitted because of cross-loadings above 0.3 (Field 2013). Table 3 shows the full wording of each item. The three factors are: 1) compassionate motivation 2) emphatic concern, and 3) emphatic distress. The first factor reflects the first dimension of compassion; compassionate motivation. It is labeled as such because it is composed of items on one's motivation to engage with a client's suffering and to alleviate this suffering. The second factor reflects the second dimension

[4] Because the Santorra Bentler correction was used for the maximum likelihood estimation to calculate parameters, the analysis could only run on complete data. Therefore, all missing data was excluded from the analysis, which results in a n of 828.

of compassion; emphatic concern. It is labeled as such because it is composed of items on the feeling of being emotionally moved by and feeling concerned for clients' suffering. The third factor is labeled as emphatic distress because it is composed of items on stress resulting from being confronted with clients' suffering and the feeling of wanting to withdrawal from helping when confronted with clients' suffering.

Because emphatic distress loaded on a factor separate from the compassion dimensions, the first hypothesis of the study is confirmed, namely that emphatic distress and compassion are distinct emotions towards the suffering of clients. However, the factor structure of compassion was not as anticipated as it was expected that empathic concern and compassionate motivation would be interconnected in such a way that they would load on one factor. This factor analysis showed that the corresponding items loaded on separate factors. Compassionate motivation and emphatic concern should thus be treated as two distinct dimensions of the underlying construct compassion. However, they should not be treated as measures of separate constructs. This is because they are understood to be both part of compassion and conceptualized and operationalized as such in the existing literature (e.g. Goetz et al. 2010; Gilbert et al. 2017).

Table 3. EFA with oblique rotated factor loadings (1n = 427)

	Items	Factor loadings		
		F1	**F2**	**F3**
Compassionate motivation (ω = 0.87)				
1	I direct attention to what is likely to be helpful to clients.	0.77		
2	I think about and come up with helpful ways for clients to cope with their distress.	0.73		
3	I take the actions and do the things that will be helpful to clients.	0.69		
4	I am motivated to engage and work with clients' distress when it arises	0.53		
5	I notice and am sensitive to distress in clients when it arises	0.50		
6	I express feelings of support, helpfulness and encouragement to clients.	0.49		
7	I reflect on and make sense of clients' distress.	0.43		
Emphatic concern (ω = 0.66)				
1	I am emotionally moved by expressions of distress in clients.		0.75	
2	I am often quite touched by things that I see happen.		0.62	
3	Other people's misfortunes do not usually disturb me a great deal. (R)		0.51	
4	I often have concerned feelings for people less fortunate than me.		0.39	
Emphatic distress (ω = 0.84)				
1	In emergency situations of clients, I feel apprehensive and ill-at-ease.			0.69
2	Being in a tense emotional situation of clients scares me.			0.62
3	I tend to lose control during emergencies of clients.			0.60
4	When I see a client who badly needs help in an emergency, I go to pieces.			0.52
5	I sometimes feel helpless when I am in the middle of a very emotional situation of a client.			0.48
6	I am usually pretty effective in dealing with emergencies of clients (R)			0.40

Note: (R) stands for reversed item

Confirmatory factor analysis

The second half of the dataset (2n = 422) was used to perform the confirmatory factor analysis. The fit of the model was assessed using the comparative fit index (CFI), the Tucker-Lewis index (TLI), the root mean square error of approximation (RMSEA), and the standardized root mean square residual (SRMR). The model fit ($\chi2$= 239.642, df = 116) is good with CFI = 0.938, TLI = 0.927, RMSEA = 0.047, and SRMR = 0.062. All items loaded significantly on the latent variables (p <.001) with standardized factor loadings ranging from 0.424 and 0.755.

Internal consistency reliability tests

The internal consistency reliability of a measurement scale concerns the homogeneity of items (DeVellis 2016). The internal consistency reliability was first tested using model fit indices. Each of the fit indices, which are mentioned above, pass the recommended thresholds indicating good internal consistency reliability. The internal consistency reliability was further tested using McDonald's omega[5]. Reliability was high for compassionate motivation ($\omega = 0.87$) and emphatic distress ($\omega = 0.84$), and acceptable for emphatic concern ($\omega = 0.66$).

Internal construct validity

As shown in Table 5, compassionate motivation, emphatic concern and emphatic distress are significantly correlated. While they are distinguishable, the correlations point out that they are related and thus not necessarily mutually exclusive.

Table 5. Internal construct validity (2n = 422)

		1	**2**	**3**
1	Compassionate motivation	1		
2	Empathic concern	0.146 (0.003)**	1	
3	Emphatic distress	-0.297 (0.000)***	0.241 (0.000)***	1

Note: ** p <0.01, *** p <0.001

The correlation between the concepts can be ascribed to three points. First, emphatic concern and compassionate motivation are significantly and positively correlated ($r = 0.146$, $p = 0.003$). It makes sense that they correlate positively as they are both dimensions underlying the construct of compassion. A frontline workers' compassion towards the suffering of clients is thus made up of the way s/he varies along these two dimensions.

[5] McDonald's omega is reported rather than Cronbach's alpha because Cronbach's alpha has been critiqued for being prone to over- and underestimation, while McDonald's omega is not (e.g. Sijtsma 2009).

Second, emphatic distress and compassionate motivation are significantly and negatively correlated (r = -0.297, p = 0.000). This means that the more emphatic distress a social worker experiences in reaction to suffering, the less compassionate motivation s/he experiences, and vice versa. This is in line with theory because emphatic distress is expected to be accompanied by feelings of wanting to withdrawal from helping, and not in the motivation to help. In addition, it is expected that those with more compassionate motivation have a certain degree of distress tolerance which protects them from experiencing emphatic distress (Gilbert et al. 2017).

Third, empathic concern and emphatic distress are significantly and positively correlated (r = 0.241, p = 0.000). This means that the more emphatic concern a social worker experiences towards the suffering of a client, the more empathic distress s/he will experience, and vice versa. Emphatic concern is thus positively related to both compassionate motivation and emphatic distress. This is quite surprising, as it was expected that emphatic concern would be positively related to feelings of motivation to help (i.e. compassion) and not to feelings of anxiety and wanting to withdrawal from helping (i.e. emphatic distress). The findings thus point out that the dimensions of compassion have opposite relationships with emphatic distress; while compassionate motivation is negatively related to emphatic distress, emphatic concern is positively related to emphatic distress.

The effect of compassion on emotional exhaustion

This study has shown thus far that emphatic distress and compassion are indeed distinct reactions to a client's suffering, and that compassion has two underlying dimensions, namely compassionate motivation and emphatic concern. At this time in the study, the effect of both the compassion dimensions on emotional exhaustion, together with the mediating role of working overtime to help clients, will be tested.

Table 6 shows the descriptive statistics of and correlations between the variables. It is noteworthy that the social workers score highest on compassionate motivation, with scores ranging from 2.714 and 5 (M = 4.257, SE = 0.401) followed by emphatic concern, with scores ranging from 1.5 and 5 (M= 3.136, SE = 0.552). The social workers score considerably lower on emphatic distress, with scores ranging from 1 to 3.5 (M = 1.880, SE = 0.492). The number of hours of working overtime to help clients in a week range from 0 to 34 hours in a week (M = 1.55, SE = 2.525). Scores on emotional exhaustion range from 1 to 4.44 (M = 2.52, SE = 0.576).

Only those control variables that correlate significantly with both an independent variable and a dependent variable were included in the model. This was done to ensure that only control variables that explain both covariation between the independent and dependent variable were included.

Table 6: Descriptive statistics and correlations

		n	M	SD	1	2	3	4	5	7	8	9	10	11
1	**Compassionate motivation**	849	4.257	0.401	1									
2	**Emphatic concern**	849	3.136	0.552	0.219 (0.000)***	1								
3	**Emphatic distress**	849	1.880	0.492	-0.276 (0.000)***	0.201 (0.000)***	1							
4	**Emotional exhaustion**	849	2.252	0.576	-0.086 (0.013)*	0.198 (0.000)***	0.294 (0.000)***	1						
5	**Working overtime**	840	1.55	2.525	0.031 (0.376)	0.091 (0.008)**	0.025 (0.463)	0.168 (0.000)***	1					
7	**Gender (1 = female)**	837	0.744	0.437	0.169 (0.000)***	0.096 (0.006)**	0.109 (0.002)**	0.109 (0.002)**	0.007 (0.830)	1				
8	**Age**	842	3.045	1.268	0.098 (0.004)**	0.117 (0.001)**	-0.126 (0.000)***	-0.080 (0.020)*	-0.009 (0.798)	-0.084 (0.015)*	1			
9	**Education**	842	2.803	0.606	0.005 (0.894)	-0.055 (0.110)	0.024 (0.489)	0.102 (0.003)**	0.017 (0.629)	0.132 (0.000)***	-0.167 (0.000)***	1		
10	**Number of years as social worker**	833	11.4	9.591	0.083 (0.016)*	-0.028 (0.796)	-0.141 (0.000)***	-0.022 (0.518)	0.041 (0.242)	-0.026 (0.462)	0.616 (0.000)***	-0.100 (0.005)**	1	
11	**Number of hours client contact in a week**	830	24.2	7.344	0.006 (0.866)	-0.029 (0.668)	-0.105 (0.003)**	-0.011 (0.750)	0.131 (0.000)***	-0.147 (0.000)***	-0.012 (0.731)	-0.170 (0.000)***	0.005 (0.880)	1

Note: * $p<0.05$, ** $p<0.01$, ***$p<0.001$

To further investigate the relation between the variables, structural equation modeling (SEM) was used or, more specifically, fully latent structural regression modeling (Kline 2015). SEM was used because of the latent nature of the dependent and independent variables and the multiple regression hypothesized. The initial model ($\chi 2 = 764.666$, df= 224, $p = 0.000$) did not have an acceptable fit, with CFI = 0.898, TLI = 0.886, RSMEA = 0.053, and SRMR = 0.56. Its modification indices were used to identify ways to increase the model fit. Models can be modified within the limitations of the relevant theory, and it is thus acceptable to attend to modifications that are theoretically defensible (Khine 2013). Based on the modification indices, six covariances between residuals of items on emotional exhaustion were added to the model as these items of all represent the same kind of experienced emotional exhaustion[6]. The similarity on the items is also reflected in the scale's high omega ($\omega = 0.9$); when an omega is too high it may suggest that some items are redundant as they are testing the same question in a slightly different away, instead of a desirable level of internal consistency (Streiner 2003). In addition, two covariances between residuals of compassionate motivation were allowed, as these items all represent the same kind of motivation to alleviate a client's suffering[7]. The model fit ($\chi 2 = 536.319$, df = 216.000, $p = 0.000$) significantly improved, with CFI = 0.941, TLI = 0.932, RSMEA = 0.041, and SRMR = 0.052. Table 7 and Figure 2 show the results of SEM analysis and the hypothesized effects.

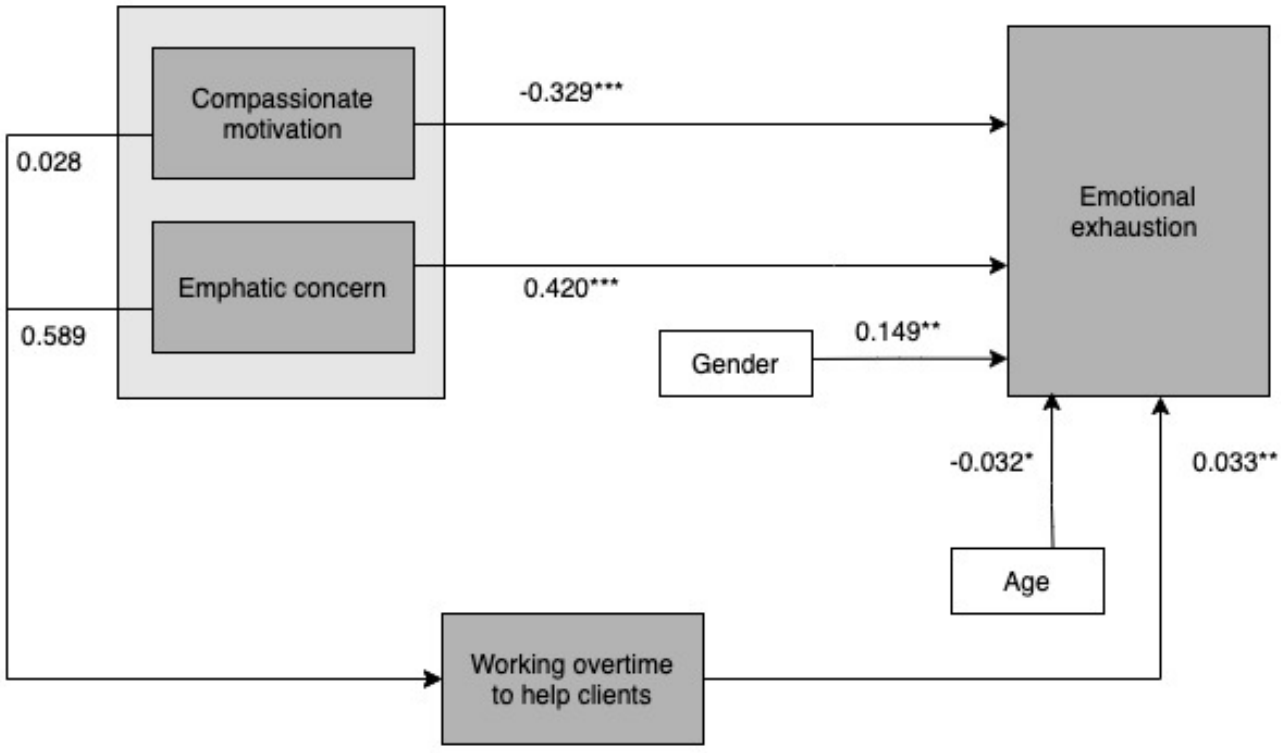
[6] Allowed covariances were EE4-EE8, EE1-EE2, EE5-EE9, EE2-EE9, EE2-EE3, and EE6-EE7
[7] Allowed covariances were CA1-CA3 and CA2-CA3

Table 7. Results of Structural Equation Modeling (n = 828)

	Dependent variables					
Independent variables	**Emotional exhaustion**			**Working overtime**		
Compassionate motivation	**z**	**St.SE**	**St.B**	**z**	**St.SE**	**St.B**
Direct effects						
Compassionate motivation	-4.778	0.069	-0.329(0.000)***	0.072	0.390	0.028(0.943)
Working overtime	2.985	.011	0.033 (0.003)**	-	-	-
Indirect effects via working overtime						
Compassionate motivation	0.071	0.013	0.001(0.944)	-	-	-
Total effects						
Compassionate motivation	-4.741	0.069	-0.328(0.000)***	-	-	-
Emphatic concern	**z**	**St.SE**	**St.B**	**Z**	**St.SE**	**St.B**
Direct effects						
Emphatic concern	5.752	0.073	0.420(0.000)***	1.729	0.341	0.589(0.084)
Working overtime	2.985	0.011	0.033(0.003)**	-	-	-
Indirect effects via working overtime						
Emphatic concern	2.419	0.008	0.019(0.016)*	-	-	-
Total effects						
Emphatic concern	5.923	0.074	0.459(0.000)***	-	-	-

Note: * p<0.05, ** p<0.01, ***p<0.001

Figure 2. Graphical representation of Results of Structural Equation Modeling



Hypothesis 2 stated the expectation that working overtime to help clients mediates the positive relationship between a frontline worker's compassion towards clients and emotional exhaustion. When testing the psychometric properties of the compassion and emphatic distress scales, it was found that compassionate motivation and emphatic concern are distinct dimensions of compassion. Therefore, Hypothesis 2 was tested twice; once for compassionate motivation (H2a) and once for emphatic concern (H2b).

The hypothesis that working overtime to help clients mediates the positive relationship between compassionate motivation and emotional exhaustion (H2a) is, based on the results, rejected. First, compassionate motivation is not positively, but negatively, related to emotional exhaustion (z = -4.779, st.B = -0.329, st.SE = 0.069, p = 0.000). In other words, the greater compassionate motivation social workers feel, the less emotional exhaustion they experience. Second, working overtime does not mediate the relationship between emotional exhaustion. Compassionate motivation isnot related to working overtime (z = 0.072, st.B = 0.028, st.SE = 0.390, p = 0.943). This was not as expected. Working overtime is positively related to emotional exhaustion (z = 2.985, st.B = 0.033, st.SE = 0.011, p = 0.003), but the total indirect effect of working overtime is not significant (z = 0.071, st.B = 0.001, st.SE = 0.013, p = 0.944). Working overtime thus does not help explain the effect of compassionate motivation on emotional exhaustion.

The hypothesis that working overtime mediates the positive relationship between emphatic concern and emotional exhaustion (H2b) can, based on the results, be accepted. First, emphatic concern is positively related to emotional exhaustion (z = 4.752, st.B = 0.420, st.SE = 0.073, p = 0.000). Second, working overtime mediates the relationship between emphatic concern and emotional exhaustion. Emphatic concern is not significantly related to working overtime (z =

2.985, st.B = 0.589, st.SE = 0.341, p = 0.084). Working overtime is, however, positively related to emotional exhaustion (z = 2.985, st.B = 0.033, st.SE = 0.011, p = 0.003) and the total indirect effect of working overtime is significant (z = 2.419, st.B = 0.019, st.SE = 0.008, p = 0.015). This shows that the positive relationship between emphatic concern and emotional exhaustion can be partly explained by working overtime.

In sum, the findings suggest that the two dimensions of compassion have opposite relationships with emotional exhaustion. The first dimension, compassionate motivation, is negatively related to emotional exhaustion, and working overtime does not play a mediating in this relationship. Emphatic concern, on the other hand, is positively related to emotional exhaustion and mediated by working overtime.

Conclusion and Discussion

The main purpose of this study was to gain more understanding on what frontline workers' compassion towards client entails. It did so by first providing conceptual clarity on compassion towards clients, and, second, by testing the relationship between compassion and emotional exhaustion and whether working overtime to help clients mediates this relationship. This study resulted in four main contributions to both literature and practice.

The first contribution of this study is that it shows that emphatic distress and compassion are different emotions towards a client's suffering. While scholars are starting to recognize their differences (Goetz et al. 2010; Atkins and Parker 2012), many scholars still do not explicitly differentiate between them or seem to confuse the terms. Based on the results of this study, it is encouraged that future research clearly differentiates – theoretically and operationally – between the concepts, as they involve distinct emotions towards a clients' suffering. In addition,

scholars writing on public service motivation are encouraged to make explicit that it is compassion and not emphatic distress they are interested in, and that they measure the concept appropriately.

A fruitful research direction this study points towards concerns gaining more understanding on the antecedents of compassion and emphatic distress. When and how does a frontline worker experience either compassion or emphatic distress towards a client's suffering? One potential explanation could be emotional regulation. Compassion is understood to involve a concern about another's suffering while being able to regulate one's own negative feelings caused by the emotional response (Strauss et al. 2016; Atkins and Parker 2012; Eisenberg 2015), contributing to the motivation to help rather than wanting to withdrawal from helping (Klimecki and Singer 2011). Emotional regulation could thus contribute to a certain degree of distress tolerance, which supports frontline workers in experiencing compassion towards client's suffering, rather than emphatic distress. Public administration scholars have shown an increased interest in the role of emotional regulation in public service work (e.g. Levitats and Vigoda-Gadot 2008; Vigoda-Gadot and Meisler 2010). This study encourages the use of these insights in gaining more understanding on the role of emotional regulation in compassion and emphatic distress.

The second contribution of this study is that it provides a more nuanced view of compassion as it revealed that compassion consist out of two related, but distinguishable dimensions: compassionate motivation and emphatic concern. In the literature there is often no explicit differentiation made between these dimensions – neither conceptually nor operationally. For example, in their scale measuring compassion, Gilbert et al. (2017) measure emphatic concern and compassionate motivation using the same scale. The results of this study point to the need

for the development of a scale on compassion with subscales on emphatic concern and compassionate motivation.

It could further be relevant to investigate whether emphasizing either compassionate motivation or emphatic concern makes a difference in the quality of the public service that is delivered, and, if so, whether this might differ between types of public services. In some types of public service, emphasis on compassionate motivation might be more desired. For example, when a child asks for help on its homework from a teacher, it is desired for the teacher to be compassionately motivated and wanting to help child. Here it is the compassionate motivation that strongly contributes to the quality of service. In other types of public service, emphasis on emphatic concern might be more desired. For example, when a client needs a listening ear from a social worker, it is desired that the social worker experiences emphatic concern and expresses concern towards the client. Here it is the emphatic concern that strongly contributes to the quality of service. By gaining more insight the role of compassionate motivation and emphatic distress, there can be contributed to the discussion on how we want the state to interact with its citizens (Zacka 2017).

The third contribution of this study is that the dimensions of compassion have opposite relationships with emphatic distress; while compassionate motivation is negatively related to emphatic distress, emphatic concern is positively related to emphatic distress. This finding is quite surprising, as it was expected that emphatic concern would be positively related to only feelings of motivation to help (i.e. compassion) and not to feelings of anxiety and wanting to withdrawal from helping (i.e. emphatic distress). A majority of the literature directly associates emphatic concern with compassion (Goetz et al. 2017; Klimecki and Singer 2011). Atkins and Parker (2012) even treat emphatic concern as *necessary* for compassion. As such, emphatic distress is believed to be accompanied prosocial behavior (Bekkers 2006). However, there are

also studies that are starting to question the relationship between emphatic concern and prosocial behavior. For example, a study by Einolf (2008), shows that emphatic concern is a weak predictor of helping behaviors. Einolf (2008) proposes that it might not be emphatic concern but its interaction with values, moral orientations and personality traits that motivates helping. The direct association between emphatic concern and compassionate motivation thus might not be as clear cut as is proposed in the compassion literature. More research on this is thus warranted.

The fourth contribution of this study is that it showed that the dimensions underlying compassion have opposite effects on emotional exhaustion. The first dimension of compassion, empathic concern, is positively related to emotional exhaustion and mediated by working overtime to help clients. The initial expectation that compassion is positively related to emotional exhaustion, partly due to working overtime to help clients, was based on the motivational aspect of compassion, and not necessarily its aspect of emphatic concern. While the finding that emphatic concern is related to emotional exhaustion is in line with former research (e.g. Miller et al., 1988), it remains unclear why this relationship is mediated by working overtime to help clients. A potential explanation for this finding could be that working overtime to help clients is actually a moderator in the relationship between emphatic concern and emotional exhaustion. The rationale behind this is that working more overtime to help clients means that one gets exposed to additional suffering of clients. This additional exposure creates more opportunity for developing emphatic concern, which, as this study how pointed out, leads to more emotional exhaustion.

More understanding is needed on how to protect frontline workers from the emotional exhaustion related to emphatic concern. an example to protect frontline workers from this could

be guiding them in using the effective coping skills (see Tummers et al. 2015), however, first more research is necessary into what coping skills would be effective in the first place.

The second dimension of compassion, compassionate motivation, is negatively related to emotional exhaustion - and working overtime to help clients does not play a mediating role in this relationship. A potential explanation for this finding could be that the working context of the social workers studied offers more possibilities of being able to help clients and success than was anticipated, leading to feelings of fulfilment and so-called compassionate satisfaction This is sometimes referred to as compassion satisfaction (Stamm 2010). Studies have pointed out how compassionate satisfaction can be a buffer of feelings of emotional exhaustion (e.g. Samios 2017). This implies that when one is able to help clients, experiencing compassion and its subsequent motivation can form a buffer against emotional exhaustion.

This study, like any other, has limitations. A first limitation of this study is that it studied a specific type of frontline worker, namely social workers. While social workers have similarities with other frontline workers, they also have specific characteristics that make their work different; think of the nature of the decisions they take, to the populations they interact with and the kind of encounters they have with clients (Zacka 2017). Unlike police officers, social workers have repeated encounters with clients through which a personal relationship can develop, while encounters with police officers are often not regular and happen on a one-time basis (Zacka 2017). Unlike teachers, social workers provide services to individuals seeking services in a time of need or distress, while teachers provide services to society at large (Zacka 2017). Differences like these can affect what compassion towards clients entails and what its effects are on the wellbeing of the provider of compassion. Investigating the role of compassion for different types of frontline workers is thus an important next step in understanding what

compassion entails in in public service delivery. Another limitation of this study is the type of organization in which the research was performed, namely one with a Christian identity. Like many religions, the Christian faith emphasizes the importance of compassion (Gilbert et al. 2017) and compassion is closely associated with both a notion of Christian duty and spirituality - resulting in a motivation to help those that are suffering (Bradley 2005). As the results of this study are based on the perceptions of Christian social workers, their religious values might have affected the conceptualization of compassion that resulted from the factor analysis. It asks for further investigation to test whether the factor structure and accompanied conceptualization of compassion holds for frontline workers without the Christian identity.

Another limitation of this study is its cross-sectional design. Regression analyses were used to explore the relationship between compassion, working overtime to help clients and emotional exhaustion. Cross-sectional designs cannot establish causality or identify long-term effects. Conducting a cross-sectional study is, however, an important and practical first step in exploring whether a relationship is there. A next step can be to use longitudinal designs to analyze the long-term effects of emphatic distress and the two dimensions of compassion; compassionate motivation and emphatic concern.

When interpreting the results of this study, one should keep in mind that the current pandemic affects people all over the world - including the care workers studied in this study. COVID-19 could especially affect the emotional exhaustion of care workers, for example because clients are infected with COVID-19, they are scared for their own health or that of their friends or family or are worried if they can keep their job or not. This could have affected the outcomes observed regarding experienced emotional exhaustion.

In conclusion, this study showed that compassion is a more complex construct and potentially damaging emotion than is often proposed. To date, compassion towards clients is often relegated to a mere supporting role, where it remained unexplored and undefined. However, compassion towards clients is a complex, multidimensional and, above all, relevant construct that deserves more attention. This study should be considered as a first step in delineating the concepts underlying compassion and paying attention to its potential damaging effects on frontline worker's wellbeing. In doing so, it hopes to encourage scholars to continue to gain more understanding on compassion, while paying attention to its essential role for public service delivery and for the effect it can have on the wellbeing of frontline workers.

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APPENDIX I: Items used in survey

Compassion (Gilbert et al. 2017)

Compassionate engagement

1. I notice and am sensitive to distress in clients when it arises.
2. I am motivated to engage and work with clients' distress when it arises.
3. I reflect on and make sense of clients' distress.
4. I am emotionally moved by expressions of distress in clients.
5. I am non-judgmental of clients' distress.
6. I tolerate the various feelings that are part of clients' distress.

Compassionate actions

7. I think about and come up with helpful ways for clients to cope with their distress.
8. I direct attention to what is likely to be helpful to clients.
9. I take the actions and do the things that will be helpful to clients.
10. I express feelings of support, helpfulness and encouragement to clients.

Personal distress (Davis 1980)

1. In emergency situations of clients, I feel apprehensive and ill-at-ease.
2. I sometimes feel helpless when I am in the middle of a very emotional situation of clients.
3. When I see a client get hurt, I tend to remain calm. (R)
4. Being in a tense emotional situation of a client scares me.
5. I am usually pretty effective in dealing with emergencies of clients. (R)
6. I tend to lose control during emergencies of clients.
7. When a client badly needs help in an emergency, I go to pieces.

Emphatic concern (Davis 1980)

1. I often have concerned feelings for clients less fortunate than me.
2. Sometimes I don't feel very sorry for clients when they are having problems. (R)
3. When I notice that a client is being taken advantage of, I feel kind of protective towards them.
4. Client's misfortunes do not usually disturb me a great deal. (R)
5. When I notice that a client being treated unfairly, I sometimes don't feel very much pity for them. (R)
6. I am often quite touched by things that I see happen in a client's life.
7. I would describe myself as a pretty soft-hearted person towards clients.

Emotional exhaustion (Maslach and Jackson 1981)

1. I feel emotionally drained from my work.
2. I feel used up at the end of the workday.
3. I feel fatigued when I get up in the morning and have to face another day on the job.
4. Working with people all day is really a strain for me.
5. I feel burned out from my work.
6. I feel frustrated by my job.
7. I feel I'm working too hard on my job.
8. Working with people directly puts too much stress on me.
9. I feel like I'm at the end of my rope.

$\omega = 0.9$

Working overtime to help clients
In an average week, how many hours do you work overtime to provide care to clients? If you do not work overtime to provide care to clients in an average week, please fill in 0.
Measure: filled in hours

Age
What is your age?
Measure: 24 or younger 25-34, 35-44, 45-54, 55-64, 64 or older

Education
What is your highest education level?
Measure: High school, MBO, HBO, WO

Gender
What is your gender?
Measure: Male / Female / Other

Number of hours providing direct care to clients
In an average week, how many hours do you have direct contact with clients?
Measure: filled in hours

Number of years as a social worker
In total, how many years have you worked as a social worker (at your current social work organizations *and* other organizations)?
Measure: filled in years