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QUALITATIVE RESEARCH

Self-care methods of social workers working in end-of-life care

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ABSTRACT

INTRODUCTION: Most people experience some form of grief and loss during their lifetimes; some even choose to work amongst it every day. Navigating through the effects of this can be an arduous task on a personal level, but what about on a professional level? Social workers are becoming more prominent in end-of-life settings and, whilst they often are well versed in self-care, how does this change when working around death and dying on a daily basis? This study sought to explore these questions and gain a greater understanding of social workers.

METHODS: This is a qualitative research study where three semi-structured interviews of social workers working in end-of-life (EOL) care were conducted to explore their perspectives of self-care regarding their profession, and to gain a greater understanding of what is beneficial for them and what requires more work.

FINDINGS: All participants had both personal and professional self-care journeys that have enabled them to avoid burnout or compassion fatigue during their careers. Whilst each participant had had some form of training on death and dying or grief and loss, there was a clear lack of job-specific training to support them through their work.

CONCLUSION: This research report highlighted three key themes for EOL social workers: personal experience of death and dying; their own self-care strategies and practices; and limitations around specific training on death and dying. Results of this study urge social workers and education providers to seek out further training development and opportunities in EOL care.

KEYWORDS: Self-care, end-of-life care; social workers; supervision; compassion fatigue; spirituality

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Inevitably, we are all going to face the reality of death in our lives, our own as well as our loved ones. Understandably, this can pose significant emotional turmoil for the ones left behind. This research attempted to look more deeply into the world of those who choose a career in this field. When experiencing death and dying, and grief and loss on a day-to-day basis, how does one prevent compassion fatigue or burnout? Self-care has been linked to greater mental health, resilience, and wellbeing (Iacono, 2017), which is beneficial for end-of-life (EOL) social workers for various reasons. Social workers are critical in EOL care due to their ability to address the psychosocial needs of patients and their families, which is reflected in the literature (Murty et al., 2015).

Terms such as *compassion fatigue* and *burnout* have been scattered throughout social work literature for some time (Quinn-Lee et al., 2014); however, there seems to be less research, literature and training on how to avoid experiencing them in a professional

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setting. Self-care is often a process or journey rather than a destination that you just arrive at; this is highlighted in this research.

Positioning of the researcher

Suzi Gallagher: This topic was chosen given my own experience caring for my grandmother through the final stages of her life. The toll it took on me, both mentally and physically, was substantial and I found it took me many months to feel like myself again. My mother, who also was a part of her care, expressed similar feelings. This left me wondering how people work in EOL care where they deal with such experiences daily, and how they develop and practise self-care when working in a field that could prove to be taxing on many levels. I am currently a registered social worker employed full time in Kirikiriroa, Aotearoa New Zealand. I also provide supervision to other social workers, where I highlight and explore the importance of self-care for my supervisees.

Literature review

A literature review was conducted to gain a deeper understanding of the current research and literature on the social workers' self-care, personal experience of death and dying, and their specific professional training to support them whilst working in EOL care.

The literature used in this review comprises predominantly academic articles sourced from the Massey University Library electronic databases. Search terms that were used to find the research were *end-of-life care*, *self-care*, *social work*, *palliative care*, *personal experience*, *supervision*, and *professional practice*—all individually as well as a mixture of them together. Themes have been identified throughout the literature review, which will help to inform the research report. These are *personal experience*, *self-care* and *methods of self-care*. The next section highlights some of the context challenges for social work in EOL.

Social workers in end-of-life care

The context of social work in EOL care is often complex and takes place within various organisations, some of which are not specifically dedicated to EOL care, such as health social workers. Factors highlighted in the literature that are important to consider include multidisciplinary teams, burnout, leadership, cultural competency, and resourcing. Social workers are appropriate leaders for this field of practice, particularly given the cultural competency and psychosocial expertise required.

Multidisciplinary teams

In the 1950s, Cicely Saunders worked towards developing a holistic model of EOL care where patients were seen as, not just those having nursing or medical needs, but as a whole person with social, psychological, spiritual, and physical needs. This led to multidisciplinary teams being developed that often comprise social workers, chaplains, psychotherapists, psychologists, volunteers, occupational therapists, and physiotherapists, not just doctors and nurses (Brown & Walter, 2014; Selman et al., 2014).

EOL care involves the collaborative efforts of several different professionals, including social workers, nurses, physicians, and support staff. They not only work in intimate spaces with the individuals experiencing life-limiting conditions, they are often also working with their bereaved families (Berzoff, 2008; Chan et al., 2015).

Burnout

A challenge identified for EOL care social workers by Davidson (2016) was that almost all respondents in the study reported feeling as though they had to provide evidence of their worth and merit in EOL care. This seemed to be a common theme in the literature, with Berzoff (2008) also highlighting the isolation social workers feel in this line of work, impacted by experiencing grief alone in a professional

setting, lack of interdisciplinary peer supervision, and the cumulative grief they experience day in and day out. Further to this, there is often a pull between resource management issues and the psychosocial needs of the client and their loved ones (Quinn-Lee et al., 2014; Silverman, 2015).

Studies have shown that the level of burnout experienced by healthcare professionals working in EOL care is not necessarily higher than those working in other contexts as their competence in stress management seems to be the key (Chan et al., 2015). A finding in the Agnew et al. (2011) research was that, on appointment, EOL health professionals are expected to have relevant experience and qualifications but ongoing training in this area was not prioritised once in the position, even though there are vast benefits in receiving such training. Informal training such as theories of grief and loss, bereavement counselling skills, and methods of assessment were beneficial; however, specialist external training opportunities were limited.

Leadership

Davidson (2016) recommended that social workers should aspire to be leaders in palliative care. Part of this is because there have been significant changes in how terminal illness and bereavement are being viewed and experienced—these are *social* issues rather than *medical*. Having social workers in leadership, trained and practised in individualised interventions, working in areas with an emphasis on social justice issues, could be the ideal arena for such professionals as they are agents of change for individuals, families, communities and wider society.

Cultural competency

Cultural competence has been argued as crucial for social workers in all settings, including EOL; however, achieving competence in this area can prove difficult when there is limited literature and research, and the diversity of cultures can be a struggle due to so many characteristics that cannot be adequately captured in a checklist. Culture goes beyond race to include such aspects of one's life, such as socioeconomic status (SES), sexual orientation, gender identity, refugee and immigrant status, religion, age, health conditions, family composition and dynamics, and various developmental, physical, learning, and psychological abilities, to name a few. As expected though, end-of-life care also has other factors that may arise, for instance, medical conditions, health behaviours, and diagnosis and prognoses (Rine, 2018; Selman et al., 2014).

Resourcing of EOL

Davidson (2016) reflected on recent studies that have shown EOL care in the United Kingdom as needing massive improvements. One reportedly found that 1 in 10 people who received EOL care did not receive the care and support they needed, often due to a disconnect between policy makers, health professionals, and these people receiving EOL care (Chaddock, 2016). This has led to a major drive for hospice care to implement public health approaches to transform EOL care services. Because social workers are leaders in anti-discriminatory and anti-oppressive practice, their presence in the realm of palliative care is becoming more sought after (Davidson, 2016).

The complexity of working in EOL care is vast, especially for social workers, due to the factors highlighted in this section. Beyond this, it is important to also consider the fact that each social worker brings their own unique personal experiences that may affect the way they practise.

Self-care

One of the significant challenges that health professionals often face in relation to self-care is finding and managing the balance between their personal and professional lives; this is no different for social workers

in the realm of EOL care. If anything, it could be considered *more* important as social workers are often drawn to this area of work following their own experiences of loss (Berzoff, 2007; Sanso et al., 2015). Sanso et al. (2015) highlighted compassion satisfaction as the ability to receive a degree of joy that a clinician experiences when helping others, which is why it is important to understand compassion fatigue and have robust self-care strategies in place.

On a personal level, Chan et al. (2015) found that coping strategies including the acceptance of, and management of one's own emotions were paramount in self-care working in EOL care. Some of the strategies they described included distraction from work, sharing with others, relaxing, dealing with loss, relationship issues, rationalising, and finding joy in life. There were also four emotional coping methods identified at a professional level: adjustment of expectations in professional identity, which includes having clear professional roles and limitations; adjustment of expectations in EOL care, where the professional develops suitable goals and is able to accept the reality of the people they are working with, and the patient achieving the best death possible; differentiation between work and self, referring to the ability to separate work from personal life; and searching for meaning in work, which involves achieving a sense of passion and satisfaction for the work (Chan et al., 2015).

Finding an authentic and sustainable self-care plan can be a long process. This can be due to many professionals developing unhealthy habits to deal with stress and taking the time to find strategies can be time consuming and sometimes disheartening. Having a plan that addresses an individual's emotional, cognitive, physical, spiritual, and relational challenges is important, and this can be difficult to find (Smit, 2017). There is no one-size-fits-all approach to self-care and therefore it is often viewed as the social worker's responsibility to develop and practise their own self-care strategies; however, embedding self-care activities throughout social work education and training could prove effective in the promotion of robust self-care strategies (Newcomb et al., 2015).

Methods of self-care

Intrinsic self-care methods are ways of caring for oneself using practices or resources that belong to that person. Some of these methods include routinely expressing, soothing, and releasing emotions by doing such things as listening to music, undertaking personal therapy, talking with confidants, mindfulness, self-compassion, enjoying a bath, or cuddling a loved one or pet (Newcomb et al., 2015; Smit, 2017).

Setting emotional boundaries can also be important. For instance, learning to say no when necessary and obtaining new skills to encourage wellbeing (this could include communication or time-management skills). Studies have shown that professionals who attend to their personal wellbeing are in a better position to achieve positive outcomes and greater satisfaction in the workplace compared to those who do not. Their levels of resilience when facing challenges are also higher (Smit, 2017).

Creativity is something that can be used as a tool for self-care. For example, expressive writing is helpful for some individuals. There are three theories that have been linked to expressive writing as a form of therapeutic intervention; these are: emotional exposure theory, which is based on the belief that directly confronting an emotional experience can result in positive emotional changes; cognitive restructuring theory, where writing can bring about cognitive changes such as structuring, labelling, and organising traumatic events, which can help make sense of confusing and upsetting times; and self-regulation theory, where expressive writing can assist in self-regulation due to being able to gain a better understanding of upsetting and/or traumatic events, labelling the emotions associated with them, and

planning appropriate reactions (Sexton et al., 2009). Furthermore, the use of art therapy in supervision has shown to reduce exhaustion, increased competency and self-efficacy, greater self- and emotional awareness, and a greater willingness to discuss death and dying (Potash et al., 2014).

Extrinsic self-care methods involve caring for oneself using physical means. Studies have investigated several exercises that can assist in one's self-care regimen, which include progressive muscle relaxation, simple breathing techniques, exercise, yoga, meditation and mindfulness, acupressure, and massage. Other suggestions include the importance of laughter and play, as this not only increases our physical wellbeing, but our mental wellbeing as well, by increasing energy levels and reducing stress. Nutrition, relaxation, and quality sleep can also play a part in the physical side of self-care (Berzoff, 2008; Newcomb et al., 2015; Smit, 2017).

Debriefing is a method used to assist in overall self-care, be it with colleagues, friends and family, or even accessing an Employee Assistance Programme (EAP) (Berzoff, 2008; Newcomb et al., 2015; Smit, 2017). Regular supervision also allows social workers the time and space to acknowledge their feelings and to evaluate and reflect on their experiences, practice and own perceptions, attitudes and anxieties around death, which is vital in preventing compassion fatigue and burnout (Arnaud, 2017; Berzoff, 2008; Potash et al., 2014; Smit, 2017). It is also used as a function to develop therapy skills, emotional awareness, case conceptualisation, and self-evaluation (Arnaud, 2017).

Compassion fatigue is a term that is often used to refer to the *cost of caring*, where professionals experience fatigue through repeated exposure to other people's suffering. This contrasts with burnout, which is brought on by cumulative stress due to unreasonable work expectations or environment. Burnout is often gradual and progressive, whereas compassion fatigue is often quicker. There is potential for transferring unmet emotional needs onto social work clients, countertransference, and inappropriate self-disclosure, putting the social workers at greater risk of vicarious trauma and burnout. An important factor in avoiding compassion fatigue is having robust self-care practices (Potash et al., 2014; Sanso et al., 2015; Smit, 2017).

Peer supervision is another method that provides experiential and relational learning where professionals can discuss countertransference responses, spiritual issues, ethical dilemmas, pain and suffering, and legal issues that may arise. This method of self-care helps prevent feelings of isolation and oppression in this line of work; it can also help promote the use of humour, which is often viewed as an important strategy in self-care practices (Berzoff, 2008).

One could argue that spirituality in self-care could fall under either or both intrinsic and extrinsic self-care methods. Spirituality is a universal aspect of personhood and can be defined as an individual's search for purpose and meaning in their life, which may or may not be related to religion (Edwards et al., 2010; Selman et al., 2014). Self-care can include reading, praying, connecting with nature, meditation or reflection, as these practices can promote and restore a sense of calm, hope, and serenity (Smit, 2017).

Smit (2017) referred to Te Whare Tapa Whā and how it highlights the importance of a holistic approach to health and wellness. It compares wellbeing (hauora) to the four walls of a house (whare). They represent spiritual wellbeing (taha wairua), which relates to confidence, self-esteem, beliefs, and values; physical wellbeing (taha tinana), which relates to interaction with Mother Earth (Papatūānuku) and personal development; mental and emotional wellbeing (taha hinengaro), which relates to emotions, thoughts, feelings, knowledge, and attitude; and social and whānau wellbeing (taha whānau), which relates to interpersonal relationships with friends and family, having a sense of belonging, and whakapapa.

For the whare to be well and healthy, each dimension needs to be balanced. All these aspects are interrelated and are the foundation for overall health and wellness (Smit, 2017).

Spirituality and culture are often inadequately articulated in models of holism due to the neglect of spirituality and culture in policy guidance, research, and multi-professional training and education (Selman et al., 2014). As spirituality is often considered so highly in one's identity, it could be being under-utilised in training and education.

Methods

The study explored the self-care strategies and practices of qualified social workers who work with people at the end of their lives. A qualitative research methodology is the approach taken for this project with theoretical underpinnings in social constructivism and the interpretivist paradigm (Merriam & Tisdell, 2016). This fits well with this research which aimed to understand the experiences of social workers in EOL care and how they construct their self-care methods and strategies. The research project received a low-risk approval from a university Human Ethics panel.

The Aotearoa New Zealand Association of Social Workers (ANZASW) was contacted to circulate the information of this study after unsuccessfully contacting organisations working in EOL care. Once the ANZASW published the research, seven responses were received from social workers offering to participate; however, it was the first three that were chosen to interview.

For this project, semi-structured interviews were used to elicit data grounded in the participants' experiences while also having the space to ask more theoretically driven questions. Semi-structured interviews invite the application of thoughtful reflexivity and intelligent creativity in relation to the broader methodological, theoretical, and ethical elements of research (Brown & Danaher, 2017; Galletta, 2013).

Pseudonyms will be used for each participant to maintain their anonymity. Leigh now works for a non-government organisation (NGO) and has also had over 20 years with a District Health Board (DHB); Carrie also works for an NGO leading a team of social workers with her own caseload; and Murray works for a DHB where he has been for several years.

Thematic analysis is used to decipher and understand the data in this research project. This approach goes further than counting explicit words or phrases and focuses on identifying and describing explicit and implicit ideas within the data, or themes (Guest et al., 2012). The themes fall under the three main aims of this research: social workers' understanding and experience of death and dying; their self-care strategies and practices; and their experience of professional training on death and dying. There are also sub-themes that have arisen under the self-care and understanding and experience of death and dying themes, which fall into both personal and professional categories.

Three participants were interviewed for this project, which could be considered a small sample size. This typically means that the findings are not able to be generalised to the larger population. However, given that this is qualitative research, a small sample size enables richly textured information relevant to the topic (Vasileiou et al., 2018). Research bias was another potential limitation, especially considering the personal nature of the topic for the researcher. As Chapman (2014) pointed out, there are ways to mitigate this, including examining one's own motives, a thorough literature review, being meticulous with one's methods, anticipating any challenges, and seeking knowledgeable feedback. This has been upheld through the project, particularly in supervision.

Findings

Social workers' understanding and experience of death and dying

Personal understanding and experiences of death and dying

Death is often referred to as part of life, so it was not particularly surprising to learn that each participant had some personal experience of death and dying. Leigh cared for her grandmother until her death at age 99; Carrie spent a lot of time with her grandmother at the end of her life; while Murray had a holiday job as a grave digger when he was younger.

Different cultural practices around death and dying vary a lot. Murray was exposed to Fijian cultural practices as some of his childhood was spent in Fiji; while Carrie spoke a lot about her Chinese culture and how it has influenced the way that she views her elders:

> Chinese respect older people but when we have respect, we do things for them. For example, I wouldn't like an older person to make me a cup of tea, I would make one for them, even in their own home. So, coming to New Zealand, I have to respect their independence. At the very beginning, I think it took me a while to adjust because of my family, and with my partner's family, I learnt more about the Kiwi culture.

Professional understanding and experiences of death and dying

All three participants spoke about how their career progression gradually, but naturally, moved them towards working with clients at the ends of their lives. For instance, both Leigh and Murray spoke about how their careers have gradually led them to working in EOL care; while Carrie believes it has been part of her upbringing within Chinese culture where the wisdom and experience of older people are valued very highly.

Whilst all participants have had personal experiences of death and dying, there has still been much to learn in different cultural and religious practices when working in EOL care. Leigh spoke about being in a room with a person who has died and how this was a very new experience for her, and Carrie shared an experience she had with a family friend whose father had passed away. She shared that it was a Tongan/Samoan family, and they had his body in the home with them.

There is also an emotional component that comes into play in this area of social work that has been described as interesting to navigate and affords an opportunity for deep reflection. Murray said, "death isn't something that is separate from life … we're all on a journey and it's really two sides of the same coin", which is a beautiful sentiment; however, he also spoke about some patients who experience the absolute despair at the thought of dying. Leigh added that it is also about her own maturity and comfortableness around death, which has taken time to adjust enough to be able to work in this area.

One participant had a negative experience with a previous employer, which was a DHB that she had been employed at for over 20 years. Regarding her time at the DHB, she shared that it felt as though the body of a person who had died was moved along very quickly, their name put on a list and never mentioned again. This contrasts with her new role at a hospice where she feels that their practices and rituals around death are more in line with her own personal values, as they sing a waiata when the body leaves the premises, which she felt is a nice acknowledgement of that person.

Social workers' self-care strategies and practices

Personal self-care strategies and practices

Various personal self-care practices were discussed throughout the interviews. For this research, this refers to the different strategies

and practices that each participant has implemented in their personal lives, away from work. Some of the practices included eating and sleeping well, getting out of the city and going into nature, reading, music, and other hobbies.

Leigh described a reflection that involves an aspect of both personal and professional self-care practice. She explained a ritual that she does to acknowledge her clients that have passed:

> It actually doesn't really feel like that quite so much. I mean, the reality is that people are dying all the time. And in my folder of people, I've got a section where I keep all of the written referrals of people that have died … I said to my colleague, you know, it's really not normal to be in social work and have this many people you've had some contact with that have died in a six-month period – I think it's about remembering that.

Professional self-care strategies and practices

This sub-theme refers to the different self-care strategies and practices that each participant undertakes in their professional capacity in the workplace. For instance, Murray explained that he does not attend the funerals of his clients:

> Some people require them to finish off and tie off ends and show that they loved, cared for and respected someone. For example, my parents, I wanted to go to their funerals, but in general, the people I work with, I don't need to do that; to go to their funerals.

Some parts of professional self-care practices that have been discussed could be seen to be quite simple; however, as each participant explained, they can have a big effect when put into practice and are not always easy to enforce. For instance, ensuring they take holidays, taking breaks, not working overtime and sticking to working hours, not taking work home, keeping strong personal/professional boundaries, and stopping to check in with colleagues and not feeling guilty about it. As Carrie mentioned:

> Sometimes I think I might just have to not answer the phone, which can actually sometimes be self-care for me; not taking the call straight away, and being aware that I don't need to take every single call as soon as it comes through … I need to park it and phone them back when I'm ready.

Two of the participants mentioned that they had accessed the Employee Assistance Programme (EAP) during their employment, but that it was not for issues around death and dying, but more structural reorganisation within their workplace and interpersonal conflicts with employers.

Supervision in various forms was discussed by each participant in relation to professional self-care: individual; external; peer, inter-organisational; providing supervision for others; as well as being valued as an employee and colleague. Each participant spoke about different things their employers had done for their employees, including a free Christmas lunch that was nicely presented for everyone, offering three wellness days where you do not need to explain your absence from work, regular check-ins with management, debriefing with peers and management, and having a team approach to self-care, with team activities such as yoga. On the flipside, the participants discussed what it was like when this did not happen and how it felt. Leigh made a comment about how she learnt how to look after herself because nobody else was.

When asked how the participants managed a situation where there was a lapse in self-care, Leigh explained:

> How I managed the last situation was to change jobs. That's what I actually did, which was quite extreme – it's not something you want to do every five minutes though. It was a big deal for me to

> leave the DHB, but it felt like the benefits of it had gotten to the point where they were outweighed by the negative things.

Death and dying in social work

During the interviews, the participants shared their views on the lack of specific education and training on death and dying, for not just social workers, but for health professionals across the board. Carrie was passionate in sharing that she believes that institutions need to include death and dying EOL care, and elder abuse, particularly with our aging population increasing. She also reflected on our need to understand cultural diversity in EOL care and death.

When considering their own specific training on death and dying the participants reflected on different workshops that they had done around grief and loss, EOL care, enduring power of attorney and care planning, palliative care through the DHB, and then others vaguely connected, such as pain management or mental health.

Discussion

The findings of this research have been divided into three key themes; personal experience and understanding of death and dying, professional experience and understanding of death and dying, personal self-care strategies, professional self-care strategies, and specific training related to working with death and dying.

Social workers' experience death and dying

Berzoff (2008) highlighted that social workers are often drawn to this work following their own personal experiences of loss. Each of the participants had their own experience of death, dying, and loss. Whilst they believed that this was not why they pursued a career in EOL care, they all stated that they had drawn on those experiences throughout their work. Supiano and Vaughn-Cole's (2011) qualitative findings found that practitioners who have a personal experience of grief suggest that the meanings of their loss can inform their developing sense of professional self.

It has been argued that the use of self in social work is in line with the wounded healer paradigm, where the wounds of the healer play an important role in choosing one's vocation (Kwan & Reupert, 2019). Kwan and Reupert (2019) found that social workers' development journeys often begin long before they start their social work training and that their childhood and adolescent events were often found to impact their professional practices. Murray, in particular, referred to his childhood and how he grew up around death; living next to a cemetery, losing a brother in an accident, and he had lost both parents.

Social workers' self-care strategies and practices

It is often believed that part of a social worker's responsibility is to develop and practise their own self-care strategies as there is no a one-size-fits-all approach. However, there were a number of common strategies amongst participants. Some of these include ensuring they finish on time and take regular breaks, not taking work home with them, and taking time out when they feel it is appropriate (Smit, 2017).

For self-care, the literature highlighted that professionals who attend to their personal wellbeing often achieve more positive outcomes, have greater satisfaction and higher resilience in the workplace. Each of the participants seemed to have robust personal self-care strategies that were practised regularly. For instance, healthy nutrition, relaxation, and quality sleep were all mentioned by participants, which reflect the findings from Berzoff (2008). Further to this, Smit (2017) also found that professionals who attended to their wellbeing were more likely to achieve positive outcomes, greater work satisfaction, and higher levels of resilience, which seems to align with the participants in this research.

Some methods revealed in the literature review were reflected in the participants' interviews. For instance, Murray referred to music as being a big part of his self-care, both making and playing different instruments; Leigh and Carrie both disclosed that mindfulness and meditation were part of their self-care practice (Newcomb et al., 2015; Smit, 2017).

Debriefing, accessing an EAP, and regular individual and peer supervision were all referred to as professional self-care strategies. As each participant was a registered social worker, they all participated in regular supervision and believed it to be beneficial, but it was not at the forefront of their self-care practice as it was only monthly. Two of the participants also accessed EAP; however, it was more around management issues rather than relating to the role of death and dying in their position. Their use of EAP was for management issues, which contrasts with what the literature highlighted about EOL social workers feeling isolated, having to prove their worth, and the cumulative grief that they experience (Berzoff, 2008).

When considering self-care, Leigh mentioned that she took drastic action and resigned. Skovholt and Ronnestad (1995, as cited in Kwan & Reupert, 2019) stated that practitioners are informed on the requirements of the role by their employers. They went on to highlight that, when externally imposed requirements differ from their natural practice, incongruence between the personal and professional selves arises. In Leigh's situation, it is important to note that some research shows that social workers must be themselves to be effective and professional (Kwan & Reupert, 2019).

Specific training on death and dying

The participants all explained how they had had some specific training whilst working in EOL care; however, this was not always prioritised by their employers and there was each of them stated that they wanted more training on the specifics of their roles. This was reflected in the literature review where Agnew et al. (2011) found that EOL health professionals were expected to have relevant experience and qualifications and that, once in the position, ongoing training was not prioritised.

It has been highlighted in previous research that ethical codes and practice guidelines may be available, but that consensus for how certain situations are managed is not always possible. Therefore, social workers cannot always rely on them to make immediate responses, instead relying on intuition or practice wisdom (Kwan & Reupert, 2019). This begs questions around safety and accountability. This contrasts with Davidson's (2016) recommendation of social workers aspiring to be leaders in EOL care as there has been a shift in how people view illness and bereavement; it is now being viewed more as a social issue than a medical one, which is more in line with social work training.

One of the participants suggested that more holistic training for health professionals in EOL care was needed; however, this could prove difficult as there are so many aspects to consider, including socioeconomic status, race, gender identity, religion, medical conditions, and diagnosis and prognoses (Rine, 2018; Selman et al., 2014), "social work is highly contextual" (as quoted in Kwan & Reupert, 2019). The participants seemed to have solid self-care practices that they have developed over time, which was similar to findings in the literature. They had no specific training on self-care itself; however, they believed that embedding self-care promotion into training would be beneficial for social workers.

One participant expressed the need for more training around gaining cultural competence in EOL care. Rine (2018) and Selman et al. (2014) highlighted that training in this area would be difficult considering the magnitude of the topic whilst also factoring in medical conditions, diagnoses and prognoses in EOL; this also seemed to be the case with spirituality.

Conclusion

The aim of this research was to explore how social workers practise self-care while working in EOL care. The data obtained from the participants highlighted the importance of robust self-care strategies, and a lack of specific training and education in EOL care. Working in EOL care can be incredibly diverse due to differences in cultural practices, religious views, and the personal experiences of the social workers. Results of this study urge social workers and education providers to seek out further training, development and opportunities in EOL care.

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