Original article

The importance of social intervention in coping with the end of life in Málaga, Spain

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Abstract

The presence of Social Work in palliative care teams is essential for comprehensive care for the person at the end of their life. The existing literature shows the relief of suffering benefits social intervention has on patients and their families. The present study aims to identify whether working with people on social aspects offers benefits in their end-of-life coping. This is done using a quantitative methodology with a descriptive and exploratory approach. The type of sampling used is snowball sampling. The instrument used is an Ad Hoc questionnaire.

The responses to the research questions show that, although the sample does not fully understand the positive consequences of social intervention, its importance and necessity are recognized. Social intervention is essential to addressing emotional support, bereavement management, and improving the quality of life of patients and their families. Professional intervention in social complications not only benefits the process of illness but also the act of dying, the farewell before death, the mourning of loved ones, and the possibility of having a dignified death. This intervention reduces suffering, promoting a better quality of life in the last moments. Promoting the human right to receive comprehensive, personalized, and dignified care is essential, as it promotes more significant serenity and support for the person and their environment.

Keywords: Palliative care; Social Work; Social intervention; Benefits; End of life; Coping.

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El alcance de la intervención social en el afrontamiento del final de la vida en Málaga, España

Resumen

La presencia del Trabajo Social en los equipos de cuidados paliativos resulta imprescindible para realizar una atención integral de la persona al final de su vida. La bibliografía existente muestra los beneficios de alivio de sufrimiento que tiene la intervención social tanto en pacientes como en sus familias. El presente estudio tiene como objetivo identificar si trabajar los aspectos sociales con las personas ofrece beneficios en su proceso de afrontamiento del final de la vida. Para ello, se utiliza una metodología cuantitativa, con un enfoque descriptivo y exploratorio. El tipo de muestreo empleado es el de bola de nieve. El instrumento utilizado es un cuestionario Ad Hoc.

Las respuestas a las preguntas de investigación muestran que, aunque la muestra no manifiesta ser plenamente consciente de las consecuencias positivas de la intervención social, se reconoce su importancia y necesidad. La intervención social resulta esencial para abordar el apoyo emocional, la gestión del duelo, y la mejora en la calidad de vida de los pacientes y sus familias. La intervención profesional en las complicaciones sociales no solo beneficia el proceso de la enfermedad, sino también el acto de morir, la despedida antes del fallecimiento, el duelo de los seres queridos y la posibilidad de tener una muerte digna. Esta intervención contribuye a la reducción del sufrimiento, promoviendo una mejor calidad de vida en los últimos momentos. Es fundamental promover el derecho humano a recibir atención integral, personalizada y digna, que promueva mayor serenidad y apoyo a la persona y su entorno.

Palabras clave: Cuidados paliativos; Trabajo Social; Intervención social; Beneficios; Final de la vida; Afrontamiento.

1. Introduction

Illness processes permeate and impact all areas of a person's life. Within the discipline of social Work, intervention aims to provide support and alleviate part of the suffering experienced. Saunders (1980, as cited in Novellas-Aguirre, 2017) argues that physical, psychological, social, and spiritual dimensions influence the pain experienced by ill individuals. Therefore, professionals from diverse disciplines play a vital role, as the surrounding social environment also endures distress throughout the illness trajectory. Health professionals face significant emotional challenges, particularly related to patient loss. Coping mechanisms—such as spiritual practices and professional support groups—are crucial for their personal and professional growth (Nandan *et al.*, 2024).

Families require multidisciplinary and multidimensional care to understand the progression of illness better, to be more effectively prepared for caregiving roles, and to address the relational, organizational, and practical challenges that may arise. Social Work is intrinsically linked to issues surrounding Human Rights (HR), as its practice is rooted in promoting social change and development aligned with principles of social justice, individual dignity, freedom of choice, self-determination, autonomy, active respect, recognition of social and human rights, and collective responsibility (Consejo General de Trabajo Social, 2012).

Currently, in Spain, 2,711 professionals are integrated into 284 palliative care teams, according to the latest update (2016) from the Spanish Society for Palliative Care. Of this total, 29.5% are medical professionals, 54.1% are nurses, 8.9% are psychologists, and 7.6% are social workers, which corresponds to one social worker per 226,334 inhabitants in Spain (Doblado-Valderrama *et al.*, 2016).

Since the inception of palliative care, the definition of the term has evolved, reflecting new nuances introduced in this specialized form of care. Radbruch *et al.* (2020) conducted a comprehensive study and proposed an updated definition of palliative care, following an extensive historical review of the concept:

> Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers. (p. 755)

This definition encompasses a broad understanding of care, aimed at all individuals experiencing serious chronic illness. Palliative care is not limited to oncological patients. However, it extends to all who suffer from intense pain and distress resulting from health conditions, impacting their physical, social, emotional, and spiritual wellbeing. While the definition refers to individuals at the end of life, it also incorporates early intervention throughout illness. The primary goal is to alleviate symptoms—particularly suffering caused by excessive pain—while addressing the individual's social support needs, enhancing dignity and quality of life. Emerging trends in grief support include digital tools and innovative therapies, which may strengthen holistic, family-centered care in Pediatric Intensive Care Units (PICUs) and other settings.

Moreover, based on the legal and regulatory analysis conducted by Cisternas-Reyes (2021), palliative care is increasingly recognized as a response to the right to die with dignity, due to its integrative and multidimensional approach to care. It represents a universal need for palliative treatment, as it contributes to improved wellbeing by addressing physical, psychological, social, and spiritual challenges faced by individuals with advanced illness.

International regulatory frameworks on this right are extensive, with some offering direct references and others implicitly. The World Health Organization (WHO) recognizes palliative care as a Human Right, linking it to the right to life, dignity in old age, autonomy and informed consent, health, wellbeing, and social protection. Ensuring the provision and assertion of these rights requires societal awareness and education. The violation of such rights—through neglect or abandonment—may constitute dehumanizing, harmful, and degrading treatment (Cisternas-Reyes, 2021).

Social challenges in advanced illness

Barbero-Gutiérrez *et al.* (2016) argue that various social complications often accompany terminal illness. Social workers play a crucial role in addressing these challenges and helping people experience this stage of life with dignity. Such intervention is grounded in analyzing factors such as new family configurations and the relational context of the patient. Professionals develop strategies for coping with grief through diagnostic mapping (Ruíz-Mosquera & Palma-García, 2021). Interventions are conducted free of bias and seek to enhance individuals' resources to foster adaptation and transformation from a resilience-based perspective. The social worker acts as a mediator in conflict resolution and agreement-building, establishes therapeutic or educational communication, and facilitates reflection to develop a jointly agreed intervention plan.

One of the key elements to consider at this stage is the patient's cultural dimension and social environment (Barbero-Gutiérrez *et al.*, 2016). Although death is a universal phenomenon, it is experienced and interpreted in diverse ways. It influences who assumes caregiving responsibilities and the beliefs, emotions, actions, and meanings assigned to painful experiences, the sense of existence, dignity maintenance, and overall wellbeing. Thus, attending closely to each individual is of great value (Ruíz-Mosquera & Palma-García, 2021), particularly to their narratives, to understand and respect their values, wishes, and preferences.

Another relevant aspect is the availability of social support, which demonstrably positively impacts health outcomes. A strong support network can ease crises, while access to basic resources, information, and emotional support helps mitigate the patient's and their family's needs. In contrast, the absence of social networks can deteriorate health and hasten death. Therefore, it is important to strengthen or introduce new social ties, foster positive relationships, and encourage habits grounded in commitment, trust, and respectful interaction. Learning to identify one's needs and personal resources, and knowing how to seek help, are key components of this process.

According to Pozo-Brito (2017), coordinating social and healthcare services and thoroughly assessing biopsychosocial risk at both the personal and family levels is essential in developing appropriate care procedures. Supporting the caregiving environment is fundamental to prevent caregiver burnout. Thus, it is necessary to assess the availability of caregivers, their responsibilities, and the family's caregiving capacity, as well as to organize these functions in a balanced manner. That includes role redistribution, needs assessment, active involvement of family members, and simultaneous Work with the entire family unit. Illness may affect many life domains, including financial stability, employment, education, leisure, emotional wellbeing, interpersonal relationships, housing conditions, accessibility barriers, hygiene, etc.

Social pain and palliative care

Pain management in palliative care must adopt a multimodal approach that addresses both the physical and social dimensions of pain. That includes using multiple analgesics and supportive therapies to treat the complex nature of pain experienced by palliative care patients (Volberg *et al.*, 2023). Specific individuals face additional vulnerabilities in conjunction with their clinical condition and require coordinated intervention involving specialized institutions—for example, individuals with mental illness, intellectual or developmental disabilities, substance use disorders, immigrant populations, those experiencing homelessness or abuse, among others. Agrafojo (2015, as cited in Fernández *et al.*, 2018) reminds us that, when Palliative Care Units were established in Spain in 1989, professionals recognized social pain as an essential consideration; failure to address it would result in continued hardship for both patients and their families, potentially influencing the progression of the illness.

As Trimbur *et al.* (2024) observe, palliative care teams—due to their expertise in communicating serious diagnoses and managing complex symptoms—are particularly well-positioned to address the needs of patients facing social challenges, especially those with co-occurring conditions such as substance use disorders. The biopsychosocial model emphasizes holistic care that encompasses all symptoms and actively involves family members in caregiving (Volberg *et al.*, 2023). Vulnerability indicators—such as social isolation, frequent changes in caregiving homes, high levels of dependency, demanding behavior, lack of cooperation, caregivers' limited health, heavy caregiving burdens, or past negative experiences—highlight the need for sensitive and tailored interventions.

According to Fernández *et al.* (2018), social workers are recognized as essential members of the interdisciplinary palliative care team, providing comprehensive care to patients and families. Their role includes social assessment and diagnosis, and, depending on the situation, may involve facilitating change processes, guiding individuals to recognize their strengths and resources, or managing access to external support. Available social resources include telecare services, home assistance, financial aid for caregivers, contributory and non-contributory pensions (e.g., for retirement or disability), assistive devices, orthopedic materials, day care centers, residential or respite facilities, advance directives, and volunteer services. Social work professionals are qualified to provide information, manage, coordinate, and refer individuals to appropriate services, making them key actors in mobilizing social resources.

Although palliative care effectively addresses social pain, a significant gap remains in healthcare professionals' understanding of its causes and treatment. This gap underscores the urgent need for enhanced education and training in palliative care settings to support better patients experiencing social pain (Silva *et al.*, 2021). Addressing emotional resources—both internal and external—requires attention to the psychosocial needs that frequently arise in these critical circumstances. They achieve this through active listening and by providing emotional support, companionship, and compassion. Some individuals may feel unprepared for the proximity of death; they must therefore be equipped with appropriate tools and receive professional responses that convey trust, validation, security, affection, support, understanding, acceptance, and guidance to manage feelings of incapacity, denial, helplessness, anger, sadness, and uncertainty (Ruíz-Mosquera & Palma-García, 2021). Family communication and relational dynamics interventions are sometimes necessary to improve caregiving practices. Such preparation also facilitates the goodbye process and may help prevent complicated grief.

Family intervention at the end of life

Another dimension of social intervention focuses on mitigating the impact of illness, which can sometimes generate misalignments in the expectations and hopes of those involved. One reason this may occur is that some individuals associate the cause of illness with past events, leading to disordered thinking. For this reason, cognitive restructuring is necessary to align thoughts and actions with the current reality, regardless of what may have occurred in the past. Pinkus *et al.* (1997, as cited in Colegio Oficial de Trabajo Social de Santa Cruz de Tenerife, 2019) conceptualize the role of clinical social Work as follows:

> The clinical social worker is a health care provider for individuals, families, and groups when there are biopsychosocial functioning problems. Clinical social Work goals are preventive and therapeutic, and the methods used are varied. These include any combination of clinical

> psychotherapy, group psychotherapy, family therapy, and interventions with social systems and the environment. (p. 5).

In some families, a phenomenon known as the "conspiracy of silence" arises—alliances formed to withhold information from the ill individual to prevent further suffering. However, this lack of information can foster false hopes and expectations. It may also further isolate the ill person and create emotional distance within the family. Professionals should confront these decisions to withhold information and reflect on whether such actions truly serve the best interests of those involved or cause more harm than good.

To do so, it is essential to identify and analyze the factors contributing to the formation of the conspiracy of silence. That enables the redirection of behaviors and interventions to empower families to develop adaptive skills and to face reality consciously. Oncology and palliative care social workers must train to carry out comprehensive biopsychosocial and spiritual assessments of grief and to implement appropriate care plans. Contemporary theories inform these practices, including the dual process and meaning reconstruction models, inform these practices (Knowles *et al*., 2024).

Receiving bad news or facing unexpected situations often triggers adaptive and defensive responses that professionals must address. These reactions may reinforce the maintenance of the conspiracy of silence. Signs of dissociation can include hopelessness, sorrow, anger, feelings of persecution, blame, dissatisfaction, impatience, restlessness, doubt, helplessness, confusion, nervousness, worry, sadness, guilt, desires, and fantasies.

Another key aspect arises when families face complex symptoms and situations, such as hospital admissions, constant pain, pain tolerance influenced by cultural norms, respiratory complications, speech disorders that hinder communication, delirium caused by illness or medication, the dying process, unexpected premature death, and anorexia due to loss of appetite.

To help families cope with these distressing experiences, professionals must address them simultaneously, as such situations can cause emotional disruption, doubt, mistrust, fear, helplessness, guilt, and suffering. Professionals should provide families with guidance, re-education, and mediation. As Librada-Flores (2020) emphasizes: “Complementing health care with adequate social and community care is a necessary and indispensable requirement if we aim to offer truly person-centered care” (p. 15).

The final days of life and the moment of death mark a stage where emotions and behaviors emerge that help people endure the experience. This phase significantly influences the grief process. Supporting the social and family environment is crucial, helping them adapt to unfolding events, resolve unresolved issues, consider the family's most vulnerable members, and ensure a meaningful farewell, even if implicitly.

According to Barbero-Gutiérrez *et al.* (2016), during this stage, doubts about what to do following death are also resolved, evaluating what may be helpful or harmful, reinforcing decisions made, and supporting those affected by their consequences. It is also essential to assist with blocks in the grief process before and after the death, normalizing the situation and emotional responses (Ruíz-Mosquera & Palma-García, 2021), while addressing legacy issues and final wishes to avoid family disputes. Finally, professionals should respect rituals as valuable tools for the farewell process.

The process of dying and grieving

Dying is an event that forms an intrinsic part of human life, requiring various interventions depending on the events that unfold during this life stage, in order to ensure a dignified death. Cifuentes-Ramírez (2013) defines death as a process involving the progressive breakdown of total human functioning, rather than a discrete act. The author proposes that interdisciplinary analysis should inform actions that support the person’s transition toward a dignified death, while considering personal characteristics and cultural context. Proper communication when delivering bad news allows for decision-making and resolution of unresolved personal matters, providing a sense of closure.

It is vital to respect the individual's right to choose how and how much they wish to be informed—the presence of supportive companionship aids in the preparation to face death. Likewise, professional competence is essential in adapting treatments to the individual's circumstances, responding to their needs, and respecting their decisions. Effective communication should address the emotional responses that arise throughout the stages of approaching death. These considerations contribute to a peaceful and dignified journey toward the end of life.

Llauradó-Sanz (2014) connects the idea of "dying well" to how death occurs—either through active engagement with the dying process or through a lack of involvement. The author notes that those who have not participated in death as a natural phase of life experience greater difficulty. For Arruda-Lima and Manchola-Castillo (2021), autonomy and dignity in the dying process are fundamental, and liberation is another essential component of a good death.

We understand liberation as the act of critical reflection that helps individuals become protagonists of their lives and decisions, allowing them to express their wishes even amid vulnerability. Once individuals receive diagnostic and prognostic information, they experience less fear of freedom. That breaks with genetic and cultural determinism and helps people no longer see the unknown as an adversary, instead fostering synergy between life and death.

Grief defines a crucial phase following death. Lacasta-Reverte *et al*. (2016) emphasize that palliative care (PC) teams address grief before and after death. Grief involves psychological, behavioral, and social phenomena experienced by individuals who have lost someone with whom they shared an emotional bond, often resulting in significant suffering. Typically, individuals do not require specialized psychological treatment or psychopharmacology, as they have internal and external psychological resources to cope with the loss.

Most PC teams in Spain offer continuous grief care, beginning before the death and extending beyond it. Professionals structure this care into three levels. The first level involves providing basic information about the grief process and available resources. This level targets the general public, who can usually navigate grief without complications. The second level entails more targeted professional counseling based on the affected area of the individual. At this level, professionals identify risk factors for complicated grief. The third level involves specialized care provided by psychologists, typically when a person lacks coping resources or when risk factors lead to pathological grief or the development of psychological disorders.

All members of the PC team receive training to provide grief support and emotional accompaniment. Psychological professionals take the lead when a case requires specialized intervention due to the risk of complicated grief (Lacasta-Reverte *et al.*, 2016).

As previously noted, most individuals experience grief adaptively. However, a minority encounter trauma-related challenges that worsen symptoms over time. Parro-Jiménez *et al.* (2021) state that complicated grief remains under-researched, with no terminology or diagnostic criteria consensus. Risk factors influencing complicated grief include sociodemographic variables, degree of kinship, emotional closeness, nature of death, time since the event, psychological vulnerabilities, social support, and the request for professional help.

Key risk factors for non-normative grief include low income, unemployment, close kinship (particularly the loss of a partner or child), young age of the deceased, traumatic or sudden death, extended time to overcome the loss, pre-existing disorders, and substance abuse. However, individuals also possess protective factors that help prevent complicated grief.

Protective factors include strong social support (the most important), receiving palliative care during the illness, prior training in coping strategies, engaging in pleasurable activities, and pursuing transcendence or spirituality (Parro-Jiménez *et al.*, 2021).

The general aim of this study is to determine whether addressing and intervening in the social aspects of the person contributes to achieving a peaceful death. To this end, the following objectives are proposed: to determine whether resolving social complications facilitates the dying process; to explore whether addressing social concerns benefits the farewell process; and to investigate whether attending to social matters prevents complicated grief. In this way, the study seeks to analyze the influence of social intervention in coping with death.

2. Methodology

This study seeks to determine whether addressing social aspects with individuals contributes positively to their process of coping with the end of life. To this end, a quantitative methodology is implemented, with both descriptive and exploratory approaches. The sampling method used is snowball sampling, which identifies key participants through a chain of referrals.

Approach

The approach employed in this study is both descriptive and exploratory (Gross, 2010). The descriptive approach focuses on observing and detailing phenomena as they occur in reality, without manipulating variables. That offers an initial insight into how interventions in social aspects may influence the coping process at the end of life. On the other hand, the exploratory approach investigates phenomena that have been little studied or seeks to understand them from a new perspective. In this case, it examines whether working on social aspects can positively impact the dying process.

This approach is beneficial given that the topic has not been fully explored in the existing literature, allowing for the opening of new lines of inquiry and the formulation of hypotheses for future research. Both approaches offer a foundational understanding of the influence of social factors at the end of life, laying the groundwork for more in-depth and nuanced investigations in the future.

Participants

The sample comprises 170 individuals: 135 women, 34 men, and one participant who preferred not to disclose their gender. Participants range in age from 18 years and older, with the most active group being those aged between 26 and 55. The least represented age group comprises individuals over 66 years old. Regarding marital status, most respondents were single (46.5%), followed by those married (39.4%). The least represented groups were those divorced (7.6%) and those in de facto partnerships (6.5%). A total of 82.4% of participants had lost someone significant after receiving palliative care; the remainder participated despite not having experienced the loss of a loved one. Notably, although the study addresses palliative care and end-of-life issues, no widowed individuals took part.

Concerning educational level, 90% of participants had completed formal education, and 83.5% continued their studies beyond compulsory schooling. Regarding employment status, data show that over half were employed by others (61.8%), while 9.4% were self-employed. A further 2.9% were engaged in domestic tasks, and 16.5% were not currently in the workforce in various administrative or personal circumstances. Additionally, 9.4% were students.

Inclusion and exclusion criteria

Inclusion criteria encompassed any adult who received the digital survey and wished to share their experiences in the context of palliative care. Exclusion criteria included being under 18 and unwilling to complete the research questionnaire voluntarily.

As the study employed an ad hoc opinion-based questionnaire distributed among the general population, including formal ethical review procedures such as approval from an ethics committee or risk minimization protocols, was unnecessary. That is due to the absence of sensitive or identifiable data that could compromise participants' privacy or wellbeing. However, informed consent was obtained before participation, ensuring respondents' anonymity. Therefore, given the nature of the data—personal opinions rather than sensitive or clinical information—the ethical framework was centered on respecting the voluntary nature of participation and guaranteeing anonymity, which is sufficient to meet ethical standards for this type of research.

Instrument

This study uses a quantitative approach and employs an online questionnaire as its primary instrument. The researchers used snowball sampling—a non-probability technique selected due to the challenge of identifying individuals familiar with or involved in palliative care contexts. The team developed an ad hoc questionnaire with 33 questions: the first six gather sociodemographic data, and the remaining 27 address the study's objectives. The final question was open-ended and not quantified, but instead categorized thematically.

Procedure

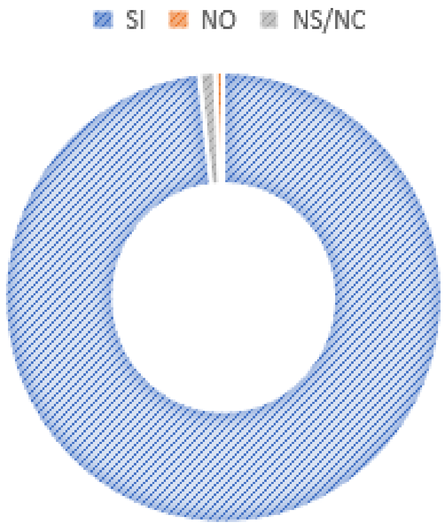
Following the design of the questionnaire, distribution was initiated through personal networks via social platforms and instant messaging services to activate the snowball effect. Individuals with experiences in palliative care were invited to participate and encouraged to share the survey with others. Most respondents were individuals involved in social action or social services. The researchers chose this recruitment strategy to capture public perceptions regarding the research topic, making the study analytical. To explore whether differences existed in responses based on lived experience, the researchers included a filter to distinguish between participants who had experienced the loss of a closely bonded individual and those who had not. They then disaggregated the results accordingly to assess whether significant divergences in perspectives emerged; ultimately, they found no substantial differences between these two groups. Another filter was applied to identify whether participants who had lost a loved one had received social work intervention, and to capture their experiences with such support. In this subset, the researchers observed relevant differences. They discuss these findings in detail in the results analysis, discussion, and conclusion sections.

3. Findings

3.1 Influence of social aspects on dying in peace

94.7% of participants affirm that resolving social difficulties that arise during an advanced illness contributes to dying in peace and with dignity. Moreover, they emphasize the importance of readjusting expectations and hopes after receiving bad news, enduring emotional impacts, and navigating ongoing changes. Attention is also drawn to the "conspiracy of silence" as it generates confusion, fear, guilt, and distress. Participants report the importance of receiving information and professional support during the final days of life.

Figure 1. Benefits of addressing social difficulties at the end of life.



Source: own elaboration

98.2% agree that addressing social challenges caused by illness is beneficial during and after death; only 0.6% disagreed, and 1.2% responded "do not know/no answer." Additionally, 97.6% agree that attending to social matters helps say goodbye before death occurs. Similarly, 96.5% believe that dealing with social difficulties during the illness can bring relief and benefit the grieving process.

3.2 Social roles at the end of life

Maintaining social roles during illness and at the end of life is considered essential for both the person receiving care and the caregiver, according to 51.2% of respondents. In contrast, 37.6% believe that preserving these roles is not important. The researchers analyzed these differing perspectives about whether individuals had received support from social work professionals, showing that 100% of those who received such care believed in preserving social roles.

Between 89% and 95% of participants agree that professional support is necessary to face the nearness of death and the emotional consequences it entails. They also emphasize that addressing unresolved personal and social matters is key to dying in peace. The researchers identified professional mediation in cases of family conflict as particularly helpful in this process.

3.3 The impact of illness on social relationships

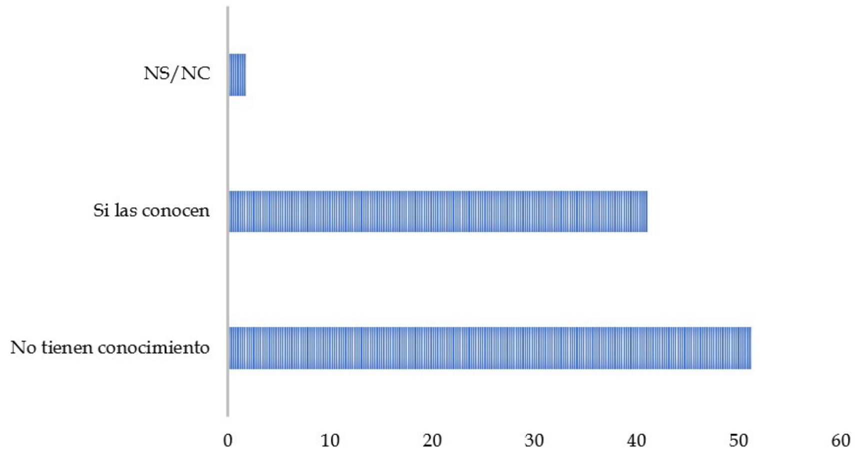
All respondents (100%) stated that illness affects families and social networks, bringing about changes and complications. They consider it essential for more than one person to be involved in caregiving to prevent caregiver overload and to extend support to family members. Participants emphasize the importance of social support in coping with adversity, acknowledging that although values and beliefs about death differ, the presence of support remains a key factor. The entirety of the sample stated that being informed and accompanied during difficult moments caused by clinical deterioration is essential, as illness impacts all aspects of a person's life. Moreover, illness can aggravate pre-existing problems. Participants frequently mentioned social resources as a vital source of support.

3.4 Social work intervention in palliative care

According to the data, 83.6% of participants reported not receiving care from social work professionals; 15.7% did, and 0.7% were unsure. Among those who did receive support, 72.7% evaluated the experience positively, 9.1% negatively, and 18.2% expressed indifference.

About 49.41% of respondents believe that only social workers have adequate training to handle social matters. Meanwhile, 18.24% consider that social workers, psychologists, educators, medical and nursing staff, pedagogues, anthropologists, social integrators, sociologists, therapists, and care assistants are all equipped to intervene. A smaller group (2.94%) believes that only psychologists have the necessary training for such interventions.

Figure 2. Awareness of social workers' roles in palliative care.



Source: own elaboration.

Regarding knowledge about the specific functions of social workers in palliative care teams, 51.2% admitted to not knowing which areas these professionals work in, while 41.1% said they did, and 1.8% did not respond.

3.5 Key aspects to improve social work intervention

When asked whether all individuals are capable of providing care to someone with a serious illness, 15.9% answered affirmatively, while 81.8% disagreed, and 2.4% gave no response.

Table 1. Areas for improvement in social intervention.

Considerations for patient and family care:	Nature of the intervention:	Improvements in professionals and institutions:
Wishes. Freedom of choice. Dignity. Beliefs. Spirituality. Legacy. Life story. Farewell. Grief support. Consideration of friends. Family relationships. Support for primary caregiver. Self-care. Financial concerns. Mental health.	Individualized. Personalized. Holistic. Respectful. Empathetic. Compassionate. Humane. Active listening. Communication. Information. Emotional support. Mediation. Focused on the present. Treating death as part of life. Preparing for loss. Psychological support.	Specialized training. Qualified personnel. Community-based interventions. Rural outreach. Interprofessional coordination. Bureaucratic and legal assistance. Work-life balance. Ongoing home visits. Support for palliative care institutions and associations. Streamlining access to social resources. Respite for caregivers.

Source: own elaboration.

An advanced chronic illness impacts the physical realm and causes deterioration in social, emotional, and spiritual domains, as evidenced by this study's results. Palliative care aims to alleviate the suffering brought on by loss of health and proximity to death for patients and their families, addressing physical, emotional, spiritual, and social dimensions to improve quality of life and dignity (Radbruch *et al.*, 2020). Palliative care professionals also underscore the central role of the family in the care they provide.

Palliative care directly links its support to the respect for human rights. Cisternas-Reyes (2021) stresses that the public must recognize this to assert these rights, highlighting the need for greater public awareness. The 2012 Code of Ethics for social work professionals outlines principles aligned with human rights, reflecting the discipline's foundation in social development and transformation.

Findings show that of the 140 individuals who experienced a personal loss, only 22 received social work intervention—72.7% of whom rated it as a positive experience. A significant proportion of participants believe that only social workers are equipped for such intervention, while 18.24% see value in collaboration with other social science professionals. Both professional competence and teamwork are valued highly.

There remains a lack of awareness about the direct benefits of addressing social issues in the context of illness, dying, and bereavement, as well as the consequences of neglecting social risk factors. While many acknowledge the social impact of palliative care and the need for intervention, more than half of respondents are unaware of social workers' roles, and very few have received support from such professionals.

This study confirms that a range of challenges—including optimal caregiving within the family, mobilizing internal and external resources, psychosocial needs, communication adapted to the family's situation, and grief—require targeted social intervention to support the individual and the family affected by advanced illness.

People likely underestimate the importance of preserving social roles due to a lack of information. Given that 100% of those who received support from social workers emphasized its value, it is plausible that they addressed this aspect during their care.

Multidisciplinary intervention is crucial for approaching the end of life, and addressing social dimensions supports both the dying process and the experience of grief. Cifuentes-Ramírez (2013) defines death as a process rather than a single event, noting that it involves the dismantling of the individual's entire functioning. Llauradó-Sanz (2014) adds that to die peacefully, one must participate actively and consciously in the dying process. Arruda-Lima and Manchola-Castillo (2021) highlight autonomy, dignity, and liberation as essential for a dignified death.

Professional intervention in social complications supports the illness trajectory, the dying process, the farewell, the grieving period, and ultimately enables a dignified and peaceful death. Lacasta-Reverte *et al.* (2016) describe grief not only as something that occurs post-mortem but also as a process that begins with the progressive loss of abilities during illness.

While individuals may have coping mechanisms, professional accompaniment remains essential to provide information, emotional support, and to detect potential risk factors requiring specialized care. Parro-Jiménez *et al.* (2021) emphasize the role of social factors as risks and protective elements in cases of complicated grief.

The study acknowledges several limitations. First, snowball sampling may have introduced selection bias, limiting the generalizability of results. Second, the Ad Hoc questionnaire may lack rigorous validation, which could affect the reliability and validity of the data collected.

Furthermore, external variables—cultural, economic, or individual differences in approaching end-of-life issues—were not controlled, which may have influenced the results. Another limitation is that participants may not have been fully aware of the positive impact of social work intervention, potentially affecting their responses.

The study's exclusively quantitative design may also fail to capture the emotional and subjective complexity of end-of-life experiences, suggesting that a mixed-methods approach could yield more profound insights. Finally, the absence of a longitudinal perspective prevents analysis of the long-term impact of social work intervention.

This initial approach to a pressing social reality opens several avenues for future research. A replication of the study using a larger, more representative sample and probabilistic sampling methods could enhance the generalizability of findings. Improving and validating the Ad Hoc questionnaire would yield more precise and comparable data.

Future research could incorporate qualitative methodologies—such as interviews or focus groups—to better understand the lived experiences of both individuals and their families and the emotional impact of social intervention. Further exploration of the role of cultural, economic, and religious contexts in shaping perceptions and effectiveness of intervention would also be valuable.

Longitudinal studies could assess the evolving impact of social intervention from diagnosis through bereavement. Research could also compare social work practices across different palliative care settings—hospitals, care centers, and home environments—to identify best practices in each context.

4. Conclusions

From the perspective of social Work as a discipline, it is essential to make its role and relevance visible in palliative care, particularly in respecting and advancing human rights. The study reveals that patients and families strongly express their need for values such as dignity and respect. They actively demand that professionals uphold these values to receive high-quality care at this stage of life.

Beyond increasing the visibility of Social Work in palliative care, it is crucial to emphasize its role in implementing interdisciplinary approaches that promote the emotional and social wellbeing of patients and their families. That includes the development of intervention strategies that not only address immediate needs but also encourage active and personalized communication among healthcare teams, patients, and caregivers. In doing so, palliative care is reinforced as a comprehensive human right, ensuring that care aligns with each individual's cultural, spiritual, and ethical values, thereby contributing to a more dignified and respectful end-of-life experience.

Among the most frequently mentioned demands throughout the study is the need to respect individuals' preferences regarding how they wish to experience their illness and the final phase of life. Participants also highlight the importance of prolonged support following a death, particularly in terms of social intervention.

Society expects palliative care professionals to embody humanization, social and communication skills, emotional support, individualized intervention, and normalizing the dying process. Regarding systemic structures, this study reflects demands for adapting response times to personal circumstances, with minimal delays in access to resources—whether care-related, service-based, financial, or material. Participants call for professionalization and specialization to meet the unique needs at the end of life.

Social Work contributes essential elements that help individuals face the illness process with greater peace of mind and quality of life, allowing for closure, dignified farewells, and the possibility of dying in peace. These aspects, in turn, positively affect the grieving process. The importance of social intervention is recognized, and there is a general awareness of the existence of social work professionals. However, a lack of knowledge remains regarding their specific roles. The few individuals who have received social work support report positive experiences with such interventions. That leads us to question: Why is the presence of social workers still so limited in palliative care units?

In conclusion, and based on the analysis of the results, it becomes evident that there is a need to raise awareness and advocate—both within the profession and across organizations—for the importance of addressing social aspects in palliative care. At the same time, professionals should make efforts to increase public understanding of the roles and contributions of social workers. Their interventions could significantly benefit both patients and their families during advanced illness, as well as help prevent complicated grief, positioning them as essential members of palliative care teams.

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Authors' Contribution statement

María Vegas-Pérez: conceptualization, data curation, formal analysis, resource acquisition, investigation, methodology, supervision, validation, visualization, writing (original draft), writing (review and editing).

Ana Cristina Ruiz-Mosquera: conceptualization, data curation, formal analysis, resource acquisition, investigation, methodology, supervision, validation, visualization, writing (original draft), writing (review and editing).

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Conflicts of Interest

The authors declare no conflicts of interest in the writing or publication of this article.

Ethical Implications

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