Implementation of the DIR Model and the DIR/Floortime Approach in the System of Palliative Care for Children

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Abstract

Introduction. *One of the systems that can be used in the system of palliative care for children is the Developmental Individual Relationship (DIR)/Floortime concept, which can be flexibly adapted to individual features of a child, and at the same time it has intelligible and clearly-defined tools for work and interaction, that take into consideration not only individual peculiarities of a patient, but also their parents and specialists.*

Purpose. *The purpose of the paper was to review the possibilities and prospects of using DIR/Floortime model in the system of palliative care for children.*

Methodology. *The paper was prepared on the basis of input from Belarusian Children's Hospice and also took into account experience of implementation of the DIR/Floortime Model (report information of ICDL' specialists).*

Results and Discussion. *In the course of the work the main tasks for providing palliative care to sick children were outlined and 6 points of introduction of the DIR /Floortime concept into this system were singled out.*

Conclusions. *The main postulates of the DIR concept fully coincide with the modern principles of palliative support. Using DIR/Floortime Model also can solve urgent tasks of the system of palliative care for children: build a team-based, positive, supportive and safe relationship around a child and family; help to prevent conflicts; improve the emotional background of the child in care.*

Keywords

Child psychology, mental health, education, palliative care, DIR Model, DIR/Floortime Approach.

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Introduction

Palliative care for sick children involves providing assistance to a wide category of patients that includes not only oncology patients but also children with congenital or/and acquired diseases and (multiple) complex developmental disorders. Thus, we cannot talk about a narrow

range of diagnoses: every child has his own individual aspect of a disease. A team of specialists, who provide palliative care for a family and a child, are tasked not only with medical, but also psychological and pedagogical support of a child and his parents. One of the standards of high-level palliative care is to provide assistance not singularly to a child, but to the entire family of a patient. In addition, the extensive experience of palliative support of patients in different countries shows that the emotional background of a palliative patient has a direct impact on the somatic and mental condition of the child and even on the nature of the course of his\her disease (Itskovich, G.,2018; 2019).

The system of palliative care in many countries is currently being created and established or improved. The model of care for terminally-ill children undergoes changes for humanism and personalized approach, which takes into account not only a patient's interests, but also peculiarities of their stay in the family. However, even in a personalized system of care specialists of different profiles who work in a team need a common frame of orienting points. It will make the teamwork focused, well-coordinated and consistent (Gomozova, E. S., & Gomozova, M. A., 2019). One of the systems that can be used in the system of palliative care for children is the Developmental Individual Relationship (DIR)/Floortime concept, which can be flexibly adapted to individual features of a child, and at the same time it has intelligible and clearly-defined tools for work and interaction, that take into consideration not only individual peculiarities of a patient, but also their parents and specialists (Pajareya, K., Sutchritpongsa, S., Kongkasuwan, R., 2019; Boshoff, K., Bowen, H., Paton, H. et all., 2020; Hess, E., 2020).Although Canada and Ukraine have vastly different histories, both countries include populations who have experienced trauma and oppression and are far from achieving positive peace. We have attempted to illustrate that, while the details are different, people in both countries have experienced and continue to experience the impact of colonization and other related structural, cultural and direct violence[1]. In addition to people suffering with more traditionally acknowledged mental illnesses such as schizophrenia and bipolar disorder, there is slow movement not only towards understanding whole health of individuals and communities as described by the World Health Organization (2005) but also towards institutionalizing systems and cultures of care that can support ongoing empowerment of individuals and communities that facilitate peaceful development.

Purpose

The purpose of the paper was to review the possibilities and prospects of using DIR/Floortime Model in the system of palliative care for children

Methodology

The paper was prepared on the basis of input from Belarusian Children's Hospice and also took into account experience of implementation of the DIR/Floortime Model (report information of Interdisciplinary Council on Development and Learning' specialists).

Results and Discussion

Therefore, providing of palliative care for sick children has the following tasks:

- To organize effective teamwork of specialists of different profiles within a single framework of the palliative system for a particular client; it implies using single terminology and following the common assistance concept, which experts can rely on for their work to be consistent and coordinated.
- A child's family must be included into the system of assistance: family members need to be trained specific methods of care and medical manipulations, but also it is crucial to teach them the correct interaction with the child and to provide them with psychological counselling and spiritual support if necessary.
- Children with complex diseases are often subjected to chronic stress associated with frequent hospitalizations, surgical treatment, as well as stress caused by instrumental and/or psychological trauma. These problems also need to be systematically addressed.
- Professionals who work in the field of palliative care often face intense severe experiences, which puts them at risk of emotional burnout. In this regard, it is necessary to focus on burnout

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prevention and psychological well-being of specialists.

Implementation of the DIR/Floortime concept into the system:

1) The DIR concept is both multidimensional and flexible. The first aspect of the DIR is the development component which shows us the current state of the child and his actual level of development. Personalized approach presupposes that we take into account not only a child's level of development, but also all his/her individual characteristics: history of illness, his sensory-motor profile, specifics of the family system where the child resides (resources and "weak" areas, history of the disease as seen by family members, psychological state of close relatives of the child, etc.). Component "D" shows us how to build interaction with each specific child and their family based on the previous two points. Besides, there are several other "dimensions" – these are the characteristics of each involved specialist, their individual profile, experience, skills and current emotional state. Basing on this data we can personalize interaction of all specialists with a patient and/or their family and fully adapt it to the child's needs.

2) The crucial role of affect in the DIR/Floortime model needs to be emphasized. The DIR/Floortime teaches us to establish and develop emotionally healthy and positive relationships. Besides, special attention is paid to compliance with ethical principles, as well as to respect for each patient, their family members, and specialists involved. The DIR/Floortime gives us specific tools for building emotionally warm relationships, with a full range of acceptance of all emotions experienced by all participants of the process. Such practice and attitude has a therapeutic role in itself – it helps to prevent emotional burnout of everyone involved and helps to regulate the emotional background of a patient, which, as we have already indicated, directly affects his/her condition as a whole.

3) Reflection. The DIR/Floortime concept increases the level of awareness in the specialist-child or specialist-parent interaction. It implies self-improvement of each specialist, development of their self-awareness, which leads to the more conscious and careful usage of their skills and abilities in work.

4) Team. The DIR / Floortime suggests teamwork of different specialists – of medical, psychological and pedagogical profiles, rehabilitation specialists, etc. However, these specialists, provided they have the necessary training, have an opportunity to coordinate their work according to the common DIR parameters, and form a single joint vision of the dynamics and prospects of a child in their care.

5) Family. The DIR/Floortime concept emphasizes a huge role of the family system and of cooperation with family members – those who take care of the child. They become the main "players" in the team. The advantages of such an approach are undeniable: it allows parents to cope with the trauma of the disease, they feel the support from outside and realize their important role within the team, also it facilitates the work of specialists, since some part of the work can be taken over by trained parents.

6) Child. For many years in post-soviet countries the role of a seriously ill patient was "inanimate" and impersonal. These people were treated as objects that needed to be manipulated and cared for. Only recently they have raised a question of the quality of life of such people and humane attitude to them. The DIR/Floortime approach helps us to avoid excessive stress while dealing with seriously ill children. As practice shows, the atmosphere of the medical institution changes dramatically for the better and stress levels of patients and their relatives reduce significantly when the staff know and successfully use the tools to establish emotionally warm and safe relationships. Moreover, it increases work motivation and improves the emotional state of employees of the institution.

Limitations of the study

Potential challenges in the implementation of the DIR/Floortime approach in the system of palliative care

1) The first difficulty we might encounter is the delay of important results. It is not enough just to train the staff and give them "tools" of the approach to get some persistent changes in the

work of the team. Each team member will have to go through a stage of internal changes, and work on self-reflection, empathy, increasing awareness of their experiences and interactions, both in the team and with patients. However, in the long run, this very approach helps to get a better result in terms of team cohesion, improving motivation and emotional state of employees.

2) The use of the DIR/Floortime requires a very subtle adjustment of the connection specialist-child, and there might appear situations when a child and a specialist will not coincide in some parameters (individual characteristics, emotional state, etc.). This will require "replacing the player" or taking some other action to deal with the problem.

3) In very rare cases, some team members might consider the DIR/Floortime concept unsuitable due to their personal characteristics. They might find it difficult to use non-directive methods, as well as to work with their emotions. Each such case requires an individual approach and search for solutions.

4) Staff training will take a certain amount of time, and then, after training, regular supervisions need to be provided. Professionals who provide assistance have to complete not only the introductory 101 course, but also 201 and/or 202 DIR/Floortime courses. Parents and attending personnel (nurses, junior nurses) can complete only the introductory 101 DIR/Floortime course, but they need to receive the support of a more qualified specialist on a regular basis.

5) The work of such a team requires regular supervisions by an independent external expert of the appropriate qualification for high efficiency maintenance.

Conclusions

Due to its flexibility, adaptability, and inclusion of the emotional aspect, the DIR/Floortime model can be widely and successfully used in the system of palliative care. The main postulates of the DIR concept fully coincide with the modern principles of palliative support. In addition, the use of this model not only increases the competence of employees, but also solves other tasks: team cohesion, prevention of emotional burnout, development of emotional intelligence, awareness and empathy of everyone involved. Building a team-based, positive, supportive and safe relationship around a child and family helps to prevent conflicts, and to improve the emotional background of the child in care.

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Conflict of interest

Author declares no conflict of interests.

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