PSYCHOLOGICAL REHABILITATION BY MEANS OF THE "MINNESOTA MODEL OF RECOVERY" AS A WAY OF DEVELOPING RESILIENCE IN CHEMICALLY DEPENDENT PERSONS

Introduction. According to the latest WHO estimates, 8-10% of the world's population is directly involved in alcohol, drug or toxic addiction. The risk group for this profile is 10-12% of the population. This social epidemic has a direct destructive effect on almost 40% of society, and indirect effects on society as a whole. Alcohol pathology remains dominant in the structure of other forms of substance dependence.

Today, around 140 million people suffer from alcohol abuse and need treatment and rehabilitation. According to statistics, alcohol consumption is the leading risk factor for the burden of disease worldwide, accounting for almost 10% of global deaths among the population aged 15-49, which has negative consequences for the health of the future generation and for the demographic situation in general. Ukraine ranks fourth in the number of deaths from alcohol[235].

Drug addiction is one of the most acute problems in today's society. In today's Ukraine, the problem of drug addiction has reached catastrophic proportions. Data on the number of people who use drugs and are treated in drug treatment facilities in Ukraine are not only very ambiguous, but often contradict each other (Bulgakov, Lynsky, & Goloshchapov, 2004; Institute of Psychiatry, Forensic Psychiatric Examination and Drug Monitoring of the Ministry of Health of Ukraine[236].

Isolated pharmacotherapy cannot provide long-term and stable remissions, does not allow for the formation of motivation to stop substance abuse, and long-term treatment cannot help the patient to successfully adapt to society. These and many other tasks are solved in the process of rehabilitation. Rehabilitation centres act as an inevitable final stage of treatment. Moreover, it is only in the process of psychological rehabilitation that the root causes of addiction are addressed[237].

These circumstances significantly actualize and confirm the need to study and analyse the development of psychological adaptability in chemically dependent individuals during psychological rehabilitation.

The problems of psychological dependence of a person are addressed in the works of R. Gross, T. Dmitrieva, B. Zeigarnik, A. Korchagina, O. Minko, I. Lysenko, I. Linsky, I. Sosin, L. Yurieva and others. These scientists prove that drug addiction is a deep psychological phenomenon that permeates all spheres of a person's life. This area is being developed by a whole cohort of modern scholars, including F. Berezin, B. Bitensky, N. Burmaka, N. Vostroknutov, Z. Zykova, G. Zolotova, N. Kurek, S. Kulakov, K. Lisetskyi, I. Linskyi, O. Lichko, P. Liutii, O. Minko, M. Mintz, E. Protsenko, and others.

The studies of our time are devoted to the specifics of the motivational sphere of drug addicts (M. Zobin, N. Litvinova, V. Rerke), their value and semantic orientation (N. Harutunyan, S. Egorchenko, D. Leontiev, N. Samykina), personality characteristics (A. Aseyeva, O. Zharkikh, V. Mendelevich, A. Leshner), characteristic features of the emotional sphere (T. Bukanovskaya, O. Kolyago, V. Chirko) and behavioural characteristics (Y. Valentik, V. Sirko) of drug addicts. The rehabilitation of this category of persons is considered in the works of O. Bondarchuk, T. Galaktionova, I. Gusev, S. Dvoryak, I. Kutyanova, N. Shtein.

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[235] Gakidou E., Afshin A., Abajobir A. A., Abate K. H., Abbafati C., Abbas K. M., ... Murray C. J. L. (2017). Global, regional, and national comparative risk assessment of behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet, 390 (10100), 1345-1422.

[236] Інститут психіатрії, судово-психіатричної експертизи та моніторингу наркотиків Міністерства охорони здоров'я України. (2014). Національний звіт за 2015 рік щодо наркотичної ситуації (за даними 2014 року).

[237] Дудко Т. Н., Котельникова Л. А. (2004). Реабилитация наркологических больных в условиях амбулатории: Методические рекомендации.

Косарецкий С. Г., Косарецкая С. В. (2002). Новые подходы в лечении и реабилитации наркозависимых. Вопросы наркологии Казахстана, 2 (2), 84-88.

In our research, we relied on the works of contemporary Ukrainian scholars M. Antonovych, Y. Bezsmertnyi, A. Vovk, P. Husak, S. Dikhtyarenko, T. Dudko, V. Ivanov, O. Kocharyan, M. Markova, S. Mykhailiv, M. Soshnikova, D. Starkov, S. Tatochenko, L. Shcherbina and foreign scholars: F. Alexander, V. Bill, D.M. Wilcox, T. Gorski, H. Graham, E. Good, M. Erikson, G. Estein, M. Clark, S. Kosarevsky, S. Kosarevska, D. Levinson, M. Rawlins, D. Samuels, M. Samuels, R. Stone, S. Folkman, D. Haley, L. Shaidukova, O. Yusopov.

The purpose of the study is to determine the effectiveness of the Minnesota Model of Recovery in the psychological rehabilitation of chemically dependent persons.

Results of the study.

Psychological characteristics of chemically dependent persons and psychological determinants of the formation of chemical dependence. The analysis of theoretical and methodological sources on this issue did not reveal a unanimous concept that would provide a clear list of psychological factors and mechanisms of addiction (including drug addiction), and this, accordingly, makes it impossible to take into account all these factors and features in the process of developing rehabilitation, psychocorrectional or prevention programmes[238]. In this regard, an in-depth study of the preconditions for the formation of drug addiction, personal changes in people with substance dependence, the specifics of psychocorrection when using social and psychological support for these people, and the outlining of its directions are of great theoretical and applied importance. The drug is the meaning-forming value of drug addiction, and its development is usuallyaccompanied by the formation of a system of specific personal meanings in the subject, which are determined by the drug as a motive for satisfying various urgent needs. In the process of drug addiction acquiring stable features of a way to meet current needs, personal meanings that are formed into a system generated by a drug become stable, rigid, and resilient, and turn into a system of characteristic personality attitudes[239].

The main factors of personality drug addiction reflect the fact that among the main ones, we can trace the loss of meaningful values of life, which are artificially realized and cause significant changes in the original (real) values. Narcologists and psychiatrists have a concept of a kind of "drug personality" or "personality of a drug addict". The personality of a drug addicted young person is influenced by premorbid features, which are determined by those nervous, mental and somatic areas of diseases and character traits that the drug addict had before the start of drug use[240].

According to the medical and physiological aspect of drug addiction, the main approach to the study of this problem is distinguished, which reduces the problem of drug addiction to physiological dependence. However, the problem of drug use is not just a physiological aspect, but is a problem of the individual who is addicted to drugs in a particular social situation[241].

Based on the results of the study of theoretical sources, it can be argued that different psychological areas have different views on the problem of drug addiction.

For supporters of the behavioural approach, the idea of a continuous influence of the social environment on the individual is typical. Positive ties to society for a drug addict are contacts with group members. Given the psychological structure, a drug addict is a personality type that does not withstand pain and emotional stress well. In the absence of close contacts with people who are similar to them, such a person loses a sense of self-confidence. Due to the "unprofitable" social development, a drug addict seeks to avoid all forms of responsibility, acquires signs of isolation and distrust of everyone who is part of the threatening world for him or her. Given all of the above, one of the social needs of people with drug addiction is to form groups. Such a group is devoid

[238] Батищев В. В., Негериш Н. В. (2001). Методология организации программы психотерапии и реабилитации больных зависимостью от психоактивных веществ, имеющих низкий уровень мотивации на лечение.

[239] Горски Т. Т. (2003). Понимание двенадцати шагов: Руководство для консультантов, терапевтов и выздоравливающих.

[240] Братусь Б. С. (1974). Психологический анализ изменений личности при алкоголизме.

[241] Кочарян С., Антонович М. (2016). Теоретичні аспекти вивчення психологічних особливостей наркозалежності. Психіатрія, неврологія та медична психологія, 3, 1 (5), 62-67.

of hierarchy, and all its members are given equal rights and almost no responsibilities towards each other. It is extremely difficult for a drug addict to escape from such a group, as it has everything he or she cannot have in the real world. Outside this environment, they find themselves in another world, filled with misunderstanding, condemnation, alienation, and aggression not only from their own family but also from society as a whole. Thus, society avoids and repels people with drug dependence, although it is in society that the cause of this disease lies[242].

The high efficiency of drug addicts' behaviour in acquiring and using drugs is also noteworthy. In this case, there are no obstacles for them in the form of the law or the police, lack of money, obstacles from society and family, and other things that can become insurmountable obstacles for an ordinary person. Such a complex chain of behavioural acts and events is characterized by a mandatory ending in the form of positive reinforcement with a vividly experienced bodily component. Withdrawal from a drug substance becomes a rejection of extremely effective behaviour in favour of actions in an unstructured, hostile environment, with a low probability of success[243].

Thus, drug addiction is a highly adaptive way of behaving, and giving it up is an inadaptive step that involves the risk of uncertainty and responsibility for oneself. It should also be noted that in this case, when a person stops using drugs, there is no guarantee of happiness or ease of being. Instead, drug use is a guarantee for the drug addict of the "disappearance" of the world with its problems.

A cognitive approach to explaining the causes and consequences of drug addiction is associated with the concept of locus of control. M. Rutter notes that some people associate a behavioural scenario with internal factors, while others associate it with external circumstances[244]. Drug addicts tend to relate their actions to external circumstances. Thus, they are convinced that other people or an accident forced them to use drugs. In this regard, the reason for the inability to stop using drugs is the lack of internal control. This approach reveals the complexity of human interaction and the situations that arise. At the same time, this approach does not provide a clear explanation of why one person tends to see the cause of their behaviour in themselves, while another person sees it in others[245]. In addition, some studies have revealed the fact that the nature of the locus of control in people with drug dependence cannot be unambiguous and categorical.

The data on the specifics of cognitive processes in people with drug addiction is more reliable and valid. In particular, it has been established that opium addiction causes degradation of imagination, dilution of thinking processes, expansion of peripheral visual perception, and a decrease in adequacy in relation to the non-verbal behaviour of others[246].

Psychoanalytic studies of drug addiction explain the development of addiction as a defect in psychosexual development, when oral dissatisfaction is formed, which subsequently leads to oral fixation. Another explanation of drug addiction within the psychoanalytic approach is fixation on the anal stage, or on the anal and oral stages of development simultaneously. According to these explanations, addiction is a regression that can only be stopped by eliminating it. Due to the lack of complete satisfaction of addiction and the hostile reaction of a frustrated personality and withdrawal, mental destruction occurs. Such people perceive drugs as a means of relieving their frustration by achieving euphoria, and the condemnation of society (which usually relates to drug use) only provokes hostile attitudes and increases guilt. As a result, the drug addict's ties to the real world are destroyed, and their defences against adverse influences become ineffective. Such people focus only on acquiring and using drugs and do not value relationships with others, and are only interested in their own pleasure from the effects of these drugs. Incomplete relationships with other

[242] Пятницкая И. Н. (1994). Наркомании.
[243] Seddon T. (2006). Drugs, Crime & Social Exclusion: Social context and social theory in British Drugs [Crime research]. British Journal of Criminology, 46, 4, 703.
[244] Петровский В. А. (1992). Психология неадаптивной активности.
[245] Ibidem.
[246] Ураков И. Г. (1990). Наркомания: мифы и реальность.

members of society are the result of the addict's inferior self, for whom libido is a "vague erotic concept"[247].

Another view is transactional analysis. E. Berne's theory does not provide a clear interpretation and understanding of the essence of drug addiction[248]. According to this theory, normal personality development is possible when the most important aspects of the "Parent", "Adult" and "Child" are in harmony with each other. Such people have good self boundaries and, although they may have serious internal conflicts, they have the ability to balance the Parent, Adult, or Child in a way that "allows" each of them to fulfil their functions. In view of this, many researchers assume that drug addicts are dominated by one ego state, most likely the Child, or that one ego state is infected by another. Drug addiction can also be thought of as a game, where each participant (family members, friends, "rescue" organizations) is assigned a certain position. It is a game because of the artificiality of behaviour, the inability to achieve spontaneity. The lack of sincerity leads to the replay of established and familiar situations. Although the game can bring certain benefits to each participant, they cannot change or develop under such circumstances, and therefore are deprived of the ability to solve the problem, to do something for recovery. This relationship is a sign of mental dependence on drugs[249].

According to the systemic approach, drug addiction is understood as a systemic complex that contains elements of different nature, level and dynamics[250]. From the perspective of systemic family psychotherapy, drug addiction is a family disease, a family problem. A person with drug addiction "draws" all their loved ones into their illness, who subsequently acquire signs of codependency, which makes it impossible to adequately perceive reality, distorts the nature of intra-family interaction and, as a result, fixes mental dependence.

The main reasons for the high vulnerability of people with drug addiction include an unstable self-concept[251]. Changes in the personality of such people include a decrease in moral and ethical qualities and exacerbation of premorbid character traits. According to P. Shabanov and O. Y. Shtakelberg, when studying the "self-image" of drug addicts, it is necessary to take into account the influence of the internal picture of the disease (i.e. the reflection of the disease in the patient's self-awareness, the patient's own attitude to it) on the processes of personality changes during the course of the disease[252]. Personality changes are a consequence of chronic intoxication and psychological maladjustment of an individual, caused by disorders of the social functioning of a drug addict, to which society responds with repression. In order to preserve their perceptions of the world and themselves, drug addicts build a system of psychological protection[253]. It should be noted that their own experience is significantly distorted, and the personality structure is defined as more rigid.

An important unconscious mechanism of behaviour that plays an important role in the process of personality formation is psychological defence. In relation to drug addicts, it is necessary to understand the extent to which the mind, will, and emotions are distorted as a result of long-term abuse. These processes occur during the development of drug or alcohol dependence, i.e. they develop gradually. As the amount of drugs used increases, so does the painful suffering. As the person's suffering increases, the wall of defence becomes stronger and grows. As a result, a person with drug addiction becomes a victim of their own psychological defence mechanism, which is aimed at minimizing negative experiences that can traumatize the person. These experiences are usually associated with discomfort, anxiety, excitement, anxiety, internal

[247] Фрейд А. (1993). Психология Я и защитные механизмы.
[248] Берн Э. (1992). Транзактный анализ и психотерапия.
[249] Берн Э. (1992). Игры, в которые играют люди. Психология человеческих взаимоотношений; Люди, которые играют в игры. Психология человеческой судьбы.
[250] Clark M. (2011). Conceptualising Addiction: How Useful is the Construct? International Journal of Humanities and Social Science, 1, 13, 55-64.
[251] Samuels D. J., Samuels M. (2012). Low Self-Concept as a Cause of Drug Abuse. Journal of drug education, 4, 421-438.
[252] Шабанов П. Д., Штакельберг О. Ю. (2001). Наркомании: патопсихология, клиника, реабилитация.
[253] Ibidem.

or external conflicts. With the help of psychological defence mechanisms, we manage to maintain the stability of our self-esteem, self-esteem, and perception of ourselves and the world around us. The use of psychological defence mechanisms, which act as buffers, also helps to protect our consciousness from too much disappointment and threats to life. It is when a person cannot overcome fears, anxiety, and worries that defence mechanisms distort reality in order to protect the person's psychological health and preserve him or her as a person. A study by S. Dikhtyarenko and M. Soshnikova records the fact that people with drug addiction (all without exception) use such psychological defence mechanisms as projection, denial, and intellectualisation[254]. Everyone has a hard time accepting personal defeat, and for a chemically dependent person, such acceptance and recognition is even more difficult, because the consciousness and behaviour of such a person has been controlled by drugs or alcohol for a long time, although they thought they had everything under their own control. The consciousness of a person with a drug addiction is usually filled with feelings of shame, anger and fear, which, in turn, distances the addict from objective reality. These destructive processes impose painful and destructive behaviours. This state of affairs forces the addict to look for what they consider to be "reasonable" excuses for their unreasonable behaviour. Only understanding their own addiction and excluding the format of future controlled use gives a real idea of the chaos in life caused by addiction and makes them want to fix it. It is at this point that a drug addict gets the opportunity to say "STOP" and a chance to change everything for the better. When accepting their own addiction, there are several protective barriers that require timely identification and overcoming by a person with drug addiction. Such individuals are characterized by the active use of psychological defence mechanisms. The last stage of addiction gradually leads to an increase in the role of such three defence mechanisms as projection, denial, and rationalization in the life of a drug addict. Aggression becomes the dominant strategy of psychological defence in communication. It occurs when there is no expected result, no improvement from psychological defence. Very often, alcohol and drug addicts try to find those responsible for their use and consider their neighbours to be guilty of it, and this is also manifested in aggression. One of the types of aggression is also self-directed aggression. It is usually associated with self-blame and self-humiliation.

People with drug addiction have an underdeveloped self-concept, reduced ability to reflect, and inadequate self-esteem. Impairments in self-awareness are most pronounced in the areas of self-control and self-regulation. Such patients show impaired self-control in the form of a tendency to react immediately to their experiences and inability to control their behaviour. The uncritical attitude of drug addicts to their condition, poor motivational sphere and difficulties in self-reporting are also noticeable[255]. The tendency to succumb to external influences and lack of specific interests correlate with the unformed "I-structures" and blurred boundaries of the "I". Diffuse boundaries of the "I" determine the inability of an individual to orientate and trust their own perceptions and feelings, as well as to act according to the circumstances. It is quite logical to link the problems of cognitive style, field-dependence-field-independence, insufficient reflection and structuring of subjective experience and the level of self-awareness of the individual[256].

Thus, according to the above data, we have a number of peculiarities of mental functioning inherent in people suffering from drug addiction. Scientists, in particular O. Kacharyan and M. Antonovych, identify inadequate self-esteem, deficit structures of inner experience, low cognitive differentiation of the "self-image", the ability to take unjustified risks, reduced ability

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[254] Діхтяренко С., Сошнікова М. (2021). Дослідження механізмів психологічного захисту алко та наркозалежних осіб. Психологічний журнал, 6, 34-45.

[255] Радионова М. С., Вяльцева И. М. (2004). Особенности Я-концепции у наркозависимых. Психологическая наука и образование, 1, 28-41.

[256] Рахимова А. Ф. (2003). Особенности структуры Я-концепции наркозависимых, прошедших реабилитацию.

Ikechukwu U. et al. (2013). The Role of Self-Esteem in the Diminution of Substance Abuse among Adolescents. International Review of Social Sciences and Humanities, 5, 2, 140-149.

Schroeder D., Laflin M., Weis D. (1993). Is there a relationship between self-esteem and drug use? Methodological and statistical limitations of the research. Journal of Drug, 23, 645-664.

to reflect, and difficulties in regulating one's own emotional state. Low cognitive differentiation[257] causes difficulties in understanding one's own life experience and reflecting on it. And this, in turn, makes it impossible to rely on it in crisis situations.

The formation and course of drug addiction is a rather complex process that involves many factors. In general, it can be considered a combination of a complex of cognitive and affective disorders and the consolidation and implementation of painful behavioural patterns. Such a complex involves physiological changes in the body, dysfunction of the emotional sphere, acting out pathological life scenarios or maladaptive psychological defence mechanisms, deformation of the value and meaning aspect of the psyche in patients with opium addiction. At the same time, an important role is played by the complex effects of the system of factors that determine the formation of drug addiction.

The development of a holistic model of drug addiction and the identification of specific mechanisms of its development is the area of interest of contemporary Ukrainian researcher S. Mykhailiv[258]. She proposed a model of drug addiction, according to which the latter is formed by the interaction of such elements of the patient's personality as motivation, thinking, bodily components, memory, emotions and fixed imagination. The main role in the formation of the addictive process is played by the fixed imagination, which the researcher understands as an emotionally saturated image created on the basis of the process of hypertrophying a part of reality in the imagination and completing it in fantasy. When an addictive agent is exposed to a specific "amalgam", a specific "amalgam" emerges – an alloy of emotion and image that acquires an independent super valuable meaning. The centre of circular connections in the process of drug addiction development is a fixed imagination that takes place between other mental processes, namely: emotions (through a super valuable emotional attitude to the object of addiction), memory, motivation and thinking (through the emergence of super valuable ideas). It should be noted that the peculiarity of such a system is its fixity – imagination, attitude, ideas. Given that the image of the imagination in terms of meaning is the possibility of the existence of an object (phenomenon), the sphere of "the desired in combination with emotional charge is the possible and / or undesirable possible". This means that a person, despite the logic of cause-and-effect relationships, understands as real, allows to himself, to the sphere of his own worries, what correlates with his desires, and the content of thinking is guided by emotions. The emerging super valuable idea provides a basis for planning certain actions, and also makes an internal plan of action, plans and programs life. Super valuable ideas reflect a malfunctioning of the content-forming function of cognitive processes and reflect a violation of cause-and-effect relationships in the awareness of life and actions, perseveration of meanings attached to various objective and subjective aspects of human life.

Based on the results of the study, the researchers can identify nine factors that influence the onset of chemical dependence: pronounced externalization and negative current state as obstacles to proving the independence of a person with drug dependence; aggressive confrontation with the world due to the lack of opportunity to achieve the values of universalism and following traditions; being at the centre of family relationships as a source of positive emotions, security and overcoming aggressive tendencies; compromise in relationships with others as a means of overcoming addiction[259].

Thus, drug addiction is caused by a complex set of factors. The formation of drug addiction is based on the specifics of a person's emotional sphere, his or her learned patterns of family interaction in the form of relationship configurations, and the peculiarities of resolving dysfunctional intrapersonal conflicts.

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[257] Кочарян С., Антонович М. (2016). Теоретичні аспекти вивчення психологічних особливостей наркозалежності. Психіатрія, неврологія та медична психологія, 3, 1 (5), 62-67.

[258] Михайлів С. (2020). Психологічне дослідження чинників формування хімічної залежності особистості. Психологія і особистість, 1 (17), 94-108.

[259] Ibidem.

Psychological features of rehabilitation of people with chemical dependence. Social and psychological rehabilitation is understood as the restoration of mental and psychological health of a subject, optimization of internal group ties and relationships, identification of potential capabilities of a person and organization of psychological correction, support and assistance.

Today, there are numerous social and psychological rehabilitation programmes, which vary in content and orientation. In general, they can be divided into three main areas: psychotherapeutic, spiritual and religious, and resocialization. There is also a classification of rehabilitation models, which distinguishes the following rehabilitation programmes: 1) the Minnesota model, 2) family support organizations, 3) therapeutic communities, 4) vocational rehabilitation, 5) faith-based rehabilitation, 6) environmental therapy.

X. Graham identifies three main paradigms of rehabilitation: the recovery paradigm, the resistance paradigm, and the risk paradigm[260].

Graham defines the recovery paradigm as a "macro-theoretical lens" that can be used to understand different theories, models, approaches and experiences, as there is no universal theoretical understanding of what recovery from addiction is. The very concept of "recovery" was born out of a critique of the medical treatment paradigm, where drug and alcohol abuse is seen as pathological from a nosological point of view, and medical treatment is seen as the only alternative. In contrast to the medical paradigm, the recovery paradigm focuses on the processes of self-determination, healing and development of the individual and is guided by a model of health rather than disease. The main parameter in the recovery paradigm is personal/spiritual development. Based on this definition, it is clear that recovery is inherently personal and therefore cannot be "provided", standardized or replicated in a service context, just as others cannot force a person to "recover"[261]. This observation is extremely important, as it implies that there can be no compulsory rehabilitation in the recovery paradigm. In general, a rehabilitation model based on the recovery model is based on the following practical principles: 1) encourages self-determination and self-management of health and well-being; 2) provides individualized, personalized and strengths-based care that is sensitive to people's unique strengths, circumstances, needs and preferences 3) supports people in identifying their goals, desires and aspirations; 4) takes a holistic approach that addresses a range of factors that affect people's wellbeing, such as housing, education, employment, family and social relationships; 5) supports people's social inclusion and community participation

The second paradigm of addiction rehabilitation is the abstinence paradigm, understood as the cessation of abuse and abstinence from drugs and drug-related crimes[262]. In other words, this paradigm takes a more pragmatic and simple view of the problem of addiction therapy than the recovery paradigm, and reduces it only to the factors of cessation of abuse (considering these factors from the perspective of positive psychology, rather than through a pathophysiological prism).

In the abstinence paradigm, researchers try to understand the specific factors of drug abuse cessation and prosocial change. Analysing the relevant literature, H. Graham identifies the following factors: age and maturity, roles and responsibilities, identity narrative, well-being and personal safety, personal resources and capacity, social resources and reciprocity, motivation and responsibility, hope and, mutual compensation and gratitude, opportunities and mobility, culture and ethnicity, religion and spirituality, recreation and creativity. This paradigm is embodied in the Good Lives Model (GLM)[263].

In this model, the main parameter targeted by the intervention is quality of life. T. Ward and S. Fortune identify eleven factors of quality of life: life (including healthy living and physical functioning); knowledge (how well-informed a person is about the things that matter to them);

[260] Graham H. (2016). Rehabilitation work: supporting desistance and recovery.
[261] Ibidem.
[262] Stone R. (2016). Desistance and identity repair: redemption narratives and resistance to stigma. British Journal of Criminology, 56, 5, 956-975.
[263] Graham H. (2016). Rehabilitation work: supporting desistance and recovery.

excellence at play (hobbies and recreational activities); excellence at work (including mastery experiences); excellence in subjectivity (i.e. autonomy, power and self-direction); inner peace (i.e. freedom from emotional turmoil and stress); relatedness (including intimate, romantic and family relationships); community (connection to wider social groups); spirituality (in the broad sense of finding meaning and purpose in life); pleasure (feeling good in the here and now); creativity (expressing oneself through alternative forms of expression)[264].

The third paradigm, according to H. Graham, is the risk paradigm[265] (Graham, 2016), which has become dominant in Western countries today in understanding rehabilitation processes. At the centre of the risk paradigm are two questions "what?": 1) what causes or contributes to drug crime and drug abuse? 2) what reduces the risk of reoffending and relapse and the risk factors associated with it? In this paradigm, interventions and responses are targeted according to risk, i.e. resources and professional attention, as well as interventions, tend to follow risk. The risk paradigm is based on the Risk-Need-Responsibility (RNR) model of rehabilitation. This model focuses on the use of three principles in correctional rehabilitation: risk, need and responsibility. The principle of risk refers to the assumption that treatment of offenders should be organized according to the level of risk they pose to society. The principle of need refers to the assumption that the most effective approach is to focus on the dynamic risk factors that make up the "central eight": criminal history, antisocial personality type, pro-criminal attitudes, social support for crime, substance abuse, family relationships, school/work, and prosocial recreational activities. The principle of responsiveness requires that interventions be appropriate to the characteristics, demographics and circumstances of the individual[266].

S. Veshneva and R. Bisaliev identify the following principles of rehabilitation: voluntary participation of the patient in the treatment and rehabilitation process; accessibility and openness of rehabilitation institutions; trust and partnership; unity of socio-psychological and medical-biological methods of targeted impact; diversity and individualization of forms (models) of rehabilitation measures. In addition, they highlight the following basic conditions and requirements for the rehabilitation process: refusal of the patient to use substances; personal responsibility for the successful implementation of the rehabilitation process; reliance on positive, personally significant social values for the patient; ensuring legal and organizational regulation of rehabilitation; creation of a single "team" ("team") of specialists in the rehabilitation institution[267].

For comparison with the Western approach, H. Graham cites the following principles: harm minimization; population health approach, which aims to improve the health of the entire population and reduce health inequalities among population groups; a continuum of service types; participation of people who use drugs; self-determination of people who use drugs; evidence-based practice and policy; partnership and cooperation; and the principle of cross-culturalism.

The Clinical Guidelines for the Medical Rehabilitation of Patients with Narcological Disorders[268] identify the following as the main objectives of rehabilitation: forming a conscious provocation and stable motivation (attitude) in the patient to refuse from substances and participate in the rehabilitation process; conducting treatment measures aimed at treating mental and behavioural disorders due to substance use and preventing relapses; treatment of existing somatic and neurological disorders and diseases; correction of the patient's personality structure and providing conditions,

[264] Ward T., Fortune C. (2013). The good lives model: aligning risk reduction with promoting offenders' personal goals. European Journal of Probation, 5 (2), 29-46.
[265] Graham H. (2016). Rehabilitation work: supporting desistance and recovery.
[266] Ibidem.
[267] Вешнева С. А., Бисалиев Р. В. (2008). Современные модели реабилитации наркозависимых. Наркология, 7, 1 (73), 55-61.
[268] Агибалова Т. В. et al. (2015). Клинические рекомендации по медицинской реабилитации больных наркологического профиля (МКБ-10 F10-F19).

Most often, a system of five groups of targets is used for rehabilitation: clinical psychotherapeutic targets (psychotherapeutic targets of nosological specificity); targets specific to the individual psychological and personality characteristics of the patient; targets specific to the psychotherapeutic process; psychotherapeutic targets specific to the clinical situation; targets specific to the psychotherapeutic method[269]. S. Kulakov notes that in the rehabilitation of drug addicts, the least developed are the targets of the 2nd, 4th and 5th groups, which is mainly due to the prevalence of boundary personal organization in addicts[270]. The authors specify the targets of psychotherapeutic intervention for patients with substance dependence as the following pathological craving for substance use; impaired nosognosia; personality dysfunctions; distorted perceptions of treatment; distorted communication attitudes; impaired self-esteem; poor reflective abilities; impaired ability to establish deep contact (within the therapeutic alliance), in particular, the ability to receive emotional support from a specialist; intrapsychic conflicts accompanied by intense but poorly understood emotions; pessimistic attitudes and the factor of "learned powerlessness" that destroy and distort the image of the future; typical disorders of object relations[271].

The content of each individual rehabilitation programme is an eclectic phenomenon, which is organized only by the professional level of its authors, intuition and capabilities (availability of certain psychologists who have certain technologies of working with addictions)[272]. H. Graham distinguishes the following groups of technologies that can be used in social and psychological rehabilitation: a group of cognitive-behavioural and psychocorrectional technologies, psychoeducation and social learning, motivational and change-oriented, arterial and creativity-oriented, relationship-oriented technologies[273].

The work of D. Starkov presents psychological and personal prognostic parameters of successful remission (which can be hypothetically interpreted as possible dynamic parameters of successful rehabilitation): the level of rehabilitation potential, the quality of life parameter, the level of pathological craving for use, the level of anxiety and depression indicators of life, the level of intrapersonal conflict and adaptive abilities, attitude to illness, attitude to health, value orientations, the level of social skills, the level of life awareness[274].

The most important problem of the rehabilitation system is the problem of motivating chemical addicts to undergo it. Individuals with chemical dependence are characterized by a high level of anosognosia, ambivalence and unstable motivation for therapy. This implies the centrality of motivational work in the complex therapy of addictions in general and the rehabilitation system in particular. The acuteness of the problem of motivating addicts to the rehabilitation process is reflected in the problem of mass illegal coercion to undergo rehabilitation and illegal detention of clients.

Within the clinical and psychological approach, the mechanisms of addictive anosognosia are considered in terms of psychological defences or as disorders in the structure of cognitive-information processes in the form of erroneous judgements and inferences or in the process of cognitive dissonance[275].

Д. Starkov also systematizes important personality characteristics of addicts that affect motivation for therapy and attitude to the disease: the super-valued idea of substance use or the presence of a pathologically altered need for substances; values: flattening (unformed) of the value-sense sphere; the effect of "values that one only knows about"; dominance of egocentric values of leisure (entertainment), rent (material), freedom (impunity), scarcity

[269] Агибалова Т. В. et al. (2015). Клинические рекомендации по медицинской реабилитации больных наркологического профиля (МКБ-10 F10-F19).
Кулаков С. (2020). Руководство по реабилитации аддиктов.
[270] Кулаков С. (2020). Руководство по реабилитации аддиктов.
[271] Ibidem.
[272] Старков Д. Ю. (2021). Динаміка мотивації адиктів у процесі соціально-психологічної реабілітації.
[273] Graham H. (2016). Rehabilitation work: supporting desistance and recovery.
[274] Старков Д. Ю. (2021). Динаміка мотивації адиктів у процесі соціально-психологічної реабілітації.
[275] Ibidem.

of higher values; closeness to new subjectively significant universal values and "moral alienation"; lack of connection with socially significant values, social standards, inability to find the meaning of existence; morality moral infantilism; egocentric orientation combined with hedonistic and communicative motivation; sphere of interests: lack of value of labour activity, predominance of utilitarian interests, narrowness of interests; motives: disappearance of long-term motives, uncertainty of life prospects; reduction of the strategic nature of life plan with a gradual cessation of the construction of new goals and a stop in personal development; differentiation of real and ideal goals; perception of time and prognostic sphere: narrowing of subjectively significant biographical time in the past and especially in the future ("amorphous" and disconnected ideas about the time perspective into the future); focus on the present and the past, with the attitude to the "present" based on the subjective past (rather than on ideas about the future); "myopathic" behaviour (situational activity, ignoring information about the consequences of one's own actions in the future, choosing smaller rewards in the present over larger ones in the future that are not perceived as real); a tendency to seek quick satisfaction of needs with minimal effort; reduced predictive competence; impaired decision-making and goal setting; lack of adaptive coping; a tendency to "compensatory illusory" activities and fantasizing.

According to D. Starkov, the most popular model among the models that consider the lack of motivation for therapy not through the "disease model" (i.e., in this case, through the phenomenon of addictive anosognosia), but through the "health model" is the model of positive change, authored by D. Prokhazka, D. Norcross and C. Di Clemente[276]. The core of this model is the consideration of low motivation to change behaviour not from the point of view of the pathology itself (addictive anosognosia syndrome, as is done in the psychopathological approach), but from the point of view of the incomplete Sinological process of motivation development.

Results of diagnostics of psychological characteristics of chemically dependent persons that determine addiction. In accordance with the defined goal, the following research methods were comprehensively applied: observation, interviewing, testing, experiment; quantitative, qualitative data processing methods; at the stage of the formative experiment, the Minnesota Model of Recovery technology was used.

The experimental base of the study was the Rehabilitation Centre for the Treatment of Drug Addicts, Alcoholics and Gamblers at the Monastery of St Sava the Blessed "Step by Step" in Melitopol, Zaporizhzhia region. Melitopol, Zaporizhzhia region (Rehabilitation centre for the treatment of drug addicts, alcoholics and gambling addicts at the monastery of St Sava the Blessed "Step by Step"[277]. The rehabilitation centre "Step by Step" offers comprehensive professional treatment of drug addiction, alcoholism and gambling addiction, has a male-only inpatient department, recovery is based on the 12-step programme, and the programme is not religious. The 12-step rehabilitation centre for alcoholics and drug addicts based at the Monastery of St Sava the Blessed in Melitopol was established in spring 2007. For more than 10 years, the centre has been providing assistance to drug addicts, alcoholics, gamblers and their families who need treatment for addiction and codependency, learning to live and work without using drugs and alcohol. The aims and objectives of the rehabilitation centre in Melitopol are to help addicts restore the biological, psychological, social and spiritual spheres of life that have been damaged by the disease, using the principles and methods of the 12 Steps.

In accordance with the objectives, the study was conducted in three stages (exploratory, experimental, and generalizing) in 2021-2022. The number of respondents was 60 people aged 23-45.

The psychodiagnostic instruments were selected with a view to their possible use during the control section.

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[276] Прохазка Д., Норкросс Д., Ди Клементе К. (2013). Психология позитивных изменений. Как навсегда избавиться от вредных привычек.

[277] Реабілітаційний центр по лікуванню наркоманів, алкоголіків і ігроманів при монастирі Святого Савви Освященного «Крок за кроком» (2007).

The following psychodiagnostic techniques are used to assess the level of rehabilitation prognosis of a chemically dependent person at the initial stage of rehabilitation in the 12-step rehabilitation centre for alcoholics and drug addicts based at the Monastery of St. Sava the Blessed in Melitopol: the RSC methodology (level of subjective control)[278]; the SLC methodology (measuring the level of meaningfulness of life)[279]; the R. Lazarus methodology for determining coping strategies[280]; and the Toronto Alexithymic Scale methodology[281].

In our research, we also assessed the following indicators in a conversation with clients:

1. Assessment of the perception of quality of life:

- Life satisfaction at the moment: high / sufficient / insufficient / low.
- Satisfaction with life in general: high / sufficient / insufficient / low.
- Satisfaction with your health: high / sufficient / insufficient / low.
- Assessment of the quality of life: high / sufficient / insufficient / low.

The subjective perception of the quality of life is good, promotes optimistic attitudes / characterized by insufficient satisfaction, pessimistic tendencies / low, with deep pessimism.

2. Completeness of nosognosia and sobriety:

- There is no full (formal) fragmentary criticism of their condition.

- Cognitive acceptance and adequacy of the experience of illness: unconditionally acknowledges the fact of drug addiction / acknowledges the disease of addiction as a concession to others / acknowledges the disease, but not drug addiction/ does not recognize himself / herself as a patient with alcohol addiction.

- Dissimulation of the disease is manifested in the form of understatement / shielding by another pathology (nervous system disorders) / partial denial / total denial / referral to the past ("I don't drink any more, I don't want to drink") / rationalization of the situation. He does not show any dissimulative tendencies.

- Experiencing the harm of the disease: experiencing threats to physical and mental health, social well-being / stating existing alcohol problems, underestimating them, trying to attribute problems caused by alcoholism to external circumstances / denying alcohol disorders, unable to analyse the nature of existing problems and their relationship to alcohol abuse.

- Emotional rejection of the disease is pronounced (indignation at the drug diagnosis or the fact of seeking drug treatment / passive protest against the drug diagnosis, trying to ignore it / indifference to the drug diagnosis, indifferent and passive attitude to the changes taking place) / intermediate (lack of emotional concern about the disease)/ unexpressed.

- Rejection of sobriety is pronounced (no readiness for a sober lifestyle) / intermediate (expresses the need for sobriety without real attempts to solve related problems) / unexpressed (a desire to lead a sober life, understanding of the complexity of the problem, and readiness to solve it are recorded). Attitudes to sobriety are firm, rational / formal, declared as socially acceptable / diffuse. Addictive attitudes are highly destructive.

3. Understanding of the rehabilitation process as a long and gradual process: full and deep / partial / no understanding.

When conducting psychodiagnostics and interviewing for individual psychological characteristics, we pay attention to the following indicators:

- reduced psychological stability;
- an increased level of alexithymia, which is a factor in the lack of emotional self-regulation skills;
- reduced level of nosognosia;
- catatonic distortion of self-esteem;

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[278] Еникеева М. И. (2003). Психологическая диагностика.
[279] Дарвиш О. Б. (2003). Возрастная психология.
[280] Крюкова Т. Л., Куфтяк Е. В. (2007). Опросник способов совладания (адаптация методики WCQ). Журнал практического психолога, 3, 93-112.
[281] Райгородський Д. Я. (Ed.). (2001). Практическая психодиагностика. Методики и тесты.

- weakness of attitudes to sobriety/high destructiveness of addictive attitudes;
- understanding rehabilitation as a long-term process;
- lack of resources in the social environment;
- poor perception of quality of life.

Based on the data obtained, we made a prognosis of readaptation: negative / intermediate (uncertain) / positive, and provided recommendations: motivational counselling; raising awareness of the medical model of alcohol (chemical) dependence; attending self-help groups (for AA/AN addicts).

After conducting the confirmatory experiment, as a result of quantitative and qualitative processing of the data obtained by the methods, the corresponding results of diagnosing the psychological characteristics of chemically dependent persons were obtained.

To identify the level of subjective control (external or internal type of behaviour), we conducted the Level of Subjective Control methodology. In our study, we used the scale of general internalization. The quantitative results of the methodology are presented in Table 1.

Table 1. Level of subjective control, scale of general internalization, N = 60

Walls		**Number of respondents**	
		Absolute number of	**%**
Wall 1 (-132 ... -13 points)	external type	-	-
Wall 2 (-12 ... -2 points)		-	-
Wall 3 (-1 ... +10 points)		-	-
Wall 4 (11 ... 22 points)		8	13,3
Wall 5 (23 ... 33 points)	norm	20	33,3
Wall 6 (34 ... 45 points)	internal type	16	26,7
Wall 7 (46 ... 57 points)		6	10,0
Wall 8 (58 ... 69 points)		10	16,7
Wall 9 (70 ... 80 points)		-	-
Wall 10 (81 ... 132 points)		-	-

The results of the methodology, presented in Table 1, give an idea of the quantitative distribution of chemically dependent people by the level of subjective control (scale of general internalization). The average level of external type of subjective control is 13.3% (8 people), the internal type of subjective control is 32 people (16 people – 26.7% have an average level of internal control, and 16 people – 26.7% have an above average level of internal control). The normal distribution includes 20 people (33.3%).

A high score on this scale (8-10) corresponds to a high level of subjective control over any significant situations, and 10 people (16.7%) have this level. These people believe that the most important events in their lives were the result of their actions. Thus, they feel responsible for these events and for the way their life is going in general. A low score on the scale (1-3 walls) corresponds to a low level of subjective control. The level of subjective control is below average in 8 people (13.3%). These subjects do not see a connection between their actions and events in their lives that are important to them, do not consider themselves capable of controlling their development, and believe that most of them are the result of chance or the actions of other people.

To determine the level of meaningfulness of life, we conducted a test of meaningful life orientations, which is an adapted version of the Purpose-in-Life Test (PIL) by D. Crumb and L. Maholick. The quantitative results of the methodology are presented in Table 2.

The results of the methodology, presented in Table 2, give an idea of the quantitative distribution of chemically dependent people by the factors of the level of meaningfulness of life, as well as by the overall indicator of the level of meaningfulness of life.

Scores on the Goals in Life scale characterize the presence or absence of future goals in the subject's life, which give life meaning, direction and time perspective. Low scores on this scale are given by 40.0% of respondents (24 people), these people live in the present or yesterday. High scores on this scale are given by 16.7 per cent (10 people), and these people can be characterized not only as goal-oriented, but also as projectors whose plans have no real basis

in the present and are not supported by personal responsibility for their implementation. The average score is 43.3% of respondents (26 people).

Table 2. Level of meaningfulness of life, N = 60

Factors.	**Levels**	**Number of respondents**	
		Absolute number of	**%**
Goals in life	High	10	16,7
	Medium	26	43,3
	Low	24	40,0
The process of life or the interest and emotional intensity of life	High	26	43,3
	Medium	23	38,3
	Low	11	18,4
Life effectiveness, or satisfaction with self-realization	High	16	26,7
	Medium	28	46,6
	Low	16	26,7
Locus of control – "I"	High	10	16,7
	Medium	20	33,3
	Low	30	50,0
Locus of control-life, or controllability of life	High	10	16,7
	Medium	22	36,7
	Low	28	46,6
Total indicator	High	14	23,3
	Medium	30	50,0
	Low	16	26,7

On the scale "Life process or interest and emotional intensity of life", 43.3% (26 people) have high scores, these people are characterized as hedonists who live for the present. Low scores on this scale were reported by 18.4 per cent (11 people), who are dissatisfied with their life in the present, while they may give full meaning to memories of the past or have a focus on the future. The average level is 38.3% (23 people), who perceive their lives as interesting, emotionally rich and full of meaning.

On the scale "Life effectiveness or satisfaction with self-realization", 26.7% (16 people) have high scores, which characterize people who are living out their lives, whose life is in the past, but whose past can give meaning to the rest of their lives. Low scores were given by 26.7 per cent (16 people), who are dissatisfied with the part of their lives they have lived. The average score is 46.6 per cent (28 people), with an average assessment of the past period of life, and a sense of how productive and meaningful the past part of life was.

High scores on the Locus of Control-Self scale were given by 16.7% (10 people), these people perceive themselves as a strong personality with sufficient freedom of choice to build their lives in accordance with their goals and ideas about its meaning. Low scores were reported by 50.0% (30 people), who are not confident in their ability to control the events of their lives. The average score is 33.3% (20 people).

High scores on the scale "Locus of control-life, or life controllability" are given by 16.7% (10 people), these people are convinced that they can control their lives, freely make decisions and implement them. Low scores were given by 46.6 per cent (28 people), who believe that their lives are beyond their conscious control, that freedom of choice is illusory and that it is pointless to make any predictions about the future.

In view of the above, it is possible to draw a conclusion about each respondent's perceptions of life. According to Table 2, 23.3% (14 people) have a high overall level of meaningfulness of life, 50.0% (30 people) have an average level, and 26.6% (16 people) have a low level. Chemically dependent people with a low level of meaningfulness of life certainly need psychological support.

To determine coping mechanisms, ways of overcoming difficulties in various areas of mental activity, coping strategies, we conducted a methodology for determining R. Lazarus' coping strategies. The quantitative results of the methodology are presented in Table 3.

Table 3: Coping strategies of chemically dependent people, N = 60

Types of copying	**Voltage levels**	**Number of respondents**	
		Absolute number of	**%**
Confrontational copying	High (severe maladjustment)	23	38,3
	Medium (adaptation potential in the borderline state)	22	36,7
	Low (adaptive copying option)	15	25,0
Remote control	High (severe maladjustment)	8	13,3
	Medium (adaptation potential in the borderline state)	44	73,4
	Low (adaptive copying option)	8	13,3
Self-control	High (severe maladjustment)	8	13,3
	Medium (adaptation potential in the borderline state)	29	48,4
	Low (adaptive copying option)	23	38,3
Finding social support	High (severe maladjustment)	8	13,3
	Medium (adaptation potential in the borderline state)	44	73,4
	Low (adaptive copying option)	8	13,3
Acceptance of responsibility	High (severe maladjustment)	16	26,6
	Medium (adaptation potential in the borderline state)	36	60,1
	Low (adaptive copying option)	8	13,3
Escape-avoidance	High (severe maladjustment)	45	75,0
	Medium (adaptation potential in the borderline state)	15	25,0
	Low (adaptive copying option)	0	0
Planning a solution to the problem	High (severe maladjustment)	45	75,0
	Medium (adaptation potential in the borderline state)	0	0
	Low (adaptive copying option)	15	25,0
Positive reassessment	High (severe maladjustment)	0	0
	Medium (adaptation potential in the borderline state)	23	38,3
	Low (adaptive copying option)	37	61,7

The results of the methodology presented in Table 3 give an idea of the levels of use of different coping strategies by chemically dependent persons.

Confrontational coping involves offensive actions to change the situation, a certain degree of hostility and risk-taking. Confrontation helps to act, to move the situation forward, to express your position and defend it. However, the downside of such a reaction is unreasonableness and rashness of actions. Where there is no awareness, it is difficult to come up with an effective solution to the problem. Adaptive coping is used by 25.0% (15 people). The adaptive variant of the confrontation strategy involves attempts to solve the problem through not always purposeful behavioural activity, taking specific actions aimed at either changing the situation or reacting to negative emotions in connection with the difficulties encountered. A high level of this coping is reported by 38.3% (23 people). With a pronounced predominance of this strategy, impulsivity in behaviour (sometimes with elements of hostility and conflict), hostility, difficulties in planning actions, predicting their outcome, correcting the behavioural strategy, and unjustified persistence can be observed. In this case, coping actions lose their purposefulness and become mainly the result of emotional tension release. Often, the confrontation strategy is seen as maladaptive, but when used in moderation, it ensures the individual's ability to resist difficulties, energy and entrepreneurship in solving problem situations, the ability to defend one's own interests, and cope with anxiety in stressful conditions. The average level of coping with adaptive potential in the borderline state is 36.7% (22 people). Psychological support for chemically dependent persons in this context is to help the individual use the adaptive coping option with its positive

aspects – the ability to actively confront difficulties and stressful influences, and minimize the negative aspects – lack of purposefulness and rationality of behaviour in a problem situation.

Distancing involves cognitive efforts to separate from the situation and reduce its significance. The distancing strategy consists of a person's attempts to switch off from the feeling of the problem, as if to devalue it. In this case, the person thinks about the situation and tries to clarify it. There is also a shift of attention from the problematic point to something else, joking. It is as if the problem does not exist, or it is not as significant as it seemed at first. Distancing helps not to burn out psychologically and ease the emotional state. However, suppressing emotions about the significance of a problem can lead to a lack of a solution to the problem as such. An adaptive version of such coping is used by 13.3% (8 people). The distancing strategy involves attempts to overcome negative feelings in connection with a problem by subjectively reducing its significance and the degree of emotional involvement in it. It is characterized by the use of intellectual techniques of rationalization, distraction, detachment, humour, devaluation, etc. Adaptive potential in the borderline state of this coping is demonstrated by 73.4% (44 respondents). Expressed coping maladaptation is observed in 13.3% (8 people). Psychological support for chemically dependent people in this context is to help the individual use the adaptive version of coping with its positive aspects – the possibility of reducing the subjective significance of difficult situations and preventing intense emotional reactions to frustration, as well as minimizing the negative aspects of coping – devaluation of their own experiences, underestimation of the significance and possibilities of effective overcoming of problem situations.

Self-control coping involves a person's efforts to regulate their own feelings and actions. In the adaptive variant of coping, self-control helps to solve the problem in the most detached way, without unnecessary worries, this level of coping is observed in 38.3% (23 respondents). At the same time, this approach hides needs and desires, which negatively affects satisfaction with problem-solving. The self-control strategy involves attempts to overcome negative feelings in connection with the problem by purposefully suppressing and restraining emotions, minimizing their impact on the assessment of the situation and the choice of behavioural strategy, high behavioural control, and the desire for self-control. The adaptive potential of coping in the borderline state is 48.4% (29 people), while 13.3% (8 people) have a high level (pronounced coping maladaptation). With such a predominance of self-control strategies, a person may have a tendency to hide their feelings and motivations in connection with a problematic situation from others. Often, this behaviour indicates a fear of self-disclosure, excessive demands on oneself, which leads to over control of behaviour. Psychological support for chemically dependent people in this context is to help the individual use an adaptive version of coping with its positive aspects – the possibility of avoiding emotionally charged impulsive actions, the prevalence of a rational approach to problematic situations, as well as minimizing the negative aspects of coping – difficulties in expressing feelings, needs and motivations in connection with a problematic situation, and over control of behaviour.

The coping strategy "Seeking social support" characterizes a person's efforts to find informational, effective and emotional support. The person's thoughts and actions are directed towards society, and he or she seeks material, mental and moral support from the outside. Stress manifests itself in an attempt to elicit sympathy from others, to express oneself, and to receive recommendations on how to act. The adaptive level of this coping is 13.3% (8 people). Receiving help from other people helps to solve the problem, and at the same time forms dependence on other people's assessment and actions. The strategy of seeking social support involves attempts to solve the problem by attracting external (social) resources. It is characterized by a focus on interaction with other people, expectations of attention, advice, and sympathy. The search for informational support involves seeking recommendations from experts and acquaintances who, from the respondent's point of view, have the necessary knowledge. The need for emotional support is mainly manifested by the desire to be listened to, to receive an empathetic response, to share one's experiences with someone. When looking for predominantly effective support, the need for help with specific actions is the leading one. Adaptive potential in the borderline state

is demonstrated by 73.4% (44 people), while 13.3% (8 respondents) have a pronounced maladaptation of this coping. Psychological support for chemically dependent people in this context is to help the individual use the adaptive version of coping with its positive aspects – adequate use of external resources to solve a problem situation, as well as minimizing the negative aspects of coping – preventing the formation of a dependent position and excessive expectations from the help of others.

Acceptance of Responsibility Coping is about recognizing one's role in the problem and attempting to solve it. The advantage of this strategy is that the individual recognizes his or her involvement in creating difficulties and understands his or her role in solving the problem. It involves thinking about one's actions, searching for personal mistakes, and identifying one's negative qualities. This is an adaptive variant of coping, which is present in 13.3% (8 people). This strategy of accepting responsibility implies that the subject recognizes his/her role in the problem and responsibility for its solution, in some cases with a distinct component of self-criticism and self-blame. With moderate use, this strategy in people with adaptive potential in the borderline state (60.1%, 36 respondents) reflects the individual's desire to understand the relationship between their own actions and their consequences, readiness to analyse their behaviour, to look for the causes of current difficulties in personal shortcomings and mistakes. At the same time, in the case of severe coping maladjustment (26.6%, 16 respondents), excessive unjustified self-criticism, feelings of guilt and hopelessness, dissatisfaction with oneself and what is happening may occur. These features are known to be a risk factor for the development of depression. Psychological support for chemically dependent people in this context is to help the individual use an adaptive version of coping with its positive aspects – the ability to understand the personal role in the emergence of current difficulties, as well as minimizing the negative aspects of coping – unjustified self-criticism and taking excessive responsibility.

Escape-avoidance coping involves a mental desire and behavioural efforts to escape or avoid a problem. Individuals try to avoid solving the problem by refusing to acknowledge its existence, making mistakes, misjudging what is happening, and being distracted. The escape-avoidance strategy involves attempts to overcome negative feelings in connection with difficulties by a person through an evasion response: denial of the problem, fantasizing, unjustified expectations, distraction, etc. Using this strategy, a person seems not to notice the difficulty and gets irritated when it is pointed out to them. If this strategy is prevalent, a person may experience unconstructive behaviours in stressful situations: denial or complete ignoring of the problem, evasion of responsibility and actions to resolve the difficulties that have arisen, passivity, impatience, outbursts of irritation, immersion in fantasies, overeating, alcohol consumption, etc. in order to reduce painful emotional stress. Often, compensation for stress through overeating and alcohol consumption is involved. A high level of coping, i.e. severe maladaptation, is observed in 75.0% of respondents (45 people). The main negative side of avoidance is its ineffectiveness in the long term. In times of stress, a person maintains their state at the proper level, but the problem itself remains unresolved. This coping is not considered to be the most effective strategy, but in case of severe unexpected stress, this position helps to reduce internal tension (in the short term and in acute stressful situations). No adaptive variant of coping was found in the respondents; the adaptive potential in the borderline state was observed in 25.0% (15 people). Psychological support for chemically dependent persons in this context is to help the individual use the adaptive coping option with its positive aspects – the ability to quickly reduce emotional stress in a stressful situation, as well as minimizing the negative aspects of coping – the impossibility of solving the problem, the likelihood of accumulating difficulties, the short-term effect of actions taken to reduce emotional discomfort.

The coping strategy "Problem-solving planning" involves arbitrary problem-focused efforts to change the situation, the main behavioural mechanism here is the creation of a plan to get out of the situation. The problem-solving planning strategy involves attempts to overcome the problem by purposefully analysing the situation and possible behavioural options, developing a strategy for solving the problem, and planning one's own actions, taking into account objective conditions,

experience, and available resources. The adaptive version of this strategy is used by 25.0% (15 people). No adaptive potential in the borderline state was found in the respondents, but 75.0% (45 respondents) had a pronounced coping maladaptation. These people do not use this adaptive strategy. Psychological support for chemically dependent people in this context is to help the individual use the adaptive version of coping with its positive aspects – mastering the ability to purposefully and systematically solve a problem situation, as well as minimizing the negative aspects of coping – reducing the likelihood of excessive rationality, insufficient emotionality, intuition and spontaneity in behaviour.

Positive Reappraisal Coping involves a person's efforts to create a positive meaning with a focus on the growth of their own personality, considering it as a stimulus for personal growth. In this case, a difficult situation is resolved by the individual through a change in attitude. An adaptive variant of this coping is observed in 61.7% of respondents (37 people), with no pronounced maladaptation of coping revealed. These people are characterized by a positive rethinking, the ability to perceive difficulties as the next stage of self-development. The disadvantages of the strategy include a person's possible inability to see other effective ways out of the situation. Adaptive potential in the borderline state is demonstrated by 38.3% (23 people). Psychological support for chemically dependent persons in this context is to help the individual use the adaptive coping option with its positive aspects – the development of opportunities for positive rethinking of the problem situation, as well as minimizing the negative aspects of coping – reducing the likelihood of underestimating the individual's ability to effectively resolve the problem situation.

To diagnose the level of alexithymia, we used the Toronto Alexithymic Scale. The quantitative results of the methodology are presented in Table 4.

Table 4. Level of alexithymia among chemically dependent people, N = 60

Level of alexithymia	**Number of respondents**	
	Absolute number of	**%**
High	6	10,0
Medium	20	33,3
Low	34	56,7

The results of the methodology, presented in Table 4, give an idea of the levels of alexithymia in chemically dependent individuals. Alexithymia is a reduced ability or difficulty in verbalizing (expressing in words) emotional states and feelings. Alexithymia is characteristic of people who, for one reason or another, have limited processing, which means they are aware of emotional impressions, experiences, feelings, and reasons for actions. Signs of alexithymia include: a problem with defining (understanding) and describing one's own experiences and feelings in words; difficulty in distinguishing between feelings and bodily sensations; poor imagination and fantasy, very rare dreams; focusing more on external events than on internal experiences. The consequence of alexithymia is excessive pragmatism and lack of creativity. The lack of joy in life leads to a sense of dullness, an "inexplicable" feeling that "everything seems to be in order, but something is wrong", and to unreasonable dissatisfaction and dissatisfaction with life. Often, with alexithymia, people of a certain personality type easily experience short-term, sharply expressed emotional outbursts, the causes of which are poorly understood. Limiting the ability to understand oneself becomes a significant obstacle to understanding what is happening, to the possibility of a holistic view of one's own life. It is difficult to look at oneself from the outside, to understand the meaning of one's own life and activities, to see them in a temporal relationship, to make a meaningful connection between the present and the past and the future, which allows a person to create and maintain inner harmony, to change one's inner world as necessary and not to be completely at the mercy of the situation. Table 4 shows that 10.0% of respondents (6 people) have a high level of alexithymia, and 33.3% (20 people) have an average level. Alexithymia can be a persistent personality trait or a temporary reaction to depression or anxiety. It develops as a result of the prevalence of defence mechanisms in the process of personality development. That is,

if the expression of feelings has brought negative results in the past – pain, fear, guilt, etc. – a person has had a negative traumatic experience and, as a result, has come to the conclusion that it is better to never show their feelings and not tell anyone about them. And in order not to accidentally blurt them out, it is better to hide them from yourself. Unfortunately, the rejection of possible pain often entails the opposite side – the rejection of possible joy. People with alexithymia are more prone to the onset and development of psychosomatic diseases and depression than others. Alexithymia may indicate that a person is closed to new experiences and is focused on negative events. Not only the emotional sphere, but also the personal and thinking spheres can be affected. A low level of alexithymia development was observed in 56.7% of respondents (34 people).

In our study, we also conducted interviews with clients, which were reported in the form "Assessment of the level of rehabilitation prognosis of a drug addict at the medical stage of rehabilitation". Based on the results of psychodiagnostics and interviews, clients are provided with recommendations from the following list: motivational counselling; raising awareness of the medical model of alcohol (chemical) dependence; attending self-help groups (for AA/AN addicts). The organization and content of self-help groups (for AA/AN addicts) are presented in the next section.

Psychological rehabilitation of chemically dependent persons using the **Minnesota Model of Recovery.** The "Minnesota model" of psychological rehabilitation of chemically dependent persons is presented in detail by T. Gorski[282]. The author describes an effective alcoholism treatment programme "AA" The Alcoholics Anonymous Society is a world-famous organization that brings together men and women who share their experiences and hopes with each other and support each other in their attempts to recover from alcoholism. This society exists on a voluntary basis. No one is forced to join it, but its members benefit greatly from their participation. Many people find sobriety through the 12 Steps. Those who try to look deeper and understand the principles on which the 12 Steps programme is based are able to use these principles more effectively in their lives. The primary goal of A.A. was to help alcoholics stop drinking. It was not a universal programme for all people. However, A.A. recognizes that the 12 Steps programme can help people with other problems as well. Other societies have already emerged that use the steps and principles of A.A., such as Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, etc.

The work of A.A. is based on the 12 Steps programme, which serves as an individual's guide to sobriety, and the Twelve Traditions, which are the guiding principles or charter norms of the A.A. organization as a whole. Knowing the 12 Steps is crucial for all people in recovery for two reasons: the steps work if you follow them; and the 12-Stepprogramme is low cost and accessible. This is why the programme is popular among people who want to recover from chemical dependency, codependency and other compulsive or addictive disorders.

Our study was conducted on the basis of the Rehabilitation Centre for the Treatment of Drug Addicts, Alcoholics and Gambling Addicts at the Monastery of St. Sava the Blessed in Melitopol[283]. Psychological rehabilitation in this centre is based on the Minnesota model of the 12 Steps programme. The centre has an inpatient department for men. The study involved 60 chemically addicted men in the ascertaining phase of the research, and these 60 men also took part in the formative experiment. The centre does not have a group that has not completed the 12-step programme, so it is not possible to compare the results of the control and experimental groups. Such a comparison is the prospect of our further research. Here is a description of psychological rehabilitation based on the Minnesota 12-step model, which is used

[282] Горски Т. Т. (2003). Понимание двенадцати шагов: Руководство для консультантов, терапевтов и выздоравливающих.

[283] Реабілітаційний центр по лікуванню наркоманів, алкоголіків і ігроманів при монастирі Святого Савви Освященного «Крок за кроком» (2007).

in the Rehabilitation Centre for the Treatment of Drug Addicts, Alcoholics and Gamblers at the Monastery of St. Sava the Blessed in Melitopol[284].

The Minnesota model treats all chemical addictions as a disease characterized by the following properties: primacy (not a symptom of another disease, such as neurosis or depression), absence of the patient's guilt, disease progression, chronicity (duration), incurability, and mortality.

According to the Minnesota model, abuse is interpreted as follows:

- recurrent substance use/codependent behaviour that leads to an inability to perform important role responsibilities at work, school or home;
- periodic substance use/codependent behaviour in situations where it is physically dangerous;
- repeated problems with the law related to substances/codependent behaviour;
- continued substance use/codependent behaviour despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

These diseases are caused by a combination of biological, psychological, spiritual and social factors:

1. One of the main symptoms of the disease is denial (both the patient and loved ones deny it).
2. Initial motivation does not give an answer to how the therapy will go.
3. The disease is incurable, but it is possible to delay its development and improve one's condition when the patient is ready to accept responsibility for his or her recovery and change.
4. The patient is given the opportunity to identify the symptoms of their disease, which may require lifestyle changes.
5. If a person is addicted to one mind-altering substance, they can easily become addicted to others, and therefore should avoid using pharmaceuticals.
6. The long-term goal of therapy should be abstinence from all psychoactive drugs for the rest of your life.
7. The participation of counsellors with personal experience of recovery in therapy is crucial.
8. Involvement of people closely related to the patient in the therapeutic process, i.e. family, friends, co-workers, etc.
9. Use of the philosophy of Narcotics Anonymous and the 12-Step Programme, thus combining spiritual aspects with the achievements of medicine, psychology and sociology.

The psychological rehabilitation programme has 4 components of influence on the disease: prevention, intervention, treatment, and recovery.

Treatment is defined as a patient-centred, time-limited process. The focus is on denial. The goal is to create conditions for possible recovery. Content – a set of measures and a set of certain conditions.

Recovery is defined as a process that comes from within the patient, unlimited in time. The goal is to stabilize remission and prevent relapse. The content is learning the skills of sober living and restoring the destroyed areas of the personality.

The general structure of the rehabilitation process includes the following components:

- Detoxification (if necessary).
- Cognitive therapy is the recognition and acceptance of the patient's illness, awareness of the destructive consequences of the disease in all spheres of life, and the need for recovery by the end of a sober life.
- Developmental therapy – teaching the patient the skills and ways of sober living, defending their boundaries, constructive communication, crisis management, relaxation and stress relief, awareness and expression of their feelings, etc.
- Family therapy – clarifying family relationships, involving family and friends in the recovery process.

[284] Ibidem.

• Spiritually-oriented therapy is the development of the personality's value potential, work on character flaws, clarification of the meaningful basis of existence for the patient, and the acquisition of vital spiritual experience necessary for recovery.

• Supportive therapy is aimed at alleviating emotional pain, helping the patient to accept themselves and their situation, and increasing their motivation for recovery.

The elements of the recovery programme include: body; mind; emotions; spirituality; personality and character; relationships; and recovery as a lifestyle.

Here is a detailed structure of the psycho-rehabilitation process:

Chemical dependence (alcoholism and drug addiction) is a chronic disease with a high risk of relapse. Like other chronic disorders, this disease requires long-term attention, in some cases – for life. Due to the fact that the main percentage of relapses occurs during the rehabilitation period, the patient needs to be provided with long-term supportive therapy. Self-help groups AA and NA are well suited for this purpose. At the same time, in the initial stages of treatment, professional intervention is often needed to remove intoxication, create and strengthen motivation, and provide psychological support to patients who are not ready to use self-help groups effectively. A treatment centre with inpatient and outpatient programmes designed for a long stay of the patient (from several weeks to a year) in the treatment process may be the best way to achieve these goals. This treatment process may include the following points:

Primary guidance counselling, which takes place either during the detoxification period or when a patient comes to a treatment centre. Its purpose is to create and strengthen motivation to continue treatment. It is conducted by a chemical dependency counsellor or psychologist. In parallel, family counselling is provided by a family counsellor or psychologist. The goal is to involve relatives in the treatment process.

Conclusion of the contract. Upon admission to treatment, the patient signs a contract, gets acquainted with the terms of treatment and the rules of the treatment centre. Conducted by the treatment programme coordinator.

Psychosocial history. The nurse or doctor takes a psychosocial history, compiling a list of highlighted problems, noting the patient's strengths and weaknesses. The history is passed on to the psychologist or counsellor who is in charge of the patient. Based on the history, an individual psychological rehabilitation plan is drawn up.

Small psychotherapy group. The patient becomes a member of the group (no more than 10 people), where comprehensive (supportive, developmental, directive, emotional and stressful) therapy is provided[285]. The group is open. It has permanent leaders – a psychologist and a counsellor. It takes place every day. The session lasts an hour and a half.

An individual psychological rehabilitation programme. It is drawn up by a psychologist or counsellor on the basis of psychosocial history. It is adjusted as the patient progresses through the course of treatment, discovers new relevant information about the patient, and advances in the programme. It includes individual meetings with a psychologist and a counsellor, receiving and completing individual tasks, reading specialized literature, etc. If indicated, it also includes medical supervision.

Educational process. It involves providing patients with cognitive information about the nature of their disease, various aspects of illness and recovery. It includes daily lectures according to the plan (two lectures lasting 45 minutes), watching videos, group discussions,

[285] Максименко С. Д., Прокоф’єва О. О., Царькова О. В., Кочкурова О. В. (2015). Практикум із групової психокорекції: підручник.

Pylypenko N., Kovalova O., Prokofieva O., Kochkurova O., Kriukova M., Zelinska Y. (2022). Contemporary Approaches to Diagnosis, Psychotherapy and Neuro-Psychocorrection of Emotional Disorders in Psychosomatic Diseases. BRAIN. Broad Research in Artificial Intelligence and Neuroscience, 13, 1, 1, 277-294.

Прокоф'єва О. О., Кошова І. В., Прокоф'єва О. А. (2019). Социодрама – ситуация всех ситуаций и событие, собирающее в себе все события. С. 243-258.

psychodramatic elements[286]. Conducted by the centre's therapeutic staff – doctors, psychologists, and counsellors.

Connection with self-help groups. Evening meetings of AA and NA groups (closed – only for patients), one of which (for example, Sunday) is open, with the possibility of the presence of former patients and recovering alcoholics and drug addicts. Speaker meetings (one or two per week), to which recovering alcoholics and drug addicts from 12-step groups are invited to share their experiences with patients. Providing patients with basic AA and NA literature, lists of groups, AA and NA periodicals. For patients in advanced stages of treatment, weekly outreach visits to groups in the city are organized. They are conducted by consultants.

Family therapy. It includes joint therapy sessions between the patient and relatives involved in the treatment process. It is conducted by the patient's psychologist.

Post-treatment plan. It is drawn up by the patient as part of an individual task. It is discussed in a small group.

The principle of a therapeutic community. Uniform rules and regulations. Discipline. Discussion of the problems of the treatment centre at community meetings. The responsibility for recovery lies with the patient, not with the therapeutic staff and treatment measures.

The staff of the rehabilitation programme includes: the head of the rehabilitation programme, 1 psychologist, 1 psychologist, 2 counsellors, and 1 social worker.

Here is a general plan for an evening outpatient rehabilitation programme.

The evening outpatient programme provides social and psychological rehabilitation for chemically dependent people and their families, using the most advanced technologies developed by US scientific and clinical organizations. The programme is based on the 12-Step programme used in Alcoholics Anonymous groups, supplemented by social counselling methods. The programme has been adapted to the conditions of Ukraine (Order of the Ministry of Health of Ukraine No. 226 of 27. 07. 1998).

The mission of the programme is to help patients with mental and behavioural disorders caused by alcohol / drug use, as well as their family members, to stop or significantly reduce their use of chemicals and improve their quality of life through social and psychological rehabilitation.

Programme objectives:

- help clients to stop using chemicals and develop a substance-free lifestyle, or at least achieve a significant period of remission;
- improving the client's physical, emotional and psychological health;
- improving the client's family and other interpersonal relationships;
- improvements in employment and training;
- improving social functioning;
- stopping illegal activities.

Expected results. Clients who have completed a full course of rehabilitation are characterized by the following features: absolutely no alcohol consumption for at least 3 months; have a professionally agreed plan of supportive therapy and further work with their psychological problems; have mastered the basic concepts of chemical dependence and ways to prevent relapse; are prepared to regularly attend AA meetings; are focused on further socialization and improving family relationships.

The philosophy of the programme is that chemical addiction (alcoholism and drug addiction) is chronic, recurrent, relapses can occur throughout life; progressive, as it usually leads to degradation and death; multimodal, affecting the addict physically, psychologically and

[286] Прокоф’єва, О. О., & Прокоф'єва, О. А. (2019). Форми психодрама-терапії як інновації в освітньому процесі. Актуальні проблеми психічного та психологічного здоров'я: зб. матеріалів Міжнар. наук.-практ. конф., 26-27 квітня 2019 р., 144, с. 185-189.

Прокоф'єва, О. (2010). Порівняльний аналіз прояву особистісних якостей у різних типів маніпуляторів і об’єктів маніпуляції у юнацькому віці. Науковий часопис НПУ імені М. П. Драгоманова, серія 12 Психологічні науки, 31(55), с. 179-192.

spiritually; fatal and multifactorial, i.e. arising from various (genetic, family, social) causes of the disease.

The 12-Step professional rehabilitation programme includes individual, group, and family counselling; participation in AA self-help groups; and an educational programme.

The educational programme includes informational classes on the concept of illness and recovery; family education and philosophy of spirituality.

As part of the rehabilitation programme, clients are required to attend meetings of self-help groups of Alcoholics Anonymous (AA) at least 3 times a week.

The 12 Steps programme was created in the 1930s in the United States as a method of treatment for alcohol addiction in Alcoholics Anonymous groups. Its essence is to recognize a simple fact: a person is powerless to cope with the problem of alcoholism alone, and therefore needs help. Help is needed in order to recover, and this means radically changing one's life, because alcohol has reduced one's entire life to the use of the substance. These steps are meant to describe the stages of transition from chronic alcoholism to sobriety. A cursory acquaintance with the content of the 12 Steps causes some people to suspect that they will be involved in some kind of organization or religious sect. However, such conclusions can only be drawn by those who have not become more familiar with the Programme and, for this reason, have not noted, for example, that members are not required to endorse any single concept of God ("A power greater than our own"). Only a more detailed acquaintance with the content of the Steps, as well as participation in AA meetings, allows us to note that each member of the Society can choose his or her Higher Power, i.e. God, "as he or she understands Him", and none of the other members has the right to impose anything on this issue. In the proposed Programme, the client "goes through" the first 3 Steps, which helps him stay sober. Let's have a look at these Steps.

Step 1 ("We have recognized our powerlessness over alcohol, we have recognized that we have lost control over ourselves") is the beginning of all actions that contribute to ending addiction. It refers to the need for surrender, without which the process of recovery cannot begin. This is a very important step, because only the awareness of one's own powerlessness and loss of control over one's own life, as well as the belief in ultimate defeat, can cause an addict to seek help.

Step 2 ("We have come to believe that only a Power greater than ourselves can restore our sanity") refers to an objective assessment of the self, because belief in a "Power greater than ourselves" is incompatible with a sense of self-exceptionalism and omnipotence. Relying on a "Power greater than oneself" is done through both acknowledging the existence of God ("as we understand Him") and seeking help from another person (therapist, spouse, AA member) or a group of people. The Second Step allows the addict to get rid of the feeling that he or she is the "centre of the universe" and, accordingly, of the oppressive responsibilities associated with this.

Step 3 ("Decided to entrust our will and our lives to God as we understand Him") is the "action step" because it relies on actions that limit one's own will and sense of power. In difficult moments of life, the "prayer of peace of mind", adopted by AA members from the Roman Emperor Marcus Aurelius, can serve as a support for those working through this step: "God, give me the intelligence and peace of mind to accept what I cannot change, the courage to change what I can, and the wisdom to know the difference."

A person has experience of beliefs and ideas that can form the basis of recovery. The bottom line is that a person stops relying on himself or herself, using everything around him or her as tools of his or her will, and seeks and receives support from the outside. A group working under the 12 Steps programme has a single task – to support the recovery process of its members, which is what is done in communities working under this programme: "Alcoholics Anonymous, Al-Anon, and communities of their relatives.

The 12-Step programme is not affiliated with a church, sect or party, which means that anyone can join it, regardless of whether they believe in God or not.

In accordance with the traditions of the Alcoholics Anonymous community, we do not speak on behalf of this community and do not claim to be able to tell the whole story about the programme.

Relatives of chemically dependent people are encouraged to participate in Al-Anon groups (for adult family members).

The rehabilitation programme is carried out on an outpatient basis (evening hours). The programme lasts 3 months (90 days).

The psychological rehabilitation programme is presented in Table 5.

Table 5. Psychological rehabilitation programme for chemically dependent people

Type of work	Duration.	Specialist	Duration of the lesson	Frequency of classes
Therapy / psychological counselling:				
individual counselling	12 sessions	conducted by a psychologist or social worker	1 hour	1 time per week
group counselling	24 sessions	conducted by a consultant	1 hour	2 times a week
Therapeutic community meetings	12 fees	employees and programme participants	1 hour	1 time per week
Educational classes:				
information and motivational sessions	24 lessons	psychologist, consultant	1 hour	2 times a week
Family psychology classes	3 lessons	psychologist	1 hour	1 time per month
Classes on working on the Steps:				
writing classes	24 lessons	psychologist	1 hour	2 times a week
oral classes	24 lessons	psychologist	1 hour	2 times a week
"Day's Results" session (introduction to the 10th Step)	90 lessons	psychologist	0.5 hours	daily
AA meetings	36 fees	consultant	not regulated	3 meetings per week
Keeping a diary of "self-observation" of emotional states of thoughts and behaviour	90	-	not regulated	daily
Group meditations	90	psychologist, consultant	15 minutes	daily

An example of a schedule of activities in a rehabilitation centre:
17.00 – 17.15 Meditation
17.15 – 18.00 Psychological or informational group counselling
18.00 – 18.10 Break
18.10 – 18.50 Completion of written assignments. Group work with literature.
18.50 – 19.00 Break
19.00 – 20.00 (30) AA group or topic group.
20.00 (30) – 20.10 (40) Break
20.10 (40) – 20.30 (21.00) Summing up the day's results.
Schedule of rehabilitation measures:
1. Meditation – 0.5 hours.
2. Group classes – 2.5 hours.
3. Group of the day's results – 1 hour.
4. Support group – 1 hour.
5. Wednesday. Classes last 3 hours. Watching films, sober living skills.
6. Weekend club. Clients work according to an approved plan.
7. Individual consultations, additional classes if necessary – 1 hour.

Another option for working with chemically dependent people is intensive, which lasts 28 days. It includes 5 stages.

Stage 1 includes the following topics:

1. Inform the group about the goals and objectives of the rehabilitation process.
2. Introduction of the group members.
3. Development and adoption of group rules by group members.
4. Expectations of group members from the rehabilitation process.
5. The history of the 12 Steps programme.
6. Information about the principles of the 12-Stepprogramme.
7. Familiarity with AA and NA literature.
8. The concept of chemical dependency.
9. The impact of drug addiction on various spheres of human life
10. Analysis of the history of drug use for each member of the group.
11. Skills to manage thoughts when the urge to use drugs arises.
12. Mechanisms of psychological protection. Denial.
13. Analysis of the degree of negative effects of drug use on various spheres of human life.
14. 14. Post-abstinence acute syndrome.
15. 1 Step of Narcotics Anonymous. The concept of powerlessness, uncontrollability.
16. Write a written version of Step 1.
17. Read Step 1 to the group.
18. Summing up the results of the first stage of rehabilitation.
19. Elements of art therapy. Drawings: "Me and my disease", "My 1st Step". Role-playing games.

The client is given from 1 to three days to write Step 1. Depending on their readiness to write. A social worker works with them to help them overcome resistance to writing the step.

Objectives: Acceptance by clients of the fact of their dependence on narcotic substances, assistance in understanding the degree of negative consequences of drug use. Acceptance of the fact of loss of control over behaviour as a result of chemical dependency.

Stage 2 involves the following topics:

1. The spiritual component of the programme.
2. Spirituality.
3. 2, 3 Steps of Narcotics Anonymous.
4. Feelings. Their impact on the physical and psychological state of a chemically dependent person.
5. Skills to identify feelings.
6. Angry, hungry, tired, lonely.
7. 7. anger. Resentment. Guilt. Shame. Causes of their occurrence. Ways to overcome negative emotional states.
8. Identification by group members of the feelings that led to their drug use.
9. Elements of art therapy: Drawing "My spirituality", "What feelings live in me".

Objectives: Clients' awareness of the need for internal changes to start a full-fledged sober life. Acceptance by clients of the need to act in accordance with the recommendations of the programme. Acquaintance with the primary skills of analysing the causes of feelings, and promoting the development of skills for dealing with emotional states that are dangerous for sobriety.

Stage 3 involves the following topics:

1. Definition of morality. Analysing the impact of drug use on a person's system of moral values.
2. 4 Steps of Narcotics Anonymous.
3. Analysis of the effects of drug use on human character.
4. Manipulation. The role of manipulative behaviour in the lives of group members during and after drug use (Prokofieva, 2010).

5. Analysing the impact of negative character traits of a chemically dependent person on their relationships with their loved ones and people around them. The seven deadly sins.

6. Skills for dealing with negative character traits. Identification by group members of those qualities that hinder the improvement of relationships with people.

7. Inferiority complexes. Their occurrence. How they affect the emotional state of the addict.

8. Ways to overcome inferiority complexes.

9. Write down Step 4.

10. 5 Steps of Narcotics Anonymous. Discussion.

11. Training on developing assertive communication skills.

Step 4 is written using a shortened questionnaire. The client is given 4-5 days to write the step. In parallel, a social worker works with the client to help him or her overcome difficulties in writing the step.

Objectives: Developing primary skills of self-analysis. To make clients aware of the need to rely on a different system of moral values than the one they use.

Elements of art therapy: Drawing "What I associate myself with, why", "My negative character qualities".

Stage 4 involves the following topics:

1. Stress. The impact of stress on human life.

2. Introduction to stress management skills.

3. Developing a plan of work to change behavioural patterns associated with drug use.

4. 4. Conflicts.

5. "Slippery" people, places, things, situations.

6. Relapse. Triggers of relapse.

7. Develop skills to recognize relapse triggers.

8. Training on the development of skills to refuse drugs.

9. Practical exercises to develop refusal skills.

Objectives: Acquaint clients with skills of working in stressful situations, conflict resolution. Assistance in understanding the relapse process, familiarization with the signs of relapse. Development of refusal skills.

Stage 5 involves the following topics:

1. Chemical dependency is a family disease. Information message.

2. Analysis of the negative effects of drug use on the family relationships of the group members.

3. 8, 9 Steps of Narcotics Anonymous. Making a list of people who have been harmed.

4. Information about the 10, 11, 12 Steps of Narcotics Anonymous.

5. Making a plan for a sober life.

Objectives: Helping clients to understand the consequences of their use on family relationships. To make clients aware of the harm caused to other people.

Each stage of the rehabilitation process involves the inclusion of elements of art therapy, role-playing games, and watching videos in group work.

The intensive rehabilitation course lasts 28 days. It includes daily attendance of the client at classes held at the centre. The total time spent in the Centre during the day is 7 hours. During the course of rehabilitation, the client must attend meetings of self-help groups of NA.

After completing an intensive rehabilitation course, the client is transferred to an outpatient programme. The outpatient programme lasts 4 weeks. The client visits the Centre twice a week.

After completing the outpatient programme, the client can attend support sessions conducted by psychologists and counsellors.

During the rehabilitation process, clients are constantly motivated to attend supportive therapy after completing the main course, as well as individual consultations with a psychologist and counsellors.

Work with clients' family members is carried out in the format of group information sessions on various topics:

1. The 12 Steps programme for family members of drug addicts.

2. The concept of the disease "chemical dependency".

3. Chemical dependency is a family disease. Codependency, signs of codependent behaviour. Control, promotion of separation.

Classes are held once a week. The duration of the lessons is 1 hour.

Group sessions are designed to help you acquire emotional management skills and develop communication skills with a chemically dependent relative.

Individual sessions are also available. Relatives of Nar-Anon self-help group clients are allowed to visit their children during the period of rehabilitation.

After psychological rehabilitation, we repeated psychodiagnostic techniques, quantitative and qualitative processing of the results of diagnosing the psychological characteristics of chemically dependent persons. The analysis of the results shows positive dynamics in people who underwent psychological rehabilitation at the Rehabilitation Centre for the Treatment of Drug Addicts, Alcoholics and Gambling Addicts at the Monastery of St. Sava the Blessed in Melitopol.

To identify the level of subjective control (external or internal type of behaviour), we conducted the Level of Subjective Control methodology. In our study, we used the scale of general internality. The quantitative results of the methodology are presented in Table 6. The average level of the external type of subjective control before the programme was 13.3% (8 people), after the programme – 3.3% (2 people); internal type of subjective control before the programme – 53.3% (32 people, including 16 people – 26.7% with an average level of internal control and 16 people – 26.7% with an above average level of internal control), after the programme – 73.3% (44 respondents, including 20 people – 33.3% with an average level of internal control, 24 people – 40.0% with an above average level of internal control). The normal distribution includes 14 people (23.3%).

Table 6. Level of subjective control, scale of general internality before and after the psychological rehabilitation programme, N = 60

Walls		**Number of respondents to the programme**		**Number of respondents after the programme**	
		Absolute number of	**У %**	**Absolute number of**	**У %**
Wall 1 (-132 ... -13 points)	external type	-	-	-	-
Wall 2 (-12 ... -2 points)		-	-	-	-
Wall 3 (-1 ... +10 points)		-	-	-	-
Wall 4 (11 ... 22 points)		8	13,3	2	3,3
Wall 5 (23 ... 33 points)	norm	20	33,3	14	23,3
Wall 6 (34 ... 45 points)	internal type	16	26,7	20	33,3
Wall 7 (46 ... 57 points)		6	10,0	10	16,7
Wall 8 (58 ... 69 points)		10	16,7	12	20,1
Wall 9 (70 ... 80 points)		-	-	2	3,3
Wall 10 (81 ... 132 points)		-	-	-	-

To determine the level of meaningfulness of life, we repeated the test of meaningful life orientations, which is an adapted version of the Purpose-in-Life Test (PIL) by D. Crumb and L. Maholick. The quantitative results of the methodology are presented in Table 7.

Table 7. The level of meaningfulness of life before and after the psychological rehabilitation programme, N = 60

Factors.	**Levels**	**Number of respondents to the programme**		**Number of respondents after the programme**	
		Absolute number of	**%**	**Absolute number of**	**%**
Goals in life	High	10	16,7	20	33,3
	Medium	26	43,3	22	36,7
	Low	24	40,0	18	30,0
The process of life or the interest and emotional intensity of life	High	26	43,3	20	33,3
	Medium	23	38,3	31	51,7
	Low	11	18,4	9	15,0
Life effectiveness, or satisfaction with self-realization	High	16	26,7	18	30,0
	Medium	28	46,6	32	53,3
	Low	16	26,7	10	16,7
Locus of control – "I"	High	10	16,7	18	30,0
	Medium	20	33,3	27	45,0
	Low	30	50,0	15	25,0
Locus of control-life, or controllability of life	High	10	16,7	21	35,0
	Medium	22	36,7	28	46,6
	Low	28	46,6	11	28,3
Total indicator	High	14	23,3	20	33,3
	Medium	30	50,0	34	56,7
	Low	16	26,7	6	10,0

Scores on the Goals in Life scale characterize the presence or absence of future goals in the subject's life, which give life meaningfulness, direction and time perspective. Before the programme, 40.0% of the respondents (24 people) had low scores on this scale, and after the programme – 30.0% (18 people). Before the programme, 16.7 per cent (10 people) had high scores on this scale, and after the programme – 33.3 per cent (20 people). Before the programme, 43.3% of respondents (26 people) had average scores, and after the programme – 36.7% (22 people).

On the scale "Process of life or interest and emotional intensity of life", 43.3% (26 people) had high scores before the programme, and 33.3% (20 people) after the programme. Low scores on this scale before the programme were 18.4 per cent (11 people), and 15.0 per cent (9 people) after the programme. Before the programme, 38.3% (23 people) had an average level, and after the programme – 51.7% (31 people).

On the scale "Life effectiveness or satisfaction with self-realization", 26.7% (16 people) had high scores before the programme, and 30.0% (18 people) after the programme. Before the programme, 26.7% (16 people) had low scores, after the programme – 16.7% (10 people). The average score before the programme was 46.6 per cent (28 people), and after the programme – 53.3 per cent (32 people).

Before the psychological rehabilitation programme, 16.7 per cent (10 people) had high scores on the Locus of Control-Self scale, and after the programme – 30.0 per cent (18 people). Before the programme, 50.0% (30 people) had low scores, after the programme – 25.0% (15 people). The average score before the programme was 33.3% (20 people), after the programme – 45.0% (27 people).

Before the programme, 16.7 per cent (10 people) had high scores on the Locus of Control-Life scale, and after the programme, 35.0 per cent (21 people) had high scores. Before the programme, 46.6 per cent (28 people) had low scores, and after the programme – 28.3 per cent (11 people). Before the programme, 36.7 per cent (22 people) had average scores, and after the programme – 46.6 per cent (28 people).

In view of the above, it is possible to draw a conclusion about each respondent's perceptions of life. According to Table 7, 23.3% (14 people) had a high overall level of meaningfulness of life before the programme, and 56.7% (34 people) after the programme; an average level before

the programme – 50.0% (30 people), and 56.7% (34 people) after the programme; a low level before the programme – 26.6% (16 people), and 10.0% (6 people) after the programme.

To identify coping mechanisms, ways to overcome difficulties in various areas of mental activity, we repeatedly conducted the methodology for identifying R. Lazarus' coping strategies after completing the psychological rehabilitation programme. The quantitative results of the methodology are presented in Table 8.

Table 8. Coping strategies of chemically dependent people before and after completing a psychological rehabilitation programme, N = 60

Types of copying	**Voltage levels**	**Number of respondents to the programme**		**Number of respondents after the programme**	
		Absolute number of	**%**	**Absolute number of**	**%**
Confrontational copying	High (severe maladjustment)	23	38,3	17	28,3
	Medium (adaptation potential in the borderline state)	22	36,7	22	36,7
	Low (adaptive copying option)	15	25,0	21	35,0
Distancing	High (severe maladjustment)	8	13,3	6	10,0
	Medium (adaptation potential in the borderline state)	44	73,4	34	56,7
	Low (adaptive copying option)	8	13,3	20	33,3
Self-control	High (severe maladjustment)	8	13,3	6	10,0
	Medium (adaptation potential in the borderline state)	29	48,4	26	43,3
	Low (adaptive copying option)	23	38,3	28	46,7
Finding social support	High (severe maladjustment)	8	13,3	5	8,3
	Medium (adaptation potential in the borderline state)	44	73,4	35	58,3
	Low (adaptive copying option)	8	13,3	20	33,4
Accepting responsibility	High (severe maladjustment)	16	26,6	10	16,7
	Medium (adaptation potential in the borderline state)	36	60,1	27	45,0
	Low (adaptive copying option)	8	13,3	23	38,3
Escape-avoidance	High (severe maladjustment)	45	75,0	30	50,0
	Medium (adaptation potential in the borderline state)	15	25,0	15	25,0
	Low (adaptive copying option)	0	0	15	25,0
Planning a solution to the problem	High (severe maladjustment)	45	75,0	25	41,6
	Medium (adaptation potential in the borderline state)	0	0	10	16,8
	Low (adaptive copying option)	15	25,0	25	41,6
Positive reassessment	High (severe maladjustment)	0	0	0	0
	Medium (adaptation potential in the borderline state)	23	38,3	18	30,0
	Low (adaptive copying option)	37	61,7	42	70,0

Confrontational coping involves offensive actions to change the situation, a certain degree of hostility and risk-taking. Before the programme, 25.0% (15 people) had an adaptive version of this coping, and after the programme – 35.0% (21 people). Before the programme, 38.3% (23 people) had a high level of this coping, and after the programme – 28.3% (17 people). Before

the programme, 36.7% (22 people) had an average level of coping with adaptive potential in the borderline state, and after the programme – the same number.

Distancing coping involves cognitive efforts to separate from the situation and reduce its significance. Before the programme, 13.3% (8 people) had an adaptive version of this coping, and after the programme – 33.3% (20 people). Adaptive potential in the borderline state in this coping before the programme was completed was 73.4% (44 respondents), after the programme – 56.7% (34 people). Expressed coping disadaptation before the programme was observed in 13.3% (8 people), after the programme – 10.0% (6 people).

Self-control coping involves a person's efforts to regulate their own feelings and actions. In the adaptive version of coping, self-control helps to solve the problem in the most detached way, without unnecessary worries; this level of coping was observed in 38.3% (23 respondents) before the programme, and in 46.7% (28 people) after the programme. The adaptive potential of coping in the borderline state before the programme was 48.4% (29 people), after the programme – 43.3% (26 people). Before the programme, 13.3% (8 people) had a pronounced coping maladaptation, and after the programme – 10.0% (6 people).

The coping strategy "Search for social support" characterizes a person's efforts to find informational, effective and emotional support. Before the programme, 13.3% (8 people) had an adaptive level of this coping, and after the programme – 33.4% (20 people). Before the programme, 73.4% (44 people) had adaptive potential in the borderline state, after the programme – 58.3% (35 people); 13.3% (8 respondents) had a pronounced maladaptation of this coping before the programme, and after the programme their number decreased to 8.3% (5 people).

Acceptance of responsibility" coping is about recognizing one's role in the problem and trying to solve it. The adaptive variant of coping was present in 13.3% (8 people) before the programme, and in 38.3% (23 people) after the programme. This strategy with adaptive potential in the borderline state was present in 60.1% (36 respondents) before the programme, and in 45.0% (27 people) after the programme; this strategy was markedly maladapted before the programme in 26.6% (16 respondents) and in 16.7% (10 people) after the programme.

Escape-avoidance coping involves a mental desire and behavioural efforts to escape or avoid the problem. A high level of coping, i.e. severe maladjustment, was observed in 75.0% of respondents (45 people) before the programme, and 50.0% (30 people) after the programme. Before the programme, no adaptive coping was detected in the respondents; after the programme, adaptive coping was observed in 25.0% of the programme participants (15 people); adaptive potential in the borderline state before and after the programme was observed in 25.0% (15 people).

The coping strategy "Problem-solving planning" involves arbitrary problem-focused efforts to change the situation, the main behavioural mechanism here is the creation of a plan to get out of the situation. Before the programme, 25.0% (15 people) had an adaptive version of this strategy, and after the programme – 41.6% (25 people). Before the programme, 16.8 per cent (10 people) of respondents had no adaptive potential in the borderline state, and after the programme – 16.8 per cent (10 people). Expressed coping maladaptation was present in 75.0% (45 respondents) before the programme, and 41.6% (25 people) after the programme.

Positive Reappraisal Coping involves a person's efforts to create a positive meaning with a focus on the growth of their own personality, considering it as a stimulus for personal growth. In this case, a difficult situation is resolved by the individual through a change in attitude. The adaptive version of this coping was observed in 61.7 per cent of respondents (37 people) before the programme, and 70.0 per cent (42 people) after the programme. Adaptive potential in the borderline state was observed in 38.3% (23 people) before the programme, and in 30.0% (18 people) after the programme. No pronounced coping maladaptation was detected before and after the programme.

To diagnose the level of alexithymia, we repeated the Toronto Alexithymic Scale. The quantitative results of the methodology are presented in Table 9. Before the programme, 10.0% of respondents (6 people) had a high level of alexithymia, after the programme – 5.0%

(3 people). The average level of alexithymia before the programme was 33.3% (20 people), after the programme – 21.7% (13 people). Low level of alexithymia before the programme – 56.7% of respondents (34 people), after the programme – 73.3% (44 people).

Table 9. The level of alexithymia of chemically dependent people before and after the psychological rehabilitation programme, N = 60

Level of alexithymia	**Number of respondents to the programme**		**Number of respondents after the programme**	
	Absolute number of	**%**	**Absolute number of**	**%**
High	6	10,0	3	5,0
Medium	20	33,3	13	21,7
Low	34	56,7	44	73,3

Conclusions. The main reason for the significant vulnerability of chemically dependent people is the instability of the self-concept. Personal changes occur as a result of chronic intoxication and psychological maladjustment, as well as due to impaired social functioning. All drug addicts, without exception, use psychological defence mechanisms, namely projection, denial, and intellectualization. Given that everyone has difficulty accepting their own defeat, such acceptance and recognition is even more difficult for people with chemical dependence. At the level of consciousness, a drug addict is mostly dominated by feelings such as fear, shame and anger. They isolate a person with drug addiction from objective reality. As a rule, drug addicts are looking for someone to blame for their drug use. Most often, these are people from the immediate environment, and this is also reflected in aggression. Autoaggression is reflected in self-humiliation and self-blame. It is extremely difficult for a person with chemical dependence to leave their comfort zone, as the drug (alcohol) creates a sense of calm and euphoria. In this regard, aggression can be considered a response to the attempts of others to deprive the drug addict of a pleasant state. There is also an absence or decrease in criticality towards one's disease and one's own personality, a reduced ability to reflect, a poor motivational sphere and difficulties in self-reporting.

The following factors influence the formation of chemical dependence: aggressive opposition to the world, given the impossibility of achieving the values of universalism and following traditions; emphasized externality and negative current state; belonging to the centre of family relationships as a source of positive emotions, security and overcoming aggressive tendencies ("star" position); dependence as a result of the inability to solve the problem of identity and find oneself in a continuum from a passive to an active position in relationships; compromise in relationships with loved ones as a means of overcoming addiction and correcting "false" justifications for the harmful effects of chemicals; social dependence of a drug addict as a factor in the lack of success in business; tension, anxiety and negative attitude to oneself as a result of the lack of opportunity to achieve the desired; family upbringing as a factor in the development of drug addiction and a resource for overcoming it; in family relationships, the impact of alliances and coalitions on the emergence of guilt in drug addicts. Drug addiction is caused by a complex set of factors, with an important role in its formation played by the specifics of the emotional sphere of a person with drug addiction, his/her learned patterns of family interaction in the form of relationship configurations, and the peculiarities of resolving dysfunctional interpersonal conflicts.

Rehabilitation aims to restore or maintain a person's status. The universal stages of the overall rehabilitation process are restorative therapy, restoration of adaptive skills, and proper rehabilitation (restoration of the patient's individual and social integrity). Successful completion of these stages determines the parameters of the duration and quality of remission, which are the main indicators of the effectiveness of comprehensive therapy for chemically dependent people.

In Ukraine, the traditional system of drug treatment for the population is used, which is provided by outpatient and inpatient units of the psychiatric service. Short-term rehabilitation is provided by state medicine, while long-term rehabilitation programmes are implemented by public and charitable organizations. The paradigm of rehabilitation processes in Western

countries today includes the predominant model of rehabilitation "Risk-Need-Responsibility" (RNR), which is focused on the application of three principles in correctional rehabilitation: risk, need and responsibility.

The conditions for effective rehabilitation are: a pronounced personal rehabilitation potential that can stimulate participation in the rehabilitation process; personal responsibility for the success of the rehabilitation process; provision of legal and organizational regulation of the rehabilitation process; focus on positive, personally significant social values for the patient; involvement of a single team of specialists in the rehabilitation centre; use of the experience of former (recovering) patients who have completed a rehabilitation programme and their involvement in rehabilitation We believe that an important problem of the system of social and psychological rehabilitation is the involvement of addicted people who do not have professional psychotherapy skills in the rehabilitation process, and the development of the "market" for rehabilitation services by commercial structures that are willing to "exploit the disease". The main task is to solve the problem of motivating chemical addicts to undergo rehabilitation. People with chemical dependence are characterized by a high level of anosognosia, ambivalence and unstable motivation for therapy. In view of this, the central issue of motivational work in the complex therapy of addictions in general and the rehabilitation system in particular is determined.

The Rehabilitation Centre for the treatment of drug addicts, alcoholics and gambling addicts at the Monastery of St Sava the Blessed "Step by Step" in Melitopol, Zaporizhzhia, was chosen as an experimental base for the study of psychological characteristics of chemically dependent persons. Melitopol, Zaporizhzhia region. The study was conducted in 2020-2021. The number of respondents at the ascertaining stage was 60 people aged 23-45. Based on the data obtained in the study, we make a forecast of readaptation and provide recommendations: motivational counselling; raising awareness of the medical model of alcohol (chemical) dependence; attending self-help groups (for AA/AN addicts).

The formative stage of the study involved 60 chemically dependent men who were enrolled in a rehabilitation programme based on the Minnesota model. The programme's mission is to help patients with mental and behavioural disorders caused by alcohol / drug use, as well as their family members, to stop or significantly reduce their chemical use and improve their quality of life by using social and psychological rehabilitation methods.

After psychological rehabilitation, we repeated psychodiagnostic techniques, quantitative and qualitative processing of the results of diagnosing the psychological characteristics of chemically dependent persons. The analysis of the results shows positive dynamics in people who underwent psychological rehabilitation at the Rehabilitation Centre for the Treatment of Drug Addicts, Alcoholics and Gambling Addicts at the Monastery of St. Sava the Blessed in Melitopol.

After completing the programme, the number of participants with an internal level of control increased significantly, indicating their readiness and psychological ability to take responsibility for the events of their own lives and for the way their lives are going in general. The number of participants who live for today or yesterday has decreased, and the number of goal-oriented respondents who are able and willing to take responsibility for the implementation of their own plans has increased. The number of hedonists decreased after completing the programme, as did the number of respondents who are dissatisfied with their lives in the present and still give meaning to memories of the past. There has been a significant increase in the number of participants who perceive their lives as interesting, emotionally rich and meaningful. The number of people who are dissatisfied with the part of their lives they have lived has decreased. The number of participants who have an average assessment of the past period of life, an adequate perception of how productive and meaningful the part of life they have lived was increased. The number of respondents who perceive themselves as a strong personality with sufficient freedom of choice has increased. The number of participants who are not confident in their ability to control the events of their own lives has halved. The number of participants who are convinced that they can control their lives, make decisions freely and implement them has increased significantly. The number of respondents who believe that their life is beyond their conscious control, that freedom of choice

is illusory and that it is pointless to make any predictions about the future has significantly decreased. These results undoubtedly indicate the effectiveness of psychological support for chemically dependent people with a low level of meaningful life, and also confirm the effectiveness of the implemented psychological rehabilitation programme.

The psychological rehabilitation programme contributed to an increase in the number of respondents with an adaptive variant of confrontational coping, and a decrease in the number of respondents with maladaptive confrontational coping. The number of participants who try to overcome negative feelings in connection with the problem by subjectively reducing its significance and the degree of emotional involvement in it, using intellectual methods of rationalization, switching attention, distraction, and humour, has more than doubled. At the same time, the number of people with "distancing" coping maladaptation has slightly decreased, which means that there are fewer participants who devalue their own experiences, underestimate the significance and possibilities of effective coping with problem situations. The number of participants who have the adaptive coping option "self-control" has increased, and the number of participants who have difficulty expressing feelings, needs and motivations in connection with a problem situation, and who have over control of behaviour has decreased. The number of participants who adaptively use coping "seeking social support" has significantly increased, and the number of participants who have formed a dependent position and excessive expectations from the help of others has decreased.

The psychological rehabilitation programme also contributed to a significant increase in the number of people who adaptively use "acceptance of responsibility" coping and understand their role in solving the problem; the number of people who may experience excessive unjustified self-criticism, feelings of guilt and hopelessness, dissatisfaction with themselves and what is happening has somewhat decreased. After completing the programme, the percentage of people with escape-avoidance coping significantly decreased. After the programme, 25.0% of participants developed an adaptive version of this coping. The number of people who use the adaptive version of "problem-solving planning" coping has significantly increased, and the number of people with disaptation of this coping has significantly decreased. After completing the programme, more respondents demonstrate the adaptive version of coping "positive reassessment", these people are characterized by positive rethinking and the ability to perceive difficulties as another stage of self-development.

The programme also helped to reduce the level of alexithymia among participants, which is characterized by the normalization of verbalization of emotional states and feelings, increased attention to internal experiences to a greater extent than to external events, and an actualization of a creative attitude to life.

The programme participants developed the ability to reflect, embarked on the path of realizing the meaning of their own lives and activities, and are working on linking the present with the past and future, which allows them to create and maintain inner harmony, change their inner world as necessary and not be completely at the mercy of the situation.

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