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INTEGRATING RESOURCES OF M. SPIVAK'S SYSTEMIC APPROACH, COGNITIVE-BEHAVIORAL THERAPY AND CULTURAL-HISTORICAL PSYCHOLOGY IN ADDRESSING CHALLENGES OF REFORMING RESIDENTIAL INSTITUTIONS FOR PSYCHIATRIC PATIENTS IN RUSSIA

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In 2016, the Russian Federation started a reform of residential institutions for psychiatric patients. An essential condition of its success is reintegration of patients into society, which implies development and implementation of effective psychosocial rehabilitation programs. **Materials and Methods.** In 2018, an integrated rehabilitation program was developed and implemented for the first time in Psychoneurological Residential Institution No. 22 in Moscow. The program integrated the principles and methods of M. Spivak's systemic approach, cultural-historical psychology, and cognitive-behavioral therapy. The rehabilitation group included 12 patients with chronic mental disorders and disabilities who had resided in the institution for 3 to 16 years. The total duration of the program was 6 months. An expert assessment of the participants' psychological and social competencies in the major life areas (housing and everyday life; work and employment; hygiene; interpersonal relations; hobbies and leisure) was carried out before and after the rehabilitation program, using Spivak's diagnostic scales. **Results**. A study of the integrated rehabilitation program effectiveness showed a statistically significant improvement in the patients' competencies in the major life areas. Follow-up of the dynamics

within the following 3 years upon the program completion revealed positive changes in their social adaptation. **Output**. A preliminary conclusion could be made that the proposed integrated rehabilitation program might be effective for shaping and training of social skills that increase the patients' autonomy, as well as for overcoming self-limiting attitudes and avoidance strategies resulting from their negative experience of social "defeats" and institutional experience of learned helplessness. Each of the three integrated approaches contributed to achieving the rehabilitation objectives. Further research with larger samples is needed.

Keywords: psychoneurological residential institutions, rehabilitation patients, psychosocial rehabilitation, cultural-historical psychology, cognitive-behavioral therapy, resocialization.

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ИНТЕГРАЦИЯ РЕСУРСОВ СИСТЕМНОГО ПОДХОДА М. СПИВАКА, КОГНИТИВНО-БИХЕВИОРАЛЬНОЙ ТЕРАПИИ И КУЛЬТУРНО-ИСТОРИЧЕСКОЙ ПСИХОЛОГИИ В РЕШЕНИИ ЗАДАЧ РЕФОРМИРОВАНИЯ ПСИХОНЕВРОЛОГИЧЕСКИХ ИНТЕРНАТОВ В РОССИИ

М.Е. СИСНЁВА
Межведомственная рабочая группа по разработке основных подходов к реформе психоневрологических интернатов при Министерстве труда и социальной защиты РФ, Москва, Российская Федерация
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В 2016 г. Российская Федерация (РФ) начала реформу психоневрологических интернатов (ПНИ). Важнейшим условием ее успеха является реинтеграция пациентов в общество, что требует разработки и внедрения эффективных программ психосоциальной реабилитации. ***Материалы и методы.*** В 2018 г. на базе ПНИ № 22 г. Москвы была впервые разработана и реализована комплексная программа реабилитации, интегрирующая принципы и методы системного подхода М. Спивака, культурно-исторической психологии и когнитивно-бихевиоральной терапии. В реабилитационную группу вошли 12 пациентов с хроническими психическими расстройствами и инвалидностью, проживающих в ПНИ от 3 до 16 лет. Общая продолжительность программы 6 месяцев. Экспертная оценка психологических и социальных компетенций участников в основных сферах жизнедеятельности (жилье и быт, труд и занятость, гигиена, межличностные отношения, хобби и досуг) проводилась с помощью диагностических шкал М. Спивака до и после прохождения программы реабилитации. ***Результаты.*** Исследование эффективности комплексной реабилитационной программы показало статистически значимое улучшение компетенций реабилитантов в основных сферах жизнедеятельности. Отслеживание динамики в последующие 3 года после завершения программы позволило зафиксировать положительные изменения в их социальной адаптации. ***Выводы.*** Можно сделать предварительной вывод об эффективности предлагаемой комплексной программы реабилитации для развития и тренировки социальных навыков, повышающих автономию реабилитантов, а также для преодоления установок на самоограничение и стратегии избегания активности, возникших в результате негативного опыта социальных «поражений» и институционального опыта выученной беспомощности. Каждый из трех интегрированных подходов вносит свой вклад в решение реабилитационных задач. Необходимы дальнейшие исследования с расширением выборки.

Ключевые слова: психоневрологические интернаты, реабилитанты, психосоциальная реабилитация, культурно-историческая психология, когнитивно-бихевиоральная терапия, ресоциализация.

Благодарности. Автор статьи выражает благодарность всем ведущим комплексной программы реабилитации, всем сотрудникам ПНИ № 22 г. Москвы и студентам факультета консультативной и клинической психологии МГППУ, принявшим участие в работе, а также главным участникам программы: 12 жителям ПНИ, решившим изменить свою жизнь и приложившим большие усилия для получения нового правового статуса.

Для цитаты: *Сиснева М.Е.* Интеграция ресурсов системного подхода М. Спивака, когнитивно-бихевиоральной терапии и культурно-исторической психологии в решении задач реформирования психоневрологических интернатов в России // Консультативная психология и психотерапия. 2021. Т. 29. № 3. С. 140—158. DOI: https://doi.org/10.17759/cpp.2021290309

Introduction. Reform of Residential Institutions in Russia: Challenges and Achievements

In the Russian Federation, many people with mental disabilities are placed in the system of residential institutions for patients with psychiatric disorders (hereinafter — PRI), intended for their accommodation and services. 156 thousand citizens of the Russian Federation live in PRI, and this figure increases by a thousand a year. 71% of them have lost their legal capacity; only 2% are employed [11]. There have been violations of the rights of residents in PRI, unfavorable environmental conditions, the absence of rehabilitation programs aimed at resocialization, and contradictions with the norms of the international "Convention on the Rights of Persons with Disabilities" ratified by the Russian Federation in 2012 [2; 5]. In 2016, after the instructions of Deputy Prime Minister O.Y. Golodets, given to the Ministry of Labor of Russia, the reform of PRI began [10]. Several pilot PRIs were chosen for the proposed changes, but, according to the opinions of several experts and government officials, cited in the media, the transformations have often been formal in nature [1].

In 2017, at the initiative of non-profit organizations (NPOs), the issue of the legal regulation of assisted living for mentally disabled people as the main alternative to PRI was included in the list of presidential orders [9], but to this day it has not been carried out. The assisted living is an institution-replacing form of social services, which provides for accommodation of small groups of disabled people in ordinary places of living along with receiving all necessary services, — an analogue of the residential facilities system in countries that have undergone the process of deinstitutionalization. The innovative experience of assisted living and assisted employment exists in Vladimir, Irkutsk, Leningrad, Nizhny Novgorod, Penza, Pskov regions, in Moscow and St. Petersburg, as well as in other regions of Russia [11].

Another important aspect of the PRI reform is the adoption of the so-called “Divided Custody Law”. It aims to implement the provisions of the "Convention on the Rights of Persons with Disabilities" on the inadmissibility of conflicts of interest in the exercise of legal capacity and on the right of persons with disabilities to live in ordinary places of living. One of its key provisions concerns the possibility of establishing so-called divided custody over mentally incapacitated patients living in PRI. Both individuals and legal entities, including NPOs, can be guardians along with the residential institutions. The Law draft passed the first reading in Duma back in 2016 but it is still under consideration.

The huge rigid system of PRIs is difficult to be reformed. Stigmatization and self-stigmatization are the most important factors preventing resocialization of patients [13; 24]. Prejudice and stereotypes lead to the isolation of patients in the institutional system instead of providing outpatient services [22]. Employers do not want people with mental illness to be around, so they do not hire them [23]. Inward-looking prejudices and stereotypes and experiences of social rejection form self-stigmatization. It leads to the formation of a system of negative beliefs about myself ("I am weak and incompetent"), low self-esteem, rejection of new life opportunities, avoidance of activity and, ultimately, learned helplessness [28; 29].

Improving the social functioning of patients, as one of the most important conditions for the success of the PNI reform, requires the development and implementation of effective rehabilitation programs.

Study objective: a preliminary assessment of the effectiveness of the integrated rehabilitation program developed with participation of personnel and invited specialists, based on PRI No. 22 in Moscow, which combine the most important achievements of the systemic approach to rehabilitation of patients with mental disorders by M. Spivak [32] with the principles and methods of cultural-historical psychology (CHP) and cognitive-behavioral therapy (CBT).

CBT in Psychosocial Rehabilitation of Patients with Schizophrenia

The effectiveness of modern CBT models, widely used in the rehabilitation of patients with schizophrenia and other severe mental disorders, has been proven both from a clinical and economic points of view [12; 16]. Rehabilitation centers' specialists actively integrate them with other approaches to increase the overall effectiveness of rehabilitation programs. Thus, the greater efficiency of rehabilitation of clients who received individual CBT in combination with the rehabilitation program of a day-care center was demonstrated in comparison with the group that received only the services of the center [20]. Analysis of data on social functioning, symptoms and hospitalizations over a three-year period showed that in the group with an integrated approach the results were not only better, but also remained stable for a longer period. The advantages of using the elements of CBT by nurses serving psychotic patients in community rehabilitation programs showed prevention of relapses, shorter period of stay in case of re-hospitalizations, recovery in labor activities [25]. In 2015, a group of American research-

ers successfully integrated cognitive-behavioral and social skills training into the work of Assertive Community Treatment groups for patients with schizophrenia [26]. The effectiveness of integrating the mindfulness-based interventions (MBI), CBT tools based on awareness and acceptance techniques, into rehabilitation of schizophrenic patients with a high-risk mental state for acute condition was also demonstrated [34]. The results showed the benefits of MBI in terms of correcting the disorders of attention, operative memory, and social cognition, as well as improving psychological well-being by empowering the patients to manage their symptoms.

A new approach to the therapy of people with severe mental disorders is being actively developed. This is the Recovery-Oriented Cognitive Therapy (CT-R), a cognitive therapy focused on recovery, based on A. Beck's cognitive model and the principles of Recovery Movement [17]. The therapy is aimed at empowering patients, achieving their personal and social recovery, increasing resilience, overcoming defeatist ways of thinking and behavior. CT-R focuses on personal advantages, activates an adaptive lifestyle, develops individually important aspirations, engages patients in personally meaningful activities to achieve their desired life goals. CT-R conceptualizes mental health in the broader context of a person's interests, values, and aspirations for a fulfilling life. Empirical studies have proven the effectiveness of the new approach in working with complex patients who have a long experience of hospitalization and serious problems of social functioning [27; 31; 33].

Mark Spivak's Model: Systemic Approach to Psychosocial Rehabilitation

M. Spivak (1929—1998) is an American psychologist who dedicated his work to the problems of rehabilitation of patients with chronic mental disorders. He led the development and implementation of rehabilitation programs for people with severe mental disorders in Israel. In the late 1980s, he implemented his approach in rehabilitation centers in Italy in the framework of deinstitutionalizing reform of Italian psychiatry, which is considered the most successful in the world, being a reference point for other countries [8].

Basic provisions and principles of the rehabilitation program. M. Spivak's model is based on the understanding of a chronic mental disorder being a result of desocialization, a process of stressful and destructive interaction between the patient and his environment, characterized by repeated episodes of non-compliance with expectations, disappointment, pain, guilt,

anger [32]. Desocialization leads to the destruction of psychological and social competencies, relapses, decrease of functioning, paralysis of productive activities — and, as a result, to placing the patient in a residential institution. Factors of social stress such as job loss, narrowed social circle, stigmatization also add to resocialization. The goal of rehabilitation is to achieve the highest possible level of development of psychological and social competencies for integration of institutional residents into society. Rehabilitation efforts are aimed at specific life areas of the residents.

The rehabilitation principles include:

1. Feasibility of the tasks assigned to the participants of rehabilitation program. Any patient has a huge experience of disappointment, and each new failure actualizes his traumatic experience. Therefore, it is extremely important to plan tasks the way that would guarantee the resident's success in archive the result.

2. Support provided by the personnel to the patients in their feelings and actions related to overcoming difficulties, considering a long history of their personal and social defeat.

3. Tolerance to "strange" behavior. The requirements are less stringent than in ordinary conditions, except for dangerous forms of behavior.

4. Non-reinforcement of negative expectations. The personnel should not demonstrate the reactions of disappointment, rejection, refusal, punishment, which are expected by the patients due to their negative experience.

5. Selective reinforcement: competent forms of behavior are encouraged, but asocial, aggressive ones are not. The most desirable types of incentives are used.

However, in the author's works, its scientific substantiation is virtually absent: the empirically verified models of motivation disorders and the associated system of beliefs formed by patients with schizophrenia during their unfavorable life experience. Such studies were carried out both in Moscow School of Clinical Psychology and CBT, and the latter were started under the guidance and with direct participation of A. Beck [18].

Justification of Rehabilitation Concept of M. Spivak, Based on Empirical Data in Works of Cultural-historical Psychology (CHP) and CBT

M. Spivak's ideas about the gradual development of competencies and regulation of availability level of tasks correspond to the concept of the zone

of proximal development of L.V. Vygotsky [3]. The activation and support of subjective position in overcoming difficulties is implemented by the reflection-activity approach [4], which develops the traditions of CHP. Thus, M. Spivak's ideas receive an important theoretical justification in the principles and research of CHP representatives.

In the study by A.B. Kholmogorova, based on solving creative problems, a situation of difficulty was modeled, and it was proved that the patients have a weakening of self-regulation of thinking, which is expressed in disorders of the mobilizing and constructive functions of reflection [15]. This leads to refusal to complete the task, leaving the situation, avoiding difficulties and intellectual effort. This phenomenon is called "self-restraint attitude" [15]. Also, the works by N.S. Kurek and A.B. Kholmogorova, based on the model of aspiration level, demonstrated disorders of the process of goal-formation in patients with schizophrenia: a weakening of aspiration level, expressed in maintaining a constant level of complexity of the goal. This is a special tactic of behavior, which helps patients to avoid situations of failure [7; 15]. The authors convincingly proved that the motivation to avoid failure dominates and the motivation to achieve goals and focus on problem-solving is practically paralyzed.

Another psychological deficit characteristic of schizophrenia is social anhedonia, which determines the weakening of communicative orientation of thinking and leads to self-isolation [6; 16]. Social anxiety plays a special role in manifestation and course of mental disorders, forcing refusal to participate in social contacts, being another reason for the destruction of their competencies and relationships [16]. We can talk about the complex nature of disorders of social cognition and behavior of patients with schizophrenia, a contribution to which is made by many interrelated phenomena.

CBT describes premorbid neurocognitive disorders in schizophrenic patients, which increase their vulnerability to experiences of unsuccess (e.g., school failure) [19]. This leads to dysfunctional beliefs ("I am worse than others"), negative assessments and maladaptive strategies of behavior, for example, avoidance of contacts and self-isolation [19]. It is empirically substantiated that patients with schizophrenia are not inclined to view their problems as having a purely biological basis. Therefore, important principles for building a therapeutic alliance are considering the patient's point of view of understanding the symptoms, conceptualizing them as problems that need to be solved, and focusing on reducing symptoms rather than on admitting oneself to have a mental disorder [35].

Preliminary Assessment of Effectiveness of Integrated Rehabilitation Program for Residents of PRI, Combining the Resources of Systemic Approach of M. Spivak, CBT and CHP

Sampling and research procedure. At the beginning of 2018, the administration of PRI No. 22 in Moscow proposed organizing a psychosocial rehabilitation program for a group of residents who had lost their legal capacity but claimed to receive limited legal capacity (LC), which could significantly expand their opportunities, although it imposed restrictions on certain actions, for example, major transactions. Participants' inclusion in the program was based on the competent opinions of the personnel as well as their own intention to obtain LC. Selection criteria included: remission for at least 2 years, self-care in everyday life, minor mood swings and behavioral disturbances, selective participation in labor and leisure activities.

The group consisted of 12 people (10 men, 2 women aged from 26 to 65) with diagnoses of chronic mental disorders (F20.0, F21.4, F06.9 and F07.9) and disability. 9 participants in the group had secondary education, 1 — incomplete secondary education, 1 — higher education, and 1 — training according to an adapted secondary education program. 7 members of the group were previously married, 4 had children. 10 participants were in remission while receiving pharmacotherapy, 2 remained in remission after discontinuation. 8 people had alcohol dependence in the past (4 of them — combined use of psychoactive substances). 5 participants had attempted suicide. At the time of the study, the participants had been living in PRI for 3 to 16 years. The total duration of the program was 6 months. In total, 7 specialists took part in the developing and carrying out various elements of the program: 4 employees of PRI and 3 invited specialists.

Methodology for assessing the effectiveness of the integrated program. To assess the level of competence of the group members before and after the rehabilitation program, 5 scales for assessing the psychological and social competencies by M. Spivak [32] were used, each of which assesses 25 simple competencies in one of the five main spheres of life: housing and everyday life, employment and productive activities, hygiene, interpersonal relationships, leisure. The final scores determine competencies at one of 3 levels: sufficiently formed, partially formed, and practically not formed.

The initial study of the level of competencies and the assessment of dynamics after completion of the rehabilitation program were carried out by five experts: three graduate students of the Faculty of Clinical and Counseling Psychology, Moscow State University of Psychology and Education,

and two employees of PRI. The students were trained at Futura Rehabilitation Center (Calabria, Italy), and the personnel of PRI received assessment tools and were trained in their correct use by the organizers of the program. The assessment considered information from several sources: a semi-structured interview with the respondents and information from personnel and relatives. In March 2018, the primary process of collecting and refining data for one respondent took about 4 hours. And the re-assessment in September 2018 took 2 hours. The assessment was carried out by consensus, the results obtained for each respondent were discussed by all five experts.

Content and structural elements of the program. The development of insufficiently formed competencies formed the tasks of individual rehabilitation plans (IRP), developed jointly with the personnel. The most important principle of their compilation was the predictable success of residents, to complete the tasks. Each step of the IRP was outlined as obviously feasible, lying in the zone of the participant's proximal development. The IRP included the following structural elements: (1) employment or participation in productive activities in PRI or in the city; (2) motivational training for the restoration of constructive activity and self-efficacy, based on supporting subject position of rehabilitants [14]; (3) development of shopping skills, also transiting the role of participants from trainees to assisting social workers in shopping services; (4) training of hygiene skills, in the form of competition; (5) a support group to discuss problems in relations with relatives. In cooperation with Moscow Alcoholics Anonymous community, a self-help group was organized for 8 people with a diagnosis of alcohol addiction in the past. Several individual activities were also carried out. A mentor was found for a girl who had been transferred to PRI from an orphanage. Two rehabilitants wanted to participate in the church community and began to attend the events held there.

Rehabilitation could have been ineffective if the environmental conditions had not been changed. Since 2018, the doors of the departments in the PRI have been open, residents can move freely around the territory. Transportation of mentally incapacitated patients outside of PRI is usually a problem for its administration as it raises concerns about ensuring their safety. The group participants received all necessary support when moving outside of PRI.

Finally, an important element of the IRP was long-term training aimed at preparing patients for LC, using basic CBT tools. The number of sessions in each module varied from 1 to 3 (1.5 hours each), depending on the difficulty level available to the participants. The training, like the entire rehabilitation program, lasted six months and consisted of 11 modules:

1. Dealing with fears and worries associated with obtaining LC.
2. Setting goals and objectives.
3. Psychoeducational module.
4. Module aimed at studying and understanding legal aspects of LC.
5. Broadening of outlook.
6. Psychological aspects of behavior during court proceedings and forensic psychiatric examination.
7. Rehearsal module (reconstruction of a court session and examination environment and role-playing in vitro).
8. Role reversal (participants act in the roles of psychologists, judges, psychiatrists).
9. Increasing stress resistance and developing self-regulation skills.
10. Development of conflict resolution skills.
11. Wrap-up module.

The following CBT methods were used in the training: journaling and thought records, identification of cognitive distortions, realistic assessment, working out alternatives and counterarguments, discovery of basic beliefs and conditional rules, cognitive reframing, evaluation of habitual coping strategies, testing new coping strategies, cognitive rehearsals, desensibilization, exposure, development of realistic plans based on available methods of goal achievement. The participants got acquainted with the basic concepts of CBT, completed homework based on structured supporting materials, and practiced in transferring the acquired knowledge into everyday actions.

An example of using CBT techniques in the first module, aimed at dealing with fears and worries of the group members*. In the special form "Fears, Concerns, Difficulties and Obstacles", the participants were asked to write down their thoughts on what might prevent them from obtaining LC. After the trainer introduced the participants to the concepts of cognitive distortions and how to deals with them, and the participants were invited to discuss the concerns they identified.*

50-year-old participant A. expressed her idea that the experts in forensic psychiatric examination were not objective. In her understanding, it was much more difficult for her as a woman to pass this examination successfully, since "experts are more loyal to men". The study of her life story showed how this belief was formed by her experience: in her youth, she dressed defiantly and was subjected to critical comments both from other women and from older men (especially in official situations, for example, when visiting registration office in the clinic). She kept defending her belief, despite the counterarguments of other participants. As evidence, she cited the "statistics" of people receiving LC in this PRI: during the previous year 4 men and only 1 woman had received positive

expert opinions. Calculations showed that 75% of men and 25% of women live in this PNI, thus, the results of expert' opinions simply reflect this objective quantitative ratio, and are not a sign of discrimination, and this was discussed by the group.

Participant B. defined his "severe anamnesis" as the main factor that could prevent him from obtaining LC: he had suffered several acute psychotic episodes and attempted suicide. To prove his case, he pointed out that every time he talked to a psychiatrist, the doctor paid special attention to these episodes, "and his face became disapproving". The group members found no cognitive distortion in this negative thought. The trainer identified the distortion in the form of "mind-reading", but this did not convince the participants as they had a long history of stigmatization. As an exercise, B. was asked to fill up a special form "My mental state before" — "My mental state now" (Similarities and Changes). As a result of this exercise, B. and the group concluded that his mental state had improved significantly, and carrying out his examination, most likely, the experts would pay more attention to his current state and dynamics than to episodes of the past.

As a homework task, the participants were asked to continue working with the form of "Fears, Concerns, Difficulties and Obstacles": to assess their negative thoughts and divide them into distorted and realistic ones, to write down counterarguments to distorted thoughts, to suggest ways to solve real problems. During the training, the participants kept notebooks for continued work with their negative thoughts, relying on the support of the trainers who observed the principles of the zone of proximal development.

Evaluation of the Program Effectiveness

A comparison of the primary assessment in March 2018 and reevaluation in September 2018 scores, applying Wilcoxon criteria, is presented in Table 1.

As shown in Table 1, according to the results of the primary assessment in March 2018, the group members received the scores corresponding to the least developed competencies in 3 areas: labor and productive activities, interpersonal relations, hobbies and leisure. The best developed competencies were formed in areas "hygiene" and "housing and everyday life". These results could be explained by the social situation of PRI, where life was centered around simple everyday actions and hygienic care, and the residents had limited opportunities for communication and productive activities.

Table 1

Comparison of the scores before and after the training

	Before (March 2018) Me (IQR)	After (Sept. 2018) Me (IQR)	p
Housing and Everyday Life	19,3 (2.6)	22,5 (2.6)	0.004
Employment and Productive Activities	18,3 (6.9)	21 (5.2)	0.037
Hygiene	21 (4.3)	23,8 (2.4)	0.004
Interpersonal Relations	17,3 (4.1)	21,3 (3.6)	0.002
Hobbies and Leisure	17,5 (4.8)	21 (2.9)	0.004

Me — median; IQR — interquartile range; significance set at $p = 0.05$.

As a result of rehabilitation, the participants improved their competencies in all 5 areas of life. Positive changes in the level of competence are statistically significant. In 2018, four members of the group received LC. In 2021, one of them entered the legal proceedings to obtain full legal capacity and plans living with his relatives. Two participants received LC in 2020. One participant left PRI and lives independently, two live outside PRI, receiving services of assisted living. One participant improved relations with his family, has an extended home stay and plans to leave PRI. Five are employed: one works in PRI, three in workshops of NPO, and one is employed in the open market. Three are undergoing legal proceedings to obtain LC in 2021.

Limitations of the study. This study is pilot and limited in sample size.

Output

The reform of PRI requires development of effective rehabilitation programs for successful and safe reintegration of PRI residents into society. This integrated program of psychosocial rehabilitation was based on combining the resources and achievements of the systemic rehabilitation approach of M. Spivak, CHP and CBT. All three approaches are in good agreement in their basic ideas and principles and are mutually supportive. Overcoming learned helplessness and sustained avoidance motivation, as a consequence

of negative social experience and long stay in institutional conditions, was carried out on the basis of creating a safe and supportive environment, training various social skills and using activation techniques, relying on the principles of the zone of proximal development and supporting the subject position of the residents, in the process of gradually strengthening the working alliance based on considering the patients' attitudes towards their problems and joint cognitive conceptualization for testing and overcoming dysfunctional beliefs and developing constructive ways to problem-solving.

The obtained preliminary data showed the effectiveness of the integrated rehabilitation program. After six months, during which the program was carried out, a statistically significant increase in the level of competence of all 12 rehabilitants was identified in the five main spheres of life by five experts, by consensus. Positive changes in the life of the participants in the next three years have been associated with obtaining limited legal capacity, employment, return to family living, leaving the institution for independent or assisted living.

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