disease. However, the issues of the connection between the two systems in the clinical picture is not paid enough attention.

To improve the effectiveness of medical care for patients with neurological disorders in those with endocrine pathology by studying pathogenetic mechanisms and clinical features in patients with thyroid gland dysfunction, taking into account non-psychotic mental disorders.

To study neurological disorders in patients with endocrine pathology. To investigate cognitive functions and emotional and personality features of patients with endocrine pathology. Patients with neurological disorders secondary to endocrine pathology. Methods: clinical-neurological and psychodiagnostic ones. In order to determine the peculiarities of cognitive functions, we used the MMSE test (Mini Mental State Examination), methods of evaluation of attention on the Schultz tables modified by Horbova F.D. and memory was tested by "Memorizing 10 words" (by Luria A.R.). To assess the personal and reactive anxiety, the Spielberger State-Trait Anxiety Inventory scale, adapted by Hanin Yu.L., and the degree of depressive disorders was determined by the Beck A.T. scale.

Neurosis-like syndrome was observed in 93% of the patients under study. Patients complained of slight irritation and emotional lability. In patients with hypothyroidism secondary to AIT neurosis-like syndrome occurred in 91% of cases, in patients with hypothyroidism without AIT - in 97%. The same number of patients with subclinical and those with clinical hypothyroidism complained of high irritability and tearfulness, but it was the patients with subclinical hypothyroidism whose neurosis-like syndrome was more pronounced. The incidence in them was 90%, and in those with clinical hypothyroidism - 94%.

The level of personal anxiety that characterizes it as a character trait on the Spielberg and Hanin scale of anxiety self-esteem had no probable differences in the studied groups and was high in patients both with and without AIT, as well as in patients with varying degrees of severity of hypothyroidism. The average index of personal anxiety in patients with hypothyroidism of the thyroid gland secondary to AIT was 55.13 ± 9.62 points, and in patients with hypothyroidism without AIT - 53.09 ± 8.24 points. In subclinical hypothyroidism, it was 54.90 ± 9.10 points, and in clinical hypothyroidism - 55.30 ± 9.02 points.

The reactive anxiety allows evaluating anxiety as a transient clinical condition. It was moderate in most patients with primary hypothyroidism, regardless of its cause and severity. However, the average index of reactive anxiety was higher in patients with AIT and amounted to 45.13 ± 9.20 points, and in patients with hypothyroidism without AIT - 32.72 ± 9.20 points. The reactive anxiety was also more pronounced in patients with subclinical hypothyroidism and amounted to 45,95 =8,10 points, and in patients with clinical hypothyroidism - 33,80 ± 8,20 points.

Neurosis-like syndrome in patients with primary hypothyroidism was practically obligatory. Patients in most cases complained of mild irritability, tearfulness, emotional lability. In the majority of patients with primary hypothyroidism, regardless of its cause and severity, there was a high personal anxiety, and the reactive one was moderate. One of the features of neurosis-like syndrome in primary hypothyroidism is the prevalence of its manifestations in patients with autoimmune thyroiditis and in patients with subclinical hypothyroidism.

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THE SYSTEM OF MEDICAL AND PSYCHOLOGICAL SUPPORT FOR WOMEN AT HIGH RISK OF PRETERM BIRTH

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Threatened premature labor (TPL) is a high-risk complication in pregnancy that not only has detrimental impact to the health of pregnant women, but could also lead to neonatal death, cerebral palsy, cognitive impairment, blindness, deafness, respiratory illness, and neonatal care complications. Thus, TPL poses a significant public health issue, with implications for child and family well-being, including impact on the psychological well-being of expectant mothers and fathers. Family resilience refers to the characteristics, dimensions and properties of families, which help families to be resilient to disruption in the face of change and be adaptive in the face of crisis situations. For all families, pregnancy is a period which may potentially create additional stressors. Pregnancies complicated with TPL pose chronic stressors due to the specific pathophysiological course of TPL, thus exhausting already limited resources available to these families. Understanding the factors associated with family resilience may provide important insight into effectively support childbearing families experiencing TPL.Women will have to create a new identity as mothers and it can be quite challenging; they have to deal with physical, psychological, emotional and relationship changes in order to find a new balance.

This study was conducted in the inpatient unit for the prevention of TPL in Storozhynets regional hospitaa. TPL women at 28 to 37 weeks of gestation ($n = 130$) and the majority of their spouses ($n = 104$) were invited to participate in the study. Women or spouses with previous diagnosed psychiatric disorders were excluded. Four validated questionnaires were used to measure the psychological outcomes (Hamilton's Depression and Anxiety Scales HDRS and HARS; the scale of mother's attachment to the baby (Cranley M., 1993); the test of the relationship of the pregnant woman (Eidemiller E. G., Dobryakov IV, Nikolskaya I. M., 2003) - to assess the status of relations in the dyad "mother - child"; experiences in Close Relationships-Revised (ECR-R) Adult Attachment questionnaire, Fraley, R. C., Waller, N. G., & Brennan, K. A., 2000); social support rating scale SSRS) in 130 TPL women hospitalized in Storozhynets regional hospital.

The development of threatened premature labor (TPL) was a stressful and life threatening event in pregnancy for the families. Levels of social support were higher in high resilient women compared to their partners in this study. This is consistent with previous report that social support buffered women against the risk of antenatal depressive symptoms.

The current study found that low resilient women also had higher pressure in pregnancy, less active coping, more depressive symptoms, higher rates of depression, less positive affect and more negative affect. Although TPL had trivial impact on most psychometric parameters of spouses, their pressure and depression should not be ignored. The present study also revealed different spectrum of interactions of psychometric factors for couples with TPL, with women's resilience negatively correlated with spouses' negative affect. These findings suggest that in addition to clinical treatment of high-risk pregnancies, psychological screening and intervention for the detection of depression should be done as early as possible on TPL women and their partners as an integrity to better promote family resilience and their well-being, including the expectant child.

Counseling can help expectant mothers, women who are facing postpartum concerns, and the partners of these women to address the various issues that pregnancy and childbirth are likely to cause. Women who experienced mental health issues before pregnancy may fear that the added challenge of motherhood will exacerbate their conditions or cause further concerns to develop, but the support of a therapist or counselor throughout their pregnancy may help them feel more at ease.

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PSYCHODYNAMIC APPROACHES TO UNDERSTANDING DEPRESSION

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This topic was chosen in connection with an increasing number of patients with depressive disorders of various registries, such as depression of the neurotic circle, and deep psychotic depressive disorders; besides, in practice, we often encounter a situation in which, despite all the methods of treatment used, namely pharmacotherapy (in particular, the combination of antidepressants with stimulating antipsychotics, normotimics, biostimulants, etc.), psychotherapy, the expected effect of therapy is still not observed. Of course, the patient is getting better, but we are not seeing the final reduction of depressive symptoms. The assumption is that the understanding of depression is not complete.

For the first time the psychodynamic aspects of the depressive state were investigated by Z. Freud and K. Abraham, who linked the onset of depression with the loss of the object (mainly the mother). In psychoanalysis, an object can mean a subject, part of a subject, or some other subject part of it, but the object is always implied as a special value. According to J. Heinz, the object is understood as the life ambitions of illusions. The object is always associated with the attraction or satisfaction of one or another attraction, is always affectively colored and has stable signs. As a result, in the subsequent, under the influence of provoking factors (psychogenic, physiological, ecological, etc.), there is a regression to the early stages of psychosexual development, in this case - precisely to the stage at which the pathological fixation arose.

Let us now imagine how the state of depression arises. The lost object is introjected into the Ego; is identified with it, to some extent, after which the Ego is split into 2 parts - actually the patient's Ego and the part identified with the lost object, as a result of the fragmentation of the ego and the loss of its energy. In turn, the Super-Ego, reacting to this, increases the pressure on the Ego, i. E. personality, but as a result of the loss of integration and differentiation of the latter, the Ego begins to react to this pressure mostly as the Ego of the lost object, onto which all negative and ambivalent feelings of the patient are projected (and the "broken off" part, belonging to one's own Ego is depleted and devastated), that's where the feeling of emptiness, to which our depressed patients so often complain, appears. As a result, negative feelings directed towards the lost (perceived as treacherous, ugly) object, concentrate on themselves, which clinically manifests itself in the form of ideas of self-deprecation, guilt that, at times, reach the level of supervalued, delusional.

It is important to mention one of the hypotheses of the emergence of depression: when the object is lost (or the relationship with it collapsed), but the subject can not tear off his attachment (the energy of the libido), this energy is directed to the self, which as a result splits, is transformed, identifying with the lost object, thus the loss of an object is transformed into a loss of the ego, all energy is concentrated inside, "isolated" from external activity and reality as a whole. But since there is a lot of this energy, it looks for an outlet and finds it, transforming itself into an endless mental pain (pain is in its original sound, existing whatever, as matter, energy, etc.).

The second hypothesis says that there are powerful aggressive feelings directed at an object that did not meet expectations, but since the latter remains the object of attachment, these feelings are directed not to the object, but again to the self that is being split. In turn, the super-ego (the instance of conscience) is making a cruel and uncompromising "trial" over one's own self, just like an object that did not justify the expectation. It should be noted that the structure of the personality organization, the type and level of organization of the patient's personality certainly affects the course of depression, like any other mental illness, and perhaps somatic too. strong sense of frustration and loss of the most important aspect of himself or his pathological ego-ideal, his " illusory world ", this state is experienced as a concrete physical event. Summarizing all of the above, the optimal way to treat depression is psychotherapy, if necessary, supplemented by psychopharmacotherapy.