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.