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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии
საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებშიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman (Кириллица)**, для текста на грузинском языке следует использовать **AcadNusx**. Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи.** Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - <http://www.spinesurgery.ru/files/publish.pdf> и http://www.nlm.nih.gov/bsd/uniform_requirements.html. В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректур авторам не высылаются, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or computer-printed on a single side of standard typing paper, with the left margin of 3 centimeters width, and 1.5 spacing between the lines, typeface - **Times New Roman (Cyrillic)**, print size - 12 (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf

In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

**Articles that Fail to Meet the Aforementioned
Requirements are not Assigned to be Reviewed.**

ავტორთა საყურადღებო!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე, დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx**. შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემავსებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრაფიის ფოტოსურათები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შედეგების ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფხიხლებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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MENTAL HEALTH IN THE MODERN WORLD: THE PROBLEM AND SOLUTIONS

Olena Kozeratska^{1*}, Adelina Gutnitska², Oksana Vdovichenko³, Vitalii Spivak⁴, Alisa Kabesheva⁵.

¹*Doctor of Medical Sciences, Chief Forensic Psychiatrist, Chief Researcher of the Scientific Research Department, State Institution "Institute of Forensic Psychiatry of the Ministry of Health of Ukraine", Kyiv, Ukraine.*

²*Teacher, Chernivtsi Medical Professional College, Chernivtsi, Ukraine.*

³*Doctor of Psychological Sciences, Professor, Department of Theory and Methods of Practical Psychology, Director of the Educational and Scientific Institute of Psychology and Social Sciences, State Institution "South Ukrainian National Pedagogical University named after K.D. Ushynsky", Odesa, Ukraine.*

⁴*Ph.D. in Psychology, Assistant Professor, Assistant Professor of the Department of Social Work, Faculty of Special Education, Psychology and Social Work, Kamianets-Podilskyi National Ivan Ohienko University, Kamianets-Podilskyi, Ukraine.*

⁵*Candidate of Psychological Sciences on Specialty Pedagogical and Age Psychology, State Institution "South Ukrainian National Pedagogical University named after K.D. Ushynsky", Odesa, Ukraine.*

Abstract.

Aim of the study: To analyze current mental health problems, assess the prevalence of mental disorders, identify key determinants, and evaluate access to mental health care in different countries.

Material and methods: A narrative analytical review with a comparative synthesis of international and national data on mental health for 2019–2025 was conducted, including scientific publications, reports and estimates from the World Health Organization, Global Burden of Disease, World Mental Health, the Organization for Economic Co-operation and Development, and national data from Ukraine.

Results: Mental health significantly affects quality of life, productivity, and social stability. The COVID-19 pandemic, military conflicts, and economic instability have increased the prevalence of depressive, anxiety, and stress-related disorders worldwide. A high global burden of mental disorders and major regional differences were identified. The treatment gap remains especially high in low- and middle-income countries, where less than 10% of the population receives adequate care. In developed countries, coverage reaches 20–40%, although inequalities, long waiting times, and stigmatization persist. In Ukraine, the prevalence of mental disorders is estimated at 31–36% due to socio-economic instability and military conflict.

Conclusions: The findings highlight the need to integrate mental health services into primary health care, expand community-based support models, and implement comprehensive policies to reduce the global burden of mental disorders.

Key words. Psychology, mental health, depression, anxiety disorders, treatment gap, socioeconomic determinants.

Introduction.

According to the World Health Organization (further – WHO), mental health is a key component of general health and refers to a state of mental well-being that enables individuals to cope with life stressors, realize their abilities, learn, work productively and contribute to their communities [1]. Therefore, mental health should be considered not only as an individual clinical characteristic, but also as an important condition for social stability, human capital development and sustainable functioning of health and social protection systems.

The scale of mental disorders (further – MD) worldwide confirms the urgency of this problem. According to WHO

and Global Burden of Disease (further – GBD) estimates, a substantial proportion of the global population lives with one or more MD, while depressive and anxiety disorders remain among the most common and disabling conditions [2,3]. These disorders reduce quality of life, impair social functioning, increase the risk of disability and contribute significantly to the global burden of disease. Their impact is especially important because MD often develop during socially and economically productive periods of life, thereby affecting education, employment, family functioning and community participation.

MD are increasingly recognized as one of the major causes of economic and social losses. Arias et al. [4] quantified the global economic value of the burden associated with MD and showed that their impact extends far beyond direct health care costs. Chodavadia et al. [5] demonstrated that depressive and anxiety symptoms are associated with substantial losses of working days and productivity, while Greenberg et al. [6] showed that major depressive disorder (further – MDD) generates both direct medical costs and indirect costs related to absenteeism and reduced work productivity. Thus, the economic consequences of MD include not only expenditures on treatment, but also reduced labor participation, decreased productivity, work disability and increased pressure on health and social protection systems.

In addition to economic losses, MD are closely connected with social inequality, marginalization and unequal access to care. Global mental health research emphasizes that poverty, unemployment, forced displacement, low social support and exclusion from education or employment increase vulnerability to MD and worsen recovery prospects [7,8]. At the same time, MD can further deepen social vulnerability by limiting educational achievement, employment stability, income security and access to health services. In this context, mental health should be understood as a multidisciplinary public health issue that combines clinical, social, economic and institutional dimensions.

The relevance of mental health has increased markedly in the context of global crises. During the COVID-19 pandemic, the prevalence of depressive and anxiety disorders increased substantially worldwide, which was associated with social isolation, fear of infection, uncertainty, economic stress and reduced access to health care [2,9]. Armed conflicts and forced displacement also increase the risk of post-traumatic stress disorder (further – PTSD), depression and anxiety disorders

among both directly affected individuals and the wider civilian population [10]. Economic instability, unemployment and declining income levels further intensify psychological distress and may increase the risk of depressive symptoms and suicidal behavior [1,11]. These crisis-related factors demonstrate that mental health is highly sensitive to broader social conditions and that populations exposed to war, displacement, poverty or prolonged uncertainty require special attention in public health analysis.

Chronic physical diseases are another important factor associated with deterioration in mental health. Evidence shows a high level of comorbidity between MD and chronic somatic conditions. In adults with chronic pain, depressive and anxiety symptoms are frequently reported and may complicate treatment, rehabilitation and daily functioning [12]. Similar patterns are observed in patients with rheumatoid arthritis, cardiovascular diseases and other chronic conditions, although prevalence estimates vary depending on diagnostic and assessment methods [13,14]. This confirms the need to analyze mental health not separately from general health, but as part of an integrated model of prevention, diagnosis, treatment and long-term care.

Despite increasing international attention to mental health, significant gaps remain in the understanding of how the global burden of MD, socio-economic determinants, crisis-related risks and access to care differ across countries. This is particularly important for countries affected by war or humanitarian crises, including Ukraine, where the mental health burden is shaped by prolonged military threat, forced displacement, socioeconomic instability and chronic uncertainty.

The purpose of this article is to analyze contemporary mental health problems worldwide by assessing the prevalence and burden of MD, identifying key socio-economic, biological, psychological and environmental determinants, and evaluating the accessibility of mental health care systems in countries with different levels of economic development and different crisis contexts.

Materials and Methods.

The study was conducted as a narrative analytical review with a comparative synthesis of international data on MH. The information base included scientific publications, reports of international organizations, and national statistical data from Ukraine for 2019–2025. The main sources were the WHO, GBD, World Mental Health (further – WMH), the Organisation for Economic Co-operation and Development (further – OECD), as well as selected national studies from Ukraine.

To assess the global and regional prevalence of MD, data from WHO reports for 2022–2025, the GBD Study for 2019–2021, OECD Health at a Glance for 2021–2025, as well as national surveys and studies from Ukraine [15] were analyzed. The analysis covered the main ICD-11 categories of MD, including depressive, anxiety, stress-related, bipolar, psychotic, substance use, behavioral, and lifestyle-related disorders. The data were summarized as percentages of the population, taking into account regional and methodological differences, as well as the dynamics observed during the COVID-19 pandemic in 2019–2021 and the subsequent stabilization period in 2022–2024.

The following countries were analyzed within this research paper: Ukraine, the United States, the United Kingdom, Germany, France, Japan, Nigeria, Pakistan, Kenya, India, and South Africa. These countries were selected because they represent different levels of economic development, different models of psychiatric and psychological care organization, and different social or crisis-related contexts, including the wartime situation in Ukraine and resource limitations in low- and middle-income countries.

For Ukraine, the analysis used data from an adult population sample assessed in 2023 during the full-scale war [15]. This estimate was interpreted as reflecting the mental health status of the adult civilian population living under conditions of prolonged military threat, forced displacement, socio-economic instability, and chronic uncertainty. It should not be interpreted as a prevalence estimate limited only to direct victims of combat or clinically diagnosed psychiatric patients. Therefore, comparisons between wartime data from Ukraine and peacetime or post-pandemic data from other countries were made with caution.

The selection of sources was based on their relevance to the aim of the study, methodological reliability, international recognition, and availability of data on the prevalence, determinants, treatment gap, and organization of care for MD. Search terms that were utilized to locate these data sources included the following keywords: MH, MD, depression, anxiety disorders, PTSD, treatment gap, MH services, COVID-19, armed conflict, Ukraine, low- and middle-income countries, primary care integration, and community-based MH care.

The sources that were utilized in this research study were included based upon their inclusion of data related to the prevalence of MD, access to psychiatric and psychological care, the biological, psychological, social, behavioral, and environmental determinants of MH, the organization of mental care for individuals with MH conditions, or data related to Ukraine and the psychological effects of war. Sources that were excluded from this research study included those that only featured data related to specialized populations, lacked data relevant to MH and MD, featured information that was generally more general and broader in nature than the aim of this research study, or that were otherwise not related to the aim of this research study altogether.

The analysis used narrative synthesis, structural and content analysis of scientific publications and strategic documents, trend analysis, and comparative analysis of quantitative indicators. The accessibility of psychiatric and psychological care, including the treatment gap, was assessed by comparing the estimated need for treatment with the actual availability of services in countries with different levels of economic development. In addition, an analytical synthesis of MH determinants was conducted, including biological, psychological, social, behavioral, and environmental factors that influence the risk of MD. For Ukraine, the impact of military conflict, forced displacement, socio-economic instability, and high psychological stress among the population was additionally taken into account.

The main indicators included the prevalence of MD, accessibility of psychiatric and psychological care, effectiveness of MH services, the treatment gap, and socio-economic,

biological, and behavioral determinants of mental health. As the criteria of the studies to be included in this review were so methodologically diverse, it was not possible to calculate pooled estimates of the prevalence of the issue within each category of country, and to perform a meta-analysis on the data from those studies. The findings of each of these studies can be summarized, but are likely to differ from other countries due to the difference in their income levels, the time in which their data was collected, and their crisis contexts. Studies that were prioritized in the review were those from internationally-recognized organizations, epidemiological studies, and peer-reviewed publications, as well as recent publications from the countries that specifically relate to the goals of this research.

Results.

From an analysis of the literature and data from various international organizations, it becomes evident that MD place a considerable burden upon the global population. Depressive and anxiety disorders are the MD that contribute to the largest proportion of the mental disorder burden across the planet (Table 1). Summarized estimates from various international organizations indicate that depressive and anxiety disorders are the most widespread types of MD across the planet as a whole [1-3]. Disorders like bipolar disorder, schizophrenia, and other psychotic disorders are less prevalent in the planet's population, but do contribute to considerable limitations in the function of those afflicted individuals [16-18]. Stress-related disorders, such as PTSD, are significant disorders among the populations that are affected by conflicts and crises [9,10]. Finally, other MD, such as eating disorders, obsessive-compulsive and related disorders, personality disorders, and neurocognitive disorders are less common categories of MD, but still contribute to the MH of the planet's population [19].

A review of the literature and data from international organizations has shown that the dynamics of the prevalence of MD in the period 2019–2021 increased against the background of the global COVID 19 pandemic and the associated socioeconomic shocks, which contributed to a significant increase in the number of cases of depressive and anxiety disorders in the world. According to WHO estimates, in the first year of the pandemic, the prevalence of anxiety and depression increased by approximately 25% compared to the pre-crisis period [9]. Data from the GBD Study 2021 also indicate that in 2019–2021, the total proportion of MD, in particular depressive and anxiety disorders, increased significantly [18]. In 2022–2024, there was some stabilization after the peak indicators of the pandemic, but the prevalence level remained higher than before the crisis [3].

An examination of international research data suggests substantial regional differences in the prevalence and burden of MD by level of economic development (Table 2). GBD 2021 estimates indicate considerable variation in the burden of MD across countries and regions, with high-income regions showing a substantial documented burden of MD [19]. OECD data also show that depression, anxiety and other MH indicators vary across countries, age groups and health systems, while the social and economic costs of mental ill-health remain substantial even in high-income settings [11,20]. These differences may reflect

not only the actual prevalence of MD, but also differences in diagnostic practices, help-seeking behavior, health system capacity and the availability of MH services.

In high-income countries, including the United States, reported rates of MD are influenced by broader diagnostic coverage, more developed reporting systems and greater availability of MH services. However, the availability of such services ensures that there is a high demand for those services to fulfil the need of patients with MDD, as a considerable proportion of those with the disorder do not receive any treatment for their symptoms [21].

In low- and middle-income countries (further – LMICs), officially reported rates of MD are often lower due to limited access to specialist care, stigma and weaker health information systems, leading to partial underestimation of the true prevalence and the true need for treatment. This is in line with the evidence regarding MH across the globe in resource-limited settings. The factors that contribute to the higher burdens of MD in these settings include poverty, social exclusion, weak health services infrastructure, and the lack of integration of MH care within general health care services [7,22].

The COVID-19 pandemic additionally contributed to the MH burden that exists globally. According to data from the WHO published during the first year of the pandemic, there was a marked increase in the number of individuals suffering from anxiety and depression [9]. The general population exhibited high rates of depression, anxiety, PTSD, and general stress symptoms [23]. More recent analyses of the GBD 2021 data indicates that the burden of MD is present across the globe in all countries and territories [24]. However, the exact figure for the burden of MD varies according to age group, specific mental disorder, and the continent from which the individuals originated.

Studies from Ukraine indicate that the adult population living under conditions of prolonged war has very high levels of psychological distress. In a sample of adults in Ukraine in 2023, 36.3% of respondents showed signs of at least one mental disorder, including increased symptoms of anxiety and depression [15]. This estimate refers to the adult civilian population assessed during the full-scale war and should not be interpreted as a prevalence rate limited only to direct victims of combat. The Ukrainian data reflect a wartime context characterized by military threat, forced displacement, socioeconomic instability and chronic uncertainty, which are known to intensify the risk of anxiety, depressive and stress-related symptoms.

Overall, these findings indicate that the burden of MD differs considerably across regions and countries. Countries affected by large-scale crises, armed conflicts or forced displacement may demonstrate elevated MH needs, while the availability of services and the quality of data strongly influence how this burden is identified, measured and addressed. Cross-national data on anxiety disorders also show that the treatment gap remains a global problem and differs substantially between countries [25].

Analysis of the availability of psychiatric and psychological care revealed substantial treatment gaps across countries with different levels of economic development. In high-income

countries, such as the United States, the United Kingdom, Germany and France, a considerable proportion of adults who need MH care still do not receive adequate treatment, despite better availability of specialists and more developed health care systems [20,21]. Long waiting lists, uneven distribution of specialists, financial barriers and stigma remain important obstacles to timely access to care [11,20].

In low- and middle-income countries, the treatment gap is even wider because of limited-service coverage, shortage of qualified professionals, weak integration of MH care into primary care and persistent stigma [7,22]. Global estimates indicate that most people with MD in resource-limited settings do not receive the care they need, and this problem is particularly pronounced

where MH services remain underfunded or concentrated in specialized institutions [7,22]. Cross-national evidence also shows that treatment gaps remain substantial for specific disorders, including MDD and anxiety disorders, even when people recognize the need for help [21,25].

According to the Organisation for OECD, unmet need for MH care remains a major challenge even in countries with relatively well-developed health systems. OECD data indicate that financial, geographical and organizational barriers continue to limit access to psychological and psychiatric care, particularly among socially vulnerable groups [11,20]. These barriers affect help-seeking behavior, delay diagnosis and treatment, and increase the long-term social and economic burden of MD.

Table 1. Global prevalence of major mental disorders according to the WHO classification (ICD 11).

Mental disorder category	Estimated global prevalence, %	Notes
Depressive disorders	3.8–5.0	One of the leading causes of years lived with disability worldwide
Anxiety disorders	4.0–6.0	Among the most common groups of mental disorders worldwide
Stress-related disorders (including PTSD)	1.0–2.5	Higher prevalence in populations affected by crises and conflicts
Substance use disorders	1.5–2.5	Includes alcohol and drug disorders; high comorbidity
Bipolar disorders	0.6–1.0	Less common, but cause significant functional limitations
Schizophrenia and other psychotic disorders	0.3–0.7	Severe disorders with a high level of disability
Eating disorders	0.5–1.4	More often reported in high-income countries
Obsessive-compulsive and related disorders	1.0–2.0	Chronic course with significant impact on daily life
Personality disorders	1.0–3.0	Often underdiagnosed due to difficulty in diagnosis
Neurocognitive disorders (including dementia)	0.8–1.2	Prevalence increases significantly with population age

Note: WHO reports and fact sheets for 2022–2025 were used to characterize current public health estimates of MDD, including depressive disorders, anxiety disorders, bipolar disorder, psychotic disorders, substance use disorders, stress-related disorders, neurocognitive disorders, and the reported increase in depression and anxiety during the COVID-19 pandemic [1, 3, 9, 16, 17]. GBD 2019 and GBD 2021 estimates were used to assess the population-level burden of MD by diagnostic category, including depressive disorders, anxiety disorders, bipolar disorder, schizophrenia, eating disorders, substance use disorders, and other ICD-11-related mental disorder groups [2, 18, 19]. Data on stress-related disorders and PTSD in conflict-affected populations were additionally interpreted using 2019 WHO-related prevalence estimates of MD in conflict settings [10]. The final ranges presented in the table reflect the overlap and variation between WHO public health estimates and GBD modelled epidemiological estimates. These values should be interpreted as descriptive approximate ranges rather than directly pooled prevalence rates, because the sources differ in reference years, diagnostic definitions, age groups, population coverage, modelling approaches, and correction for underreporting.

Table 2. Estimated prevalence of mental disorders in different countries of the world by income category.

Country	Estimated prevalence of mental disorders, %
Ukraine	31–36
USA	20–21
United Kingdom	18–25
Germany	20–27
France	19
Japan	8–10
Nigeria	12–15
Pakistan	10–12
Kenya	11–12
India	10–15
South Africa	15–16

Note: data are summarized based on WHO reports and fact sheets for 2022–2025 [1, 3, 22], GBD 2019 and 2021 estimates [2, 19, 24], WMH data on treatment gaps and cross-national MH indicators [21, 25], OECD sources for 2021–2025 [11, 20], and national or country-specific studies, including the 2023 adult population data from Ukraine [15]. The estimates should be interpreted as descriptive comparative indicators rather than fully equivalent epidemiological measures because the compared countries differ in diagnostic approaches, survey instruments, population coverage, timing of data collection, reporting systems, access to MH care, and social context. The Ukrainian estimate reflects wartime adult population data collected in 2023 during the full-scale war; therefore, direct comparisons with peacetime or post-pandemic data from other countries should be made with caution.

Table 3. Key determinants of MH and their impact.

Factor category	Factor	Potential impact on mental health
Biological	Genetic vulnerability / family history	Increases susceptibility to depression, anxiety and other mental disorders
	Chronic diseases / physical health	Poor physical health increases the risk of depression, anxiety and psychological distress
Psychological	Emotional regulation and coping skills	Influences resilience and vulnerability to stress
	Traumatic experiences	Increases the risk of PTSD, depression and anxiety disorders
Social	Poverty and economic instability	Economic stress increases the risk of mental disorders and psychological distress
	Education	Higher educational attainment may improve health literacy, coping resources and help-seeking behavior
	Employment instability / unemployment	Increases the risk of mental health problems, stress and social insecurity
	Social support	Protective factor; social isolation increases psychological vulnerability
	Stigma and discrimination	Reduces help-seeking behavior and increases psychological stress
Environmental	Violence and conflicts	Increase the risk of PTSD, depression and anxiety disorders
	War and geopolitical stress	Cause substantial psychological strain in conflict-affected populations
	Environmental pollution	May increase psychological distress and mental health-related morbidity
Lifestyle	Nutrition	Nutritional deficiencies may increase vulnerability to depression and anxiety
	Sleep and physical activity	Regular sleep and physical activity support mental health and stress regulation
	Substance use	Increases the risk of mental health problems and worsens clinical outcomes

Note: coping refers to cognitive and behavioral strategies used by individuals to manage stressful situations, reduce psychological distress and adapt to adverse life events.

Overall, the available evidence confirms that the treatment gap remains a systemic problem in MH care. It is observed both in high-income countries and in low- and middle-income countries, although its causes and scale differ by health system capacity, financing, workforce availability and social attitudes toward MD. These findings support the need to expand access to effective MH services, integrate MH care into primary care, develop community-based support models and reduce stigma at the population level [7,22].

The next stage of the analysis focused on the determinants of MD. The relationship between MD and biological factors, including genetic vulnerability and chronic diseases; psychological factors, including emotional regulation and traumatic experiences; social and economic factors, including poverty, unemployment and social isolation; and behavioral and environmental factors, including substance use, pollution, war and pandemic-related stress, was examined (Table 3) [7,9,11]. The findings indicate that reducing the burden of MD requires a comprehensive approach that combines investment in health systems, integration of MH care into primary care, prevention and early intervention programs, stigma reduction and intersectoral coordination [7,22].

Discussion.

The results obtained demonstrate high consistency with the data of leading international organizations and studies, in particular the WHO, the GBD Study, The Lancet, and the Organisation for OECD. The increase in the prevalence of MD in 2019–2021, particularly depression and anxiety disorders, is consistent with WHO and GBD Study estimates that the global burden of these conditions has increased significantly over this period [2,9]. During the first year of the COVID-19 pandemic, the prevalence of depression increased by 27.6% and anxiety disorders by 25.6% worldwide, highlighting the significant impact of global crises on MH. Meta-analytic evidence also suggests high levels of mental health problems in different population groups during the pandemic, namely the systematic review by Nochaiwong

et al. [23] found that about 28% of the population reported symptoms of depression, 26.9% of anxiety, 24.1% of PTSD, and 36.5% of stress during COVID-19. Organisation for OECD [11] confirms that MH disorders remain one of the leading causes of disability in countries with different income levels. However, it is worth noting that estimates of the prevalence of MD can vary depending on the methodology: WHO and GBD often use modeling and correction for underreporting, while national statistical systems are based on registered diagnoses and surveys, which may partly explain the discrepancies in the reported indicators [24].

Analysis of the availability of MH care has confirmed the existence of significant treatment gaps in most countries. OECD data show that the “treatment gap” in MH exceeds 50% globally, i.e. a significant proportion of people in need of care do not receive it due to financial, organizational, geographical and human resources barriers, and in countries with lower socioeconomic status these figures are even higher [11]. The WHO Mental Health Gap Action Programme (mhGAP) estimates that 76–85% of people with MD in low- and middle-income countries do not receive the necessary treatment, which highlights the scale of inaccessibility of care in these settings [16,22]. Analysis of data from the WMH Surveys showed that, for example, almost 72.4% of people with anxiety disorders did not receive any treatment during the year, and only about 27.6% received any intervention, of whom even fewer received adequate treatment. It is estimated that even in high-income countries, only a fraction of people with MD receives minimally adequate treatment, and the treatment gap remains significant due to stigma, low recognition of the problems and inequalities in access [20]. Finally, the data are consistent with previous global estimates showing that in developed countries the treatment gap can be as high as 35–50% among people with severe MD, while in resource-limited countries it is 76–85% [16,17]. Also, serial treatment assessments gap for specific disorders, such as depression or anxiety disorders, confirm that

a large proportion of people who need treatment remain without it, even if they recognize the need for help [11,25].

A review of the evidence-based literature on models for integrating MH care supports the view that integrating MH services into primary care and developing community-based models can improve access to and effectiveness of care, particularly in the context of limited resources and a broader public health approach. Systematic reviews show that such models can improve clinical outcomes and access to care compared with standard approaches, particularly for depression and other conditions in low- and middle-income countries where the shortage of specialists is particularly acute [26]. In particular, a review on the integration of MH care into primary care found that patients in integrated treatment models have better outcomes compared to usual care, and such approaches are perceived as feasible and cost-effective in a range of contexts, including with high similarity of outcomes in LMICs.

Strategies for integrating MH services into primary care – from training primary care workers to building multidisciplinary teams – contribute to increased detection, treatment and follow-up of MD. Such approaches may also reduce stigma because care becomes more accessible and closer to the patient's everyday environment [27].

International organizations emphasize that reducing the burden of MH problems requires an integrated approach combining health care, education, social protection and employment. Recent review evidence indicates that interventions targeting social determinants of MH, including demographic, economic, neighborhood and cultural factors, may contribute to prevention and improvement of MH outcomes in the general population [28]. Therefore, effective MH strategies should combine early detection, primary care integration, community-based support, stigma reduction and social interventions within comprehensive national mental health systems.

Limitations.

This review has several limitations that should be considered when interpreting the findings. First, the study was conducted as a narrative analytical review rather than a systematic review. Therefore, formal PRISMA-based screening, risk-of-bias assessment and meta-analytical pooling were not performed. This limits the possibility of formulating precise pooled estimates of the prevalence of MD across countries.

Second, the analyzed sources were methodologically heterogeneous. WHO reports, GBD estimates, OECD data, WMH findings and national studies differed in reference years, diagnostic criteria, survey instruments, population coverage, age groups and reporting systems. Therefore, the estimates presented in this review should be interpreted as descriptive comparative indicators rather than fully equivalent epidemiological measures.

Third, cross-country comparisons may be affected by underreporting, especially in low- and middle-income countries. Stigma, limited access to psychiatric and psychological care, shortage of trained professionals and weak health information systems may reduce the recorded prevalence of MD and underestimate the real treatment gap. In addition, the review may not have fully covered non-English and locally published

literature, although such sources may contain important national or regional data.

Finally, the Ukrainian data should be interpreted in the context of the full-scale war. The estimate for Ukraine reflects the mental health status of the adult civilian population assessed under wartime conditions and should not be directly equated with peacetime estimates from other countries. Military threat, forced displacement, socio-economic instability and chronic uncertainty may increase the prevalence of anxiety, depressive and stress-related symptoms, while differences in data collection conditions may also affect comparability.

Conclusion.

The state of MH in the world remains a serious global problem, with depressive and anxiety disorders accounting for a substantial share of this burden. Ukraine is characterized by one of the highest estimated prevalences of MD among the compared countries (31–36%), which reflects the combined impact of war-related stress, forced displacement, socio-economic instability, chronic uncertainty, and limited access to psychiatric and psychological care. In highly developed countries, the prevalence is lower (18–27%), while in low- and middle-income countries official data on MH are likely to be underestimated due to limited availability of services, underdiagnosis, weak reporting systems, and high levels of stigma.

The treatment gap remains significant in all regions; however, priority responses should differ by context. In high-income countries, they should include reducing waiting lists, improving affordability of psychological care, expanding early detection in primary care, and strengthening referral pathways between family physicians, psychologists, psychiatrists, and social services. In LMICs, priority should be given to training primary care providers in basic mental health interventions, expanding community-based psychosocial support, developing tele-mental health services, and reducing stigma.

For Ukraine and other conflict-affected settings, mental health policy should include systematic screening for PTSD, depression, and anxiety at the primary care level, mobile multidisciplinary teams for internally displaced persons, veterans, families of military personnel, and civilians exposed to traumatic events, as well as regional monitoring systems to identify communities with the highest mental health needs. Future research should focus on the long-term mental health consequences of war, forced displacement, and economic instability, and should compare the effectiveness of primary care-based, community-based, and digital mental health interventions in conflict zones and resource-poor settings.

Thus, reducing the burden of MD requires context-specific models of care adapted to high-income countries, resource-limited settings, and conflict-affected populations. A comprehensive approach combining medical, psychological, social, and economic strategies is essential for improving the availability, continuity, and effectiveness of MH services.

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- კვლევის მიზანი: თანამედროვე ფსიქიკური ჯანმრთელობის პრობლემების ანალიზი, ფსიქიკური აშლილობების გავრცელების შეფასება, ძირითადი დეტერმინანტების იდენტიფიცირება და სხვადასხვა ქვეყანაში ფსიქიკური ჯანმრთელობის სერვისებზე ხელმისაწვდომობის შეფასება. მასალა და მეთოდები: ჩატარდა ნარატიულ-ანალიტიკური მიმოხილვა ფსიქიკური ჯანმრთელობის შესახებ 2019–2025 წლების საერთაშორისო და ეროვნული მონაცემების შედარებითი სინთეზით, რომელიც მოიცავდა სამეცნიერო პუბლიკაციებს, ჯანმრთელობის მსოფლიო ორგანიზაციის, Global Burden of Disease-ის, World Mental Health-ის, ეკონომიკური თანამშრომლობისა და განვითარების ორგანიზაციის ანგარიშებსა და შეფასებებს, აგრეთვე უკრაინის ეროვნულ მონაცემებს. შედეგები: ფსიქიკური ჯანმრთელობა მნიშვნელოვან გავლენას ახდენს ცხოვრების ხარისხზე, შრომისუნარიანობასა და სოციალურ სტაბილურობაზე.

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სოციალურ-ეკონომიკურ არასტაბილურობასა და სამხედრო კონფლიქტთან არის დაკავშირებული. დასკვნები: მიღებული შედეგები ადასტურებს ფსიქიკური ჯანმრთელობის სერვისების პირველადი ჯანდაცვის სისტემაში ინტეგრაციის, საზოგადოებაზე დაფუძნებული მხარდაჭერის მოდელების განვითარების და კომპლექსური პოლიტიკის განხორციელების აუცილებლობას ფსიქიკური აშლილობების გლობალური ტვირთის შესამცირებლად.

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