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SCIENCE BOX

PREVALENCE OF MILD MENTAL DISORDERS DURING NORMAL PREGNANCY

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Abstract: Analysis of literary data describes the prevalence and clinical picture of mild mental disorders during normal pregnancy and their effects on the course of pregnancy. The possibilities of using psychotherapy in the treatment of pregnant women with these diseases are considered, the possibilities of psychopharmacotherapy are discussed.

Keywords: pregnancy, non-psychotic mental disorders, neurotic disorders, vegetative-vascular dystonia, depression.

Introduction. In recent years, there has been an increase in the number of pregnant women among mentally ill women [9, 21, 54], which is associated with an increase in mental illness in the population, as well as an increasing interest in the problem of mental disorders that occur during pregnancy [19]. Literary evidence [20, 29, 32, 51] shows that various mental disorders occur in 29-80% of total births, while borderline mental disorders occur in 10,0–79,3% of pregnant women [45, 58].

In turn, higher complications of pregnancy and childbirth in mental disorders in pregnant women [11], a higher percentage of cesarean delivery, and a higher rate of neonatal pathology [35] have been reported. Pregnancy and the postpartum period are generally considered to be the time when the risk of developing mental disorders increases, and pregnancy and childbirth itself can trigger the development of latent mental disorders that already exist [51].

Clinical forms of borderline mental illness in pregnant women are dominated by cases of asthenia (49,2%) and less (21,8%) depressive-hypochondria [37]. Among the causes that provoke asthenia, the leading role belongs to psychogenic factors, on the basis of which there is a psychological conflict, which depends on the importance of pregnancy in a woman's life [32]. Neurotic diseases are considered an intermediate link in gestosis pathogenesis [37] and the most unfavorable of them [31] are considered asthenic and hypochondrial neurosis, which manifests itself in nervous weakness, hypochondria, phobia, increased anxiety, asthenia, severe intraversion and intrapsychic disorder. According to other data [31], borderline mental disorders (neuroses and "psychopathies" – personality disorders) can be recorded in 56,7% of pregnant women who have not previously sought psychotherapeutic help. (As for the high proportion of personality disorders in pregnant women, from our point of view, it does not exceed the average in the population, but different levels of decompensation are possible due to endocrine shifts and psycho-emotional stress during pregnancy.personal pathology with clinically defined forms). In fact, clinical manifestations of neurosis in pregnant women are manifested in the form of neurasthenic, hysterical, depressive and obsessive-phobic syndromes [24]. In pregnant women [29] 26,2% identified a state of psycho-emotional stress at the pre-clinical level, and 29% of those tested reported borderline mental disorders. In the group of individuals with a long-term state of emotional stress, pregnant women

with mental changes were introduced, the level of which did not reach the generally accepted diagnostic criteria and was considered a manifestation of improper adaptation of the body [3].

Women complained of emotional lability, hyperesthesia, anxiety, irritability, tears, fatigue. The authors include these donosological manifestations in the asthenic variant of psychodesadaptive States [27].

In mentally ill women, complications during pregnancy and childbirth are 6 times more common than in the general population [43]. Modern psychology, which studies fetal behavior and the development of a newborn, attaches great importance to the characteristics of the emotional interaction of the expectant mother in terms of her readiness for motherhood with the fetus, psychological attitudes and adequacy of reactions [53, 56].

Therefore, the question of the relationship of mental disorders and the specific pathology of pregnancy, the influence of borderline mental pathology on pregnancy, fetal development, the postpartum state of the mother and child is important.

The study of the psychological characteristics of pregnant women indicates the presence of a compensated Psychovegetative disorder in physiological pregnancy, which is manifested by a decrease in mood, difficult psychological adaptation and emotional instability [7]. It is believed that the state of pregnancy is at the limit of norm and mental pathology [53]. With the onset of pregnancy, many women note changes in well – being that correspond to the clinical picture of the asthenic symptom complex - "psychosomatic reaction to pregnancy" [43], their frequency ranges from 13,7 to 33,3% [27, 32].

Researchers in donosological mental disorders in pregnant women [18], along with their emotional or physiological discomfort [5], found donosological mental changes in 73% of cases in healthy pregnant women, which include subcompensated and decompensated pregnancy response types. The subcompensated type reflected a decrease in mood, poor overall health, an abundance of various complaints, attention to its somatic state, emotional instability, a desire to find sympathy from others. The decompensated type demonstrated previously hidden character traits (hypochondriac fixation, increased anxiety levels, impaired interpersonal relationships, predisposition to affective epidemics, socio-psychological difficulties in adaptation). The effect of the factor of donosological mental changes in pregnant women on the development of complications of the pregnancy process has been identified and proven [30]. In such women, the complex course of pregnancy and childbirth is 2 times more common than in women without diseases, while pathological conditions of the fetus and newborn are 3 times more common [18].

Clinical studies of borderline mental disorders have shown that the most common option (63%) is a neurotic response [29].

On the basis of the development of pregnancy, there are pregnancy and neurotic reactions that act as psychogenies, in which pregnancy is not the main etiological factor, but only contributed to the development of the disease. The main reason for the development of neurotic pathology in such cases was a violation of family relations. Non-procedural disorders similar to neurosis caused and exacerbated by pregnancy were reported in 23,5% of cases, and individuals with decompensated personality disorder during pregnancy accounted for 2,8% [29].

The leading place in the genesis of non-psychotic diseases is occupied by a woman's personal characteristics, motivation to give birth to a child, level of personal anxiety, features of pregnancy and previous obstetric experience. The absence of harmonious relationships in the family, when the birth of

a child is intended to correct the breakdown of these relationships, leads to a decrease in the level of acceptance of the unborn child and, indirectly, the development of neurotic diseases. In pregnant women with borderline mental disorders, premorbid personality traits [14] are distributed as follows: 21-28% identified a harmonious personality warehouse,and 64-71,2% of women found character accentuations (with a predominance of psychasthenic, epileptoid and Schizoid types).

Before the ICD-10 criteria were introduced, vegetative diseases were treated as a separate disease – as part of vegetative-vascular (or neurocirculatory) dystonia (VSD, NCD) or syndromes in various forms of psychopathology. In psychiatric evaluation, vegetosomatic disorders in modern literature are described as the most common "mask" of mental pathology, represented mainly by deleted atypical affective symptom complexes, often a depressive circle, less often – manic, as well as neurotic syndromes and personal disorders [12, 25, 26]. The problem of NCD in obstetrics remains relevant, since this pathological condition leads to serious complications in pregnancy, childbirth, postpartum, leads to an increase in perinatal death and negatively affects the further mental development of the child [6]. In recent years, the incidence of NCD in pregnant women has increased 3 times and accounted for 19,8 percent of diseases of internal organs [15]. Other authors also suggest a link between vegetative disorders, emotional states, and pregnancy complications [43, 48, 53]. Vegetative dystonia syndrome (SVD) involves vegetative and emotional disorders [4], is a mandatory manifestation of pregnancy, occurs in 92% of those examined and is based on Psychovegetative syndrome due to high anxiety and initial neuroendocrine remodeling of the body [4]. During pregnancy, SVD reflects the tension of the adaptation mechanisms of the female body.

Currently, there is a generally accepted opinion that mental disorders during pregnancy negatively affect its course and results. In this regard, the issue of optimal options for correcting such diseases and methods of their prevention is relevant. Since none of the psychotropic drugs can be considered completely harmless, psychotherapy can be the most optimal way to treat borderline mental disorders during pregnancy.

For pregnant women with mental disorders, choosing the right treatment is of great importance. In pregnant women with neurotic disorders, in the case of gestosis of pregnant women, it is proposed to use psychotropic drugs [27], in particular phenibut-type tranquilizer-nootropics [21, 28, 33]. In addition, along with pharmacotherapy, it is recommended to use psychotherapeutic methods in an integrated approach to the correction of mental disorders [27]. For a differentiated approach to treatment, when taken at the expense of a dispensary for pregnancy, it is considered necessary to conduct a psychological examination of women with the determination of the psycho-emotional profile of the individual.

According to psychological tests, there are three groups to undergo psychotherapy based on behavioral methods (behavioral approach). The first includes patients with astheno-neurotic syndrome. They are advised to undergo calming psychotherapy. The second group includes pregnant women with depressive-hypochondrial syndrome. They should undergo psychotherapy of a stimulating nature. Individuals with a stable psycho-emotional profile of an individual (third group) have rational psychotherapy. Classes are held in the form of autotre, in 2-5 courses of 10-12 sessions, at least two weeks during pregnancy between courses [37]. Similar measures allow not only to prevent pregnancy complications, but also to improve the delivery process and the condition of the newborn [23].

Given the high frequency of donosological mental disorders and neurotic disorders, the researchers concluded that 86% of pregnant women need episodic or ongoing help from psychiatrists

and psychotherapists [20, 29] and that almost 40% of women take psychotropic drugs during pregnancy [26].

Foreign authors have a similar point of view, emphasizing the need for close cooperation of Obstetricians and psychiatrists in the management of pregnancy in women suffering from any mental pathology. Psychiatrists should not only provide counseling assistance, but also actively participate in the process of monitoring and treating these women [39, 57, 59, 60].

Since depression during pregnancy is a risk to the mother and baby, it is important to diagnose depression in time during pregnancy and provide an appropriate treatment [46]. The clinician must measure the relative risks of different treatments and take into account individual indications. There are suggestions [42] the use of selective serotonin reuptake inhibitors (SSRIs) in the treatment of pregnant women with depressive disorders, while the risk of side effects has not been fully confirmed so far. However, [50] it is known that the idea of a high risk of psychotropic treatment during pregnancy has not been proven, and depression treated during pregnancy does not have a serious perinatal risk. This can be a direct risk or secondary risk to the fetus – unhealthy behavior of the mother as a result of depression.

There is evidence [44] that birth defects in infants of women who used SSRIs in the first trimester were not detected more often than infants of women who did not use drugs. According to the authors, the use of SSRIs during pregnancy is not associated with a negative risk of perinatal outcome. Other authors cite similar information [36, 38, 40, 55], antidepressants, especially SSRIs, do not increase the risk of birth defects. However, the risk of not receiving adequate antidepressant therapy clearly exceeds the risk of side effects of using antidepressants in the mother and fetus [34].

[56] it has been found that women who discontinue treatment with antidepressant have more frequent recurrence cases compared to women who continue to receive treatment. Pregnant women with decreased mood may have decreased appetite and a risk of consuming alcohol or drugs – factors that negatively affect the fetus [49, 52]. Therefore, it is important to measure the benefits of treating depression during pregnancy and the risk of using antidepressants during this period.

Tranquilizers are widely used not only in psychiatry, but also in obstetric practice [13]. They easily cross the placenta barrier. After intravenous administration of diazepam to women in labor, it is found in fetal blood after 5 minutes and in a higher concentration than in the mother's blood. This can cause the drug to accumulate in the blood of the fetus. Therefore, when prescribing tranquilizers, pregnant women should carefully weigh the ratio of benefits of the drug, which can harm the child and the mother herself.

Conclusions. Thus, literary evidence suggests a high prevalence of non-psychotic mental disorders in women during the physiological course of pregnancy. Individual-personal, socio-environmental, psychogenic and biological factors (endocrine changes as a result of pregnancy) play an important role in their genesis. It becomes clear that during pregnancy, especially first of all, biopsychosocial components of borderline mental disorders are clearly observed. This condition requires timely identification of not only pregnant women with this type of mental illness, but also a risk group, timely implementation of psychocorrectional measures and, if necessary, psychotherapeutic and psychopharmacological treatment aimed at maintaining the mental health of the mother.prevention of mental disorders in the unborn child.

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