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THE INFLUENCE OF PREGNANCY AND CHILDBIRTH ON THE DEVELOPMENT OF NEUROSIS-LIKE CONDITIONS IN POSTPARTUM WOMEN

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Today, there has been a significant increase in the number of women giving birth among mentally ill women [9], which is associated with an increase in neurosis-like disorders in the population, and there is also increasing interest in the problem of neurosis-like disorders that arise during labor and delivery [19]. The studied literature data [20] indicate that various neurosis-like disorders occur in 29–80% of the total number of births, and borderline mental disorders occur in 10.0–79.3% of women in labor [15]. Which, in turn, allows us to conclude that there is a relationship between the neurosis of such disorders and the high incidence of complications of labor and delivery [11], the high percentage of cesarean sections and the high incidence of pathology in newborns [18]. The period of childbirth and the postpartum period is generally considered to be a time of increased risk of developing neurosis-like disorders, and pregnancy and childbirth themselves can become provoking factors in the development of existing hidden mental disorders [17].

Neurotic disorders are an intermediate link in the pathogenesis of gestosis [7], and the most unfavorable of them [11] are considered to be asthenic and hypochondriacal neurosis, manifested in irritable weakness, hypochondria, phobias, increased anxiety, asthenia, severe introversion and intrapsychic disorder. Clinical manifestations of neuroses in women in labor appear in the form of neurasthenic, hysterical, depressive and obsessive-phobic syndromes [14]. In 26.2% of women giving birth [9], a state of psycho-emotional stress of a preclinical level was detected, and borderline mental disorders were noted in 29% of those examined. The group of people with a state of prolonged emotional stress included women in labor with the presence of mental changes, the level of which did not reach generally accepted diagnostic criteria and which were regarded as a manifestation of maladjustment of the body [3]. Women in labor complained of emotional lability, hyperesthesia, anxiety, increased irritability, tearfulness, and fatigue. The authors attribute these prenosological manifestations to the asthenic variant of psychodisadaptive states [7].

Modern psychology, which studies the behavior of the fetus and the development of the newborn, attaches great importance to the peculiarities of the emotional interaction of the expectant mother with the fetus in terms of her readiness for motherhood, the adequacy of psychological attitudes and reactions [3, 6]. Therefore, the question of the relationship between neurosis-like disorders and the specific pathology of childbirth, about the influence of borderline neurosis-like disorders on the course of labor, fetal development, and the postpartum state of mother and child is important.

A study of the psychological characteristics of women in labor indicates the presence of

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a compensated psychovegetative disorder during physiological labor, manifested by decreased mood, difficult psychological adaptation, and emotional instability [7]. There is an opinion that the state of childbirth is on the border between normal and mental pathology [3]. With the onset of labor, many women note changes in well-being that correspond to the clinical manifestation of the asthenic symptom complex - a "psychosomatic reaction to pregnancy" [4], the frequency of which ranges from 13.7 to 33.3% [7].

Researchers of pre-nosological mental disorders in women in labor [18] note that in addition to the presence of emotional or physiological discomfort [5], in healthy women in labor in 73% of cases pre-nosological mental changes are detected, which include subcompensated and decompensated types of response to pregnancy. The subcompensated type reflected a reduced background mood, general poor health, an abundance of various complaints, concentration on one's physical state, emotional instability, and the desire to find sympathy from others. The decompensated type exhibited character traits that were previously latent (hypochondriacal fixation, increased levels of anxiety, impaired interpersonal relationships, a tendency to affective outbursts, socio-psychological difficulties in adaptation). The influence of the factor of prenosological mental changes in women giving birth on the development of complications of the gestational process has been identified and proven [20]. Complicated labor and delivery in such women is observed 2 times more often than in women without disorders, and pathological conditions of the fetus and newborn occur 3 times more often [18].

A clinical study of borderline mental disorders showed that the most common variant (63%) is a neurotic reaction [19]. There are actually gestational mental disorders, which are based on pregnancy, acting as psychogenic, and neurotic reactions, in which pregnancy was not the main etiological factor, but only contributed to the development of the disease. The main reason for the development of neurotic pathology in these cases was disturbances in family relationships. Neurosis-like disorders of a non-procedural nature that arose and worsened in connection with pregnancy were noted in 23.5% of cases, and persons with personality disorders decompensated during childbirth accounted for 2.8% [9].

In the genesis of non-psychotic disorders, the leading place is occupied by the woman's personal characteristics in combination with the motivation for childbearing, the level of personal anxiety, the characteristics of the course of labor and previous obstetric experience. The lack of harmonious relationships in the family, when childbearing is intended to correct the violation of these relationships, leads to a decrease in the level of acceptance of the unborn child and indirectly to the development of neurotic disorders. Premorbid personality traits in women giving birth with borderline mental disorders [14] are distributed as follows: 21–28% had a harmonious personality type, character accentuations were identified in 64–71.2% of women (with a predominance of psychasthenic, epileptoid and schizoid types).

Before the introduction of ICD-10 criteria, autonomic disorders were considered either as a separate disease - vegetative-vascular (or neurocirculatory) dystonia (VSD, NCD), or as part of syndromes in various forms of psychopathology. During a psychiatric

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assessment, vegetosomatic disorders in modern

literature are described as the most common "mask" of mental pathology, which is represented mainly by erased atypical affective symptom complexes, often depressive, less often manic, as well as neurotic-type syndromes and personality disorders [12]. In obstetrics, the problem of NCD remains relevant, since this pathological condition causes serious complications of labor, childbirth, and the postpartum period, leads to an increase in perinatal mortality and negatively affects the further mental development of the child [6]. In recent years, the frequency of cases of NCD in women in labor has increased more than 3 times and amounted to 19.8% of diseases of internal organs [15]. Other authors also indicate a connection between autonomic disorders, emotional states and childbirth complications [3, 8, 13]. Autonomic dystonia syndrome (VDS), which includes both vegetative and emotional disorders [4], is an obligate manifestation, occurs in 92% of those examined and is based on a psychovegetative syndrome caused by high anxiety and initial neuroendocrine restructuring of the body [4]. SVD during childbirth reflects the tension of the adaptation mechanisms of the woman's body.

Currently, it is generally accepted that mental disorders during childbirth have a detrimental effect on its course and outcome. In this regard, the question of optimal options for correcting such disorders and ways to prevent them is relevant. Since no psychotropic medication can be considered completely harmless, psychotherapy may be the most appropriate treatment option for borderline mental disorders during childbirth.

Choosing the right treatment method for women in labor with mental disorders is of great importance. In women in labor with neurotic disorders, in the event of gestosis in parturients, it is proposed to use psychotropic drugs [14], in particular tranquilizers-nootropics such as phenibut [11, 18]. In addition, it is recommended to use psychotherapeutic methods along with pharmacotherapy in an integrated approach to the correction of mental disorders [7]. It is believed that for a differentiated approach to treatment, it is necessary, when registering for childbirth, to conduct a psychological examination of women to determine the psycho-emotional profile of the individual.

According to psychological testing, three groups are distinguished for psychotherapy based on behavioral methods (behavioral approach). The first includes patients with astheno-neurotic syndrome. They are recommended to undergo sedative psychotherapy. The second group includes pregnant women with depressive-hypochondriacal syndrome. They should undergo stimulating psychotherapy. Persons with a stable psycho-emotional personality profile (third group) undergo rational psychotherapy. Classes are carried out in the form of auto-training, 2-5 courses of 10-12 sessions with intervals between courses of at least two weeks throughout the birth [17]. Similar measures allow not only to prevent complications of childbirth, but also to improve the course of labor and the condition of the newborn [13].

Considering the high incidence of prenosological mental disorders and neurotic disorders, researchers conclude that 86% of women in labor need occasional or constant assistance from psychiatrists and psychotherapists [20], and almost 40% of women take psychotropic drugs during childbirth [16].

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Foreign authors adhere to a similar point of view, pointing out the need for close cooperation between obstetricians-gynecologists and psychiatrists in the management of childbirth in women suffering from any mental pathology. Psychiatrists should not only provide advisory assistance, but also take an active part in the process of monitoring and treating these women [9, 17, 19, 20].

Because depression throughout labor carries risks for both mother and baby, it is important to promptly diagnose depression during pregnancy and provide an appropriate treatment approach. The clinician must weigh the relative risks of different treatment approaches and take into account individual indications. There are proposals [2] to use selective serotonin reuptake inhibitors (SSRIs) in the treatment of women in labor with depressive disorders, although it is indicated that the risk of side effects has not yet been fully verified. At the same time, it is known [50] that the opinion about the high risk of psychotropic treatment during childbirth is unproven, and untreated depression during childbirth carries significant perinatal risks. These may be direct risks to the fetus or secondary risks - unhealthy maternal behavior resulting from depression.

There is evidence [4] that congenital deformities in infants of women who used SSRIs in the first trimester were detected no more often than in infants of women who did not use the drugs. The authors suggest that SSRI use during labor is not associated with an increased risk of adverse perinatal outcome. Similar data are provided by other authors [6, 8, 10], who claim that antidepressants, especially SSRIs, do not increase the risk of congenital deformities. At the same time, the risk of not receiving adequate antidepressant therapy clearly exceeds the risk of side effects from the use of antidepressants in both the mother and the fetus [14].

It was found [6] that women who stopped treatment with antidepressants had more frequent relapses compared to women who continued treatment. Pregnant women who suffer from low mood may have a decreased appetite and may be at risk of taking alcohol or drugs - factors that have a negative impact on the fetus [9, 12]. Therefore, it is important to weigh the benefits of treating depression during labor against the risks of using antidepressants during this period.

Tranquilizers are used quite widely not only in psychiatric practice, but also in obstetric practice itself [13]. They easily pass through the placental barrier. After intravenous administration of diazepam to women in labor, it is detected in the fetal blood after 5 minutes, and in a concentration higher than in the mother's blood. This may lead to accumulation of the drug in the fetal blood. Therefore, when prescribing tranquilizers, pregnant women should carefully weigh the ratio of the benefits that the drug will provide with the possible harm to the child and the mother herself.

Thus, literature data indicate a high prevalence of non-psychotic mental disorders in women during the physiological course of childbirth. Individual-personal, social-environmental, psychogenic and biological factors (endocrine changes as a result of childbirth) play a significant role in their genesis. It becomes obvious that during childbirth, especially during the first one, the biopsychosocial components of borderline mental disorders are clearly visible. This circumstance requires the timely identification

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of not only women in labor with this type of mental disorder, but also a risk group, for the timely implementation of a set of psychocorrectional measures, and, in necessary cases, psychotherapeutic and psychopharmacological treatment aimed at preserving the mental health of the mother and preventing mental disorders in future child.

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