VAN TIP DERGİSİ Medical Journal

CLINICAL RESEARCH / KLİNİK ÇALIŞMA

Van Tıp Derg 29(4):407-415,2022
DOI: 10.5505/vtd.2022.80588

Postpartum Depression, Hypomania, Emotion Regulation Difficulties and Evaluation of Their Relationships

Postpartum Depresyon, Hipomani, Duygu Düzenleme Güçlükleri ve Aralarındaki İlişkilerin Değerlendirilmesi

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Abstract

Introduction: Postpartum depression is associated with complications that can endanger the health of both the mother and indirectly the baby. It is especially important to screen for hypomanic symptoms in this period and to differentiate between unipolar and bipolar bipolar disorders. On the other hand, difficulties experienced in the regulation of emotions may be important in describing unipolar or bipolar disorders that may be observed in this period. For this reason, it is aimed to investigate how postpartum depression, hypomanic symptoms and emotions are regulated in the postpartum period and the relationships between these phenomenologies.

Materials and Methods: This study was carried out by evaluating 164 puerperant women who did not have any complicated or negative experiences during pregnancy and delivery, who did not have a family history in terms of psychiatric disorders, and who agreed to be a participant, on the tenth postpartum day. All cases read and answered by them; were evaluated with the Turkish versions of the modified hypomania checklist (mHCL), Edinburgh postpartum depression scale (EPDS), and difficulty in emotion regulation scales (DERS).

Results: The mean EPDS score was 7.39 ± 2.45, and the results obtained in 7.9% of the cases were above the cut-off point. The mean of hypomania evaluation scores was calculated as 5.14 ± 2.71. However, the rate of those with at least three hypomanic symptoms was 85.3%, and the rate of those with at least five hypomanic symptoms was 55.5%. Correlations were observed between ' impulse, clarity, and non-acceptance ' subtypes of the DERS scale and hypomanic symptoms. However, it was determined that they did not show any correlation with the scores obtained from EPDS.

Conclusion: It seems that identifying difficulties in emotion regulation may be important in differentiating hypomanic symptoms in the postpartum period. In this period, the distinction between unipolar depression and bipolar disorder is particularly difficult and requires careful evaluation. For this reason, we believe that it would be more beneficial to use clinical interviews, which include emotion regulation difficulties, in evaluations.

Keywords: Depression; unipolar; depressive disorder,;

Özet

Giriş: Postpartum depresyon hem anne hem de dolaylı olarak bebeğin sağlığını tehlikeye atabilecek komplikasyonlarla ilişkilidir. Bu dönemde hipomanik belirtilerin taranması tek veya çift kutuplu bipolar bozuklukların ayrıştırılabilmesi özellikle önemlidir. Öte yandan duyguların düzenlenmesinde yaşanılan güçlükler bu dönemde gözlenebilecek tek veya çift kutuplu rahatsızlıkların betimlenmesinde önemli olabilir. Bu nedenle postpartum dönemdeki lohusalarda doğum sonrası depresyon, hipomanik belirtiler ve duyguların ne şekilde düzenlendiği ve bu fenomenolojiler arasındaki ilişkilerin araştırılması amaçlanmıştır.

Gereç ve Yöntem: Bu araştırma gebelik ve doğum sürecinde herhangi bir komplike veya olumsuz deneyim yaşamamış, psikiyatrik rahatsızlıklar açaısından aile öyküsü olmayan ve katılımcı olmayı kabul eden 164 lohusanın doğum sonrası onuncu gününde değerlendirilmesi ile gerçekleştirilmiştir. Tüm olgular kendileri tarafından okunan ve cevaplanan; modifiye hipomani kontrol listesi (mHCL), Edinburgh postpartum depresyon ölçeği (EPDS) ve duygu düzenleme güçlüğü ölçeklerinin Türkçe versiyonları ile değerlendirilmiştir.

Bulgular: Ortalama EPDS skoru 7.39 ± 2.45 olarak bulundu ve olguların %7.9'unda alınan sonuçlar kesme puanının üzerindeydi. Hipomani değerlendirme skorlarının ise ortalaması 5.14 ± 2.71 olarak hesaplandı. Fakat en az üç hipomanik belirti gösterenlerin oranı % 85.3, en az beş hipomanik belirti gösterenlerin oranı ise % 55.5 olarak değerlendirildi. DERS ölçeğinin 'dürtüsellik, açıklık ve kabul etmeme' alt tipleri ile hipomanik belirtiler arasında korelasyonlar olduğu izlendi. Fakat EPDS'den alınan puanlar ile herhangi bir korelasyon göstermedikleri saptanmadı.

Sonuç: Duygu düzenlemede güçlüklerin belirlenmesinin postpartum dönemde hipomanik belirtilerin ayrımlaştırılmasında önemli olabileceği görülmektedir. Bu dönemdeki bireylerde tek kutuplu depresyon ile bipolar rahatsızlığın ayrımı özellikle zordur ve çok dikkatli bir değerlendirme gerektirmektedir. Bu nedenle değerlendirmelerde duygu düzenleme güçlüklerini içeren klinik görüşmelerin kullanılmasının daha faydalı olacağı kanaatindeyiz.

Anahtar Kelimeler: Depresyon; tek kutuplu; depresif bozukluk; doğum sonrası depresyon; hipomani; duygusal düzenleme.

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Received: 25.03.2022, Accepted: 14.09.2022

Introduction

The postpartum period makes puerperal women highly vulnerable to various psychiatric disorders. In this period, especially it is important to distinguish between unipolar depression and depression with mixed symptoms. Postpartum depression may present as a newly diagnosed depressive disorder or as a component of bipolar disorder (1). Although the frequency of being watched varies according to the society, average frequency can be accepted as 10 -16% to puerperal women (1). On the other hand, the incidence of all types of bipolar disorders in which including depression, hypomania and manic episodes can be seen has been reported to be 5% (2). Event recent studies show that a significant proportion of women diagnosed with postpartum depression actually have bipolar disorder. In the postpartum period, our attention is generally focused on depressive symptoms rather than manic symptoms, which probably causes the diagnosis of bipolar disorder to be overlooked. Depressive episodes can form the first affective episodes of bipolar disorders. Therefore, some of the bipolar disorder cases are misdiagnosed as major depressive disorder (1). This suggests that the frequency of bipolar disorder may actually be higher than normal. Of course, this is also valid for the postpartum period. On the other hand, disturbances in the emotion regulation process may also be a stimulus for the emergence of depressive mood in this period. Or it may develop as a component of the stabilization process of bipolar disorder (3,4). It has also been found that people diagnosed with depressive disorder have more difficulties in regulating their negative emotions compared to those who have not been diagnosed with depression (3,4). Similarly, in the case of mania or hypomania, we see that patients have to regulate their emotions, suppress some of them, and emphasize some of their emotions more (5,6). Therefore, it seems important to clarify the relationship between these phenomenologies in the evaluation of bipolar disorders and unipolar depression.For this reason, it seems possible with detailed examinations and evaluations whether this sensitive period, in which manic or hypomanic symptoms can be seen in addition to depressive symptoms, can be considered only as a depressive disorder or as a subtype of bipolar disorder. With this background, we aimed to screen depressive and hypomanic symptoms during postpartum period and evaluate the relationship between emotion regulation difficulties and mood symptoms.

Materials and Methods

Ethics: Ethics committee approval of the study was obtained from Çanakkale Onsekiz Mart University Clinical Research Ethics Committee, dated 06.09.2017, with approval number 2011-KAEK-27/2017-E.92049. The study was carried out in accordance with the Declaration of Helsinki Principles. Consent of all participants was obtained. The sample of this descriptive study consists of puerperant women who applied for a follow-up examination on the tenth postpartum day. It was carried out with women who applied to our outpatient clinic consecutively without any elimination other than the exclusion criteria we have stated and whose consent was obtained to participate in the study. The study could be carried out with 164 puerperant women who met these conditions and volunteered within the specified time period. The puerperant women who had any complications during pregnancy and delivery (e.g; women who experienced preterm birth, preeclampsia, gestational diabetes, gestational hypothyroidism, threatened miscarriage or were at high risk in anomaly screening tests during the gestational period) and those with familial genetic predisposition were not included in the study. Puerperant's who could not speak the language of the scale, could not read and write and inadequate judgment skills were excluded from the study. These cases were initially excluded from the study, as they were identified during the evaluation of demographic characteristics. For this reason, no further information could be given in our study on the number of puerperant women excluded from the sample, the difficulties they experienced in mood regulation, and the presence of depressive or hypomanic symptoms. Of course, family history is a very important risk factor for both mental conditions. However, we did not include those with a family history in our study in order to make a clear distinction as to whether the relationship between the assessed factors and mental state was the factor's primary activity or acted as an inducing or regressing factor when combined with family history. This situation should be considered as a limitation in terms of the aggregate-based frequency statistics of the study.

Data Collection Tools

Sociodemographic Data Form: This form was contain the following information: age, the

education level of the woman, fixed monthly income of the family, parity status, planning status of this pregnancy, tokophobia.

Edinburgh Postpartum Depression Scale (EPDS): This scale determines the risk of depression during pregnancy and postpartum period, and it was developed by Cox et al. (7) to measure the severity of depression. It is a scale that focuses on the evaluation of cognitive and emotional symptoms of depression rather than the somatic symptoms. It contains a total of 10 questions and provides a four-point likert-type measurement. Each item is evaluated with scores ranging from 0 to 3. The total score ranges from 0 to 30. It is easy to apply because it is short and understandable and people fill it on their own. Although the scale itself does not make a definitive diagnosis of depression, scoring 13 and above is still considered a sign of possible depressive disorder, because the cut-off score was shown as 13. The scale was adapted to Turkish in 1996 by Engindeniz et al. (8) and its validity and reliability were evaluated by the same team. The sensitivity and specificity of the test were determined as 84% and 88%, respectively.

The modified Hypomania Checklist (mHCL-32): The Hypomania Checklist (HCL-32) was developed by Angst et al. (9) to help diagnose bipolar disorders, to detect hypomanic symptoms in patients diagnosed with major depressive disorder. It was adapted to Turkish by Altınbaş et al. (10) It is used to evaluate the presence and clinical correlations of manic symptoms whose concomitent in patients with depression. The scale is scored with yes 1 and no 0 points, and the total score varies between 0 and 32. The cut-off score of the scale is considered to be 14.

Difficulties in emotion regulation scale (DERS): It was developed by Gratz and Roemer (11). This scale consists of the following sub-dimensions of emotional reactions: (1) difficulty engaging in goal-directed behavior (goals), (2) lack of emotional awareness (awareness), (3) lack of emotional clarity (clarity), (4) nonacceptance of emotional responses (non-acceptance), (5) limited access to emotion regulation strategies (strategies), (6) impulse control difficulties (impulse). Rugancı et al. (12) made the Turkish adaptation of the scale.

Table 1. Sociodemographic clinical characteristics of the cases

Average age		**23.81 ± 2.86 (years) (min:19/max:29)**
Education level	Primary Education	54.9% (n=90)
	High School	29.9% (n=49)
	University	15.2% (n=25)
Parity	Primiparous	54.3% (n=89)
	Multiparous	45.7% (n=75)
Gravida	Primigravida	52.4% (n=86)
	Multigravida	47.6% (n=78) (min:1/max:7)
Planning status of pregnancy	Planned	23.2% (n=38)
	Unplanned	76.8% (n=126)
Tokophobia	Had Fear	70.7% (n=116)
	Not Feared	29.3% (n=48)
Type of birth (in this pregnancy)	Cesarean Section	42.1% (n=69)
	Spontaneous Vaginal Delivery	57.9% (n=95)
Type of birth (previous)	Cesarean Section	14.6% (n=24)
	Spontaneous Vaginal Delivery	31.1% (n=51)
	No Prior Birth	54.3% (n=89)

Statistical Analysis: The data obtained in the study were analyzed with the Statistical Package for the Social Sciences (SPSS) 22.0 program. In the evaluation of the interactions of the independent variables with each other; Mann Whitney U test was used for non-parametric components and Logistic Regression analysis was used to evaluate the difficulties experienced in the regulation of mood and depression and hypomania scores. In the evaluations, cases where the p value was less than 0.05 were considered statistically significant.

Table 2: Evaluation results of EPDS, mHCL and DERS scales.

	mean ±Std.D.	min -max
EPDS score	7.3902 ±2.45077	4 -18
mHCL score	5.1402 ±2.70625	0 -14
DERS non-acceptance	14.6524 ±2.99405	7 -20
DERS goals	19.3171 ±3.23470	10 -25
DERS impuls	16.7622 ±4.15920	6 -27
DERS awareness	13.3537 ±3.03708	16 -20
DERS strategies	25.0549 ±4.30900	9 -35
DERS clarity	13.2256 ±1.96699	19 -17

Table 3: Evaluation of the relationship between sociodemographic factors and EPDS and mHCL scores.

	EPDS score					mHCL score				
	B	**Std.E.**	**Beta**	**t**	**Sig.(p)**	**B**	**Std.E.**	**Beta**	**t**	**Sig.(p)**
Average age	-0.110	0.135	-0.129	-0.815	0.417	0.010	0.150	0.011	0.066	0.947
Education level	-0.120	0.466	-0.036	-0.257	0.797	-0.685	0.515	-0.187	-1.329	0.186
Parity	0.060	0.679	0.023	0.088	0.930	-1.116	0.750	-0.380	-1.488	0.139
Gravida	-0.087	0,427	-0.041	-0.203	0.840	0,062	0.183	0.026	0.336	0.737
Planning status of pregnancy	-0.547	0.557	-0.094	-0.981	0.328	0.280	0.616	0.004	0.046	0.963
Tokophobia	0.674	0.504	0.126	1.338	0.183	0.301	0.557	0.051	0.541	0.589
Type of birth (this time)	0.998	0.454	0.202	2.198	**0.029**	0.949	0.502	0.174	-1.892	0.060
Type of birth (previous)	-0.596	0.419	-0.178	-1.424	0.156	0.538	0.471	0.230	1.140	0.256

Results

The mean age of puerperant women included in the study was calculated as 23.81 ± 2.86. The mean age range found is important in terms of meeting the reproductive period in which the mental and physical competencies of the women in whom the study was carried out were at a high level. While 45.7% (n=75) of women had given birth before, 54.3% (n=89) experienced this for the first time. Most of the pregnancies were unplanned (76.8% (n=126), but none of them were unwanted pregnancies. Although 54.3% of the women experienced childbirth for the first time, it is important that the rate of those who experienced the fear of childbirth (tokophobia) was 70.7% (n=116). It is remarkable that 36% of women who have experienced labor before are afraid of an event they are still experiencing. These results made us think that tokophobia is a suppressive factor in planning the next pregnancy. Other sociodemographic characteristics related to the study are presented in Table 1. Although the mean score of depressive mood was found to be7.39 ± 2.45, only 7.9% (n=13) the womenhadan EPDS score above the cut-off score. On the other hand, the mean score from the hypomania rating scale was 5.14 ± 2.71. And only five puerperant women (3%) had hypomania scores above the cut-off score. But nevertheless, at least three mixed symptoms or signs were detected in 140 (85.3%) women and at least five in 91 (55.5%) women. In Table 2, the average scores of the subjects forming the sample of the study from each scale (difficulty in emotion regulation scale (DERS), the hypomania rating scale (mHCL), and the postpartum depression rating scales (EPDS)) are presented in detail. In the evaluation carried out in the light of these data, no statistical correlation was found in terms of the presence of hypomanic symptoms in women who scored above the cut-off point in the postpartum depression evaluation scale. Except for the mode of delivery, no statistically significant relationship was found between other demographic factors and EPDS and mHCL scores. A statistical relationship was found between the mode of delivery and only postpartum depression. The relationship between all evaluated demographic factors and the scores obtained from the EPDS and mHCL scales are presented in detail in Table 3. A statistical

Table 4: The relationship between the scores obtained from the emotion regulation difficulties scale and the scores obtained from the postpartum depression and hypomania scales.

DERS	EPDS score					mHCL score				
	B	Std.E.	Beta	t	Sig.(p)	B	Std.E.	Beta	t	Sig.(p)
non-acceptance	0.181	0.073	0.221	2.477	0.140	-0.182	0.073	-0.201	-2.489	0.014
goals	0.055	0.065	0.073	0.846	0.399	-0.067	0.065	-0.080	-1.034	0.303
impuls	-0.086	0.058	-0.147	-1.489	0.138	-0.173	0.058	-0.266	-2.979	0.003
awareness	0.110	0.074	0.135	1.483	0.140	0.006	0.074	-0.007	0.082	0.935
strategies	0.031	0.048	0.054	0.646	0.519	-0.027	0.048	-0.042	-0.556	0.579
clarity	0.098	0.103	0.079	0.950	0.344	-0.236	0.104	-0.171	-2.277	0.024

Table 5. Demonstrating the relationship between EPDS and mHCL cut-off scores and other phenomenology.

	EPDS cut-off score (test positive) p value	mHCL cut-off score (test positive) p value
EPDS cut-off score (test positive)		0.506
mHCL cut-off score (test positive)	0.506	
EPDS score	-	0.494
mHCL score	0.572	-
DERS non-acceptance	0.300	0.187
DERS goals	0.286	0.204
DERS impuls	0.861	**0.002**
DERS awareness	0.725	**0.020**
DERS strategies	0.612	0.308
DERS clarity	0.194	0.652

correlation was observed between only three of (non-acceptance, impuls and clarity) the six different components evaluated by the emotion regulation difficulties scale (DERS) and the scores obtained from the hypomania checklist. However, it was concluded that there was no statistical correlation between the scores obtained from this scale and the EPDS scores. The statistical relationships between each sub-component of the emotion regulation difficulties scale and postpartum depression (EPDS) and hypomania (mHCL) scores are presented in Table 4 in detail. On the other hand, the relationship between those with EPDS scores above the cut-off point and those with mHCL scores above the cut-off score with the sub-components of the emotion regulation difficulties scale was separately evaluated and presented in Table 5. As a result of this analysis, no relationship was found between the postpartum depressive symptoms and the sub-components of the emotion regulation scale. However, a statistical relationship was found between those with hypomania symptoms and two different sub-components (impulse and awareness) of the emotion regulation difficulties scale. Considering Tables 4 and 5, we believe that there is a stronger correlation between changes in emotion regulation (especially in terms of impulsivity) and hypomanic symptoms in the postpartum period.

Discussion

Although different rates are given due to the differences in the method used for the prevalence

of postpartum depression, studies show that it develops in approximately 10-16% of women who have just given birth (1). O'Hara and Swain (13) also reported an average prevalence rate of 13% in their meta-analysis. They reported that this wide variability in the incidence may be due to the evaluation times of the cases and the evaluation methods (13). In the Chronic Disease Prevalence Survey, the prevalence of depression in women in Turkey was reported as 13.1% (14). On the other hand, in a study examining 2811 cases diagnosed with major depression, the rate of individuals with mixed features of depression according to DSM-5 was reported as 7.5% (15). These studies, which reported different results, make us think that many physiological changes (decreased sexual desire, fatigue, appetite changes, sleep disorders, etc.) observed during pregnancy and postpartum period can be confused with depressive symptoms. In our study where we evaluated with EPDS, we found the frequency of monitoring as 7.9%. However, it should be remembered that those with a family history were not included in our study. These studies suggest that the prevalence of depression observed in the postpartum period is similar to the depression risk of the woman throughout her life, and it would be insufficient to explain the emotional exhaustion in the postpartum period with postpartum depression alone. Regarding this very complex period, Çelik et al. (16) reported a correlation between mixed symptoms and depressive symptoms in the postpartum period. It was reported that 79.4% of participants in this study had at least 1 manic symptom, 71.4% had at least 3 manic symptoms, and 68.3% had at least 5 manic symptoms (16). It has been reported that bipolar disorder may develop in 21.4-54% of women with postpartum depression depending on the diagnostic criteria used in a review. It was also presented as a result of the review that these cases are younger and may start sooner after birth, and may be seen more frequently in those with atypical depressive symptoms (17). In another study conducted in Turkey, according to mHCL-32 results, researchers reported that they detected at least 1 mixed depression symptom in 50 women (%79.4), at least 3 in 45 women (%71.4) and at least 5 in 43 women (%68.3) (16). In the findings of our study, it was found that mixed symptoms were experienced at a similar rate. As we mentioned above, this situation supports our argument that many normal changes observed in the postpartum period can be evaluated in terms of depression and hypomanic symptoms can be ignored. We concluded that none of the sociodemographic characteristics we evaluated were associated with the scores obtained from the hypmania checklist. On the other hand, we found out that among the same factors, only the type of delivery may be related to the scores obtained from the Edinburgh Postpartum Depression Scale (EPDS). In a study which carried out in Turkey, Ege et al. (18) examined the relationship of various factors for postpartum depression. As a result of their study, they reported that the mean EPDS score was associated with the socioeconomic status of the family, age, education, parity, mode of delivery, whether the pregnancy was planned or not, and the frequency was almost 33.2% (18). In their study, Leigh et al. (19) examined the risk factors separately prenatal period and postnatal period. They reported that prenatal anxiety (such as fear of childbirth) and low social support may be risk factors. On the other hand, they stated that antenatal depression could be a tool for postpartum depression along with its risk factors (19). Göker et al. (20) in their studies with a similar number of women in smilar geography close area, they reported there was no significant difference between EPDS scores when compared according to age, mode of delivery, education, gravidity, wanting the pregnancy, fear about birth, gender, family type, and income level. Meanwhile, they found the rate of postpartum depression at 31.4%, in same study (20). Difficulty in emotion regulation is lack of awareness of emotions, inability to understand and accept emotions, having difficulty in controlling impulses while experiencing negative emotions, and having difficulties in accessing adaptive emotion regulation methods are defined by its dimensions (21). In depressive disorders, difficulties may arise in the use of certain emotion regulation strategies to reduce the impact of negative emotional experiences (22,23). But, the individual's clinically different symptoms may hide the different relationships between the use of emotion regulation strategies and depression and hypomania (21). For this reason, it was thought that the information about whether the difficulties experienced in the regulation of emotions are related to individual symptoms can give an idea whether the use of emotion regulation strategies is related to the variations in the clinical presentation of these disorders (22,23). As a matter of fact, when the relationships between the clinical symptoms of individuals with depressive

symptoms and different emotion regulation strategies were examined, significant findings were obtained (21,24). Similarly, when the manic/hypomanic symptoms of individuals with bipolar disorder with their positive or negative emotion regulation states are evaluated, it has been reported that there is a relationship between the strategies they develop and manic symptoms (5). Also the early emotion regulation models of bipolar disorder, similar to the theories about depression, focused on difficulties in emotion regulation. Similarly, the results of another study show that positive emotion regulation in bipolar disorder is particularly problematic for individuals at risk for mania (25). The results of a study evaluating the patterns of mood swings and emotion regulation in bipolar disorder are as follows. Responses related to both mental changes and regulation of emotions are guided by internal evaluations. For this reason, it has been suggested that emotion regulation strategies will act in this direction in the face of an internally positive evaluation of the individual's high mood. Likewise, it has been said that negative evaluation of the same mood will activate down-regulation strategies (26). Given that bipolar disorder is characterized by episodes of extreme low and high mood, maladaptive emotion regulation strategies seem to be associated with bipolar disorder (5). Evidence suggests that difficulties in emotion regulation are prominent in psychopathology, particularly in relation to rumination, which has been found to contribute to a range of mental health conditions (27). In a study comparing individuals in three different groups with unipolar depression, anxiety disorder, and bipolar disorder in the euthymic period using DERS, it was reported that bipolar individuals were significantly less affected by DERS subscales (awareness, non-accepting and clarity) than the unipolar depression (28). Taş et al. (29) also reported that they reached similar results in their studies. In another study, in which patients with bipolar disorder were divided into three groups according to their euthymic, depressive and hypomanic symptoms and compared with a healthy control group, it was reported that those with bipolar disorder had higher subscale scores other than 'awareness' (30). In the same study, it was reported that scores from the DERS subcomponent which is 'impulse', predict hypomanic symptoms, and while scores from the 'strategies' subcomponent predict depressive symptoms (30). The relationship they found between the DERS 'impulse' subtype and hypomania is important in terms of the similar results we obtained in our study. As a different point of view, in a review evaluating emotion regulation strategies with bipolar disorder, it was stated that individuals with bipolar disorder used maladaptive strategies more. They also added that emotion regulation strategies similar to those in unipolar depression are found in bipolar depression and that strategies to ensure compliance are insufficient (5).

Study Limitations: The fact that the study was conducted in a relatively small population in a certain environment and that those with a family history of psychiatric diseases were not included in the study may constitute a limitation in terms of generalizing the results of this study.

Conclusion

Although we did not find a statistically significant correlation between postpartum depression and hypomania, it should be noted that hypmanic symptoms are observed at a considerable rate in the postpartum period. Our evaluations are based on self-report scales and therefore there is a recall bias. In addition, it should be considered that the scale used to identify individuals at risk of depression may have limitations in terms of specificity and sensitivity in the postpartum period. However, the results of our study should be interpreted with all limiting factors. In conclusion, we think that prospective and longitudinal follow-up studies are needed to evaluate the presence and possible effects of hypomanic symptoms in postpartum depression. For this reason, we believe that it would be more beneficial to use clinical interviews, which include emotion regulation difficulties, in evaluations.

Ethical Consent: Çanakkale Onsekiz Mart University Clinical Research Ethics Committee, dated 06.09.2017, approval number 2011-KAEK-27/2017-E.92049

Conflict of Interest: The authors have no conflict of interest for this study.

Financial Support: No financial support was received for this study.

Authorship Contributions: medical practices: EP, HIT; concept: EP, HIT, KA; design: EP, HIT, KA**;** data collection or processing: EP, HIT; analysis or interpretation: KA, HIT, EP; literature search: EP, HT, KA; writing: EP, HIT

Acknowledgement: We would like to express our gratitude to all referees who evaluated and contributed to our study.

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