The Edinburgh Postnatal Depression Scale (EPDS) - (J L Cox, J M. Holden, R Sagovsky – 1987)

This 10 item self report measure is designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period.

The EPDS is not a diagnostic tool and must always be used in conjunction with clinical assessment.

The EPDS includes one question (Item 10) about suicidal thoughts and should be scored before the woman leaves the office in order to detect whether this item has been checked. Further enquiry about the nature of any thoughts of self-harm is required in order for the level of risk to be determined and appropriate referrals made where indicated to ensure the safety of the mother and baby.

As it reflects the woman's experience of the last 7 days, the EPDS may need to be repeated on further occasions as clinically warranted.

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The Edinburgh Postnatal Depression Scale

Today's Date: _ _ / _ _ / _ _ _ _ Weeks pregnant: _____ or week postnatal: _____

Surname: _____ Given Name:_____ Total Score: _____

INSTRUCTIONS:

Please select one option for each question that is the closest to how you have felt in the PAST SEVEN DAYS.

1. I have been able to laugh and see the funny side of things:

( )As much as I always could
( )Not quite as much now
( )Definitely not so much now
( )Not at all

2. I have looked forward with enjoyment to things:

( ) As much as I ever did
( ) Rather less than I used to
( ) Definitely less than I used to
( ) Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

( ) Yes, most of the time
( ) Yes, some of the time
( ) Not very often
( ) No, never

4. I have been anxious or worried for no good reason:

( ) No, not at all
( ) Hardly ever
( ) Yes, sometimes
( ) Yes, very often

5. I have felt scared or panicky for no very good reason:

( ) Yes, quite a lot
( ) Yes, sometimes
( ) No, not much
( ) No, not at all

6. Things have been getting on top of me:

( ) Yes, most of the time I haven't been able to cope at all
( ) Yes, sometimes I haven't been coping as well as usual
( ) No, most of the time I have coped quite well
( ) No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

( ) Yes, most of the time
( ) Yes, sometimes
( ) Not very often
( ) No, not at all

8. I have felt sad or miserable:

( ) Yes, most of the time
( ) Yes, quite often
( ) Not very often
( ) No, not at all

9. I have been so unhappy that I have been crying:

( ) Yes, most of the time
( ) Yes, quite often
( ) Only occasionally
( ) No, never

10. The thought of harming myself has occurred to me:

( ) Yes, quite often
( ) Sometimes
( ) Hardly ever
( ) Never

Comments:

_____
_____
_____
_____

NB: If you have had **ANY** houghts of harming yourself, please tell your GP or your midwife today.

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* Murray and Cox 1990 * Cox, Holden & Sagovsky 1987

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The Edinburgh Postnatal Depression Scale

Clinical Scoring Guide

INSTRUCTIONS:

Add the number next to each circle that has been filled in. This is the total score. See below for the range of scores on the EPDS.

TOTAL SCORE: ☐

1. I have been able to laugh and see the funny side of things:

( )As much as I always could
( )Not quite as much now
( )Definitely not so much now
( )Not at all

2. I have looked forward with enjoyment to things:

( ) As much as I ever did
( ) Rather less than I used to
( ) Definitely less than I used to
( ) Hardly at all

*3. I have blamed myself unnecessarily when things went wrong:

( ) Yes, most of the time
( ) Yes, some of the time
( ) Not very often
( ) No, never

4. I have been anxious or worried for no good reason:

( ) No, not at all
( ) Hardly ever
( ) Yes, sometimes
( ) Yes, very often

*5. I have felt scared or panicky for no very good reason:

( ) Yes, quite a lot
( ) Yes, sometimes
( ) No, not much
( ) No, not at all

*6. Things have been getting on top of me:

( ) Yes, most of the time I haven't been able to cope at all
( ) Yes, sometimes I haven't been coping as well as usual
( ) No, most of the time I have coped quite well
( ) No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping:

( ) Yes, most of the time
( ) Yes, sometimes
( ) Not very often
( ) No, not at all

*8. I have felt sad or miserable:

( ) Yes, most of the time
( ) Yes, quite often
( ) Not very often
( ) No, not at all

*9. I have been so unhappy that I have been crying:

( ) Yes, most of the time
( ) Yes, quite often
( ) Only occasionally
( ) No, never

*10. The thought of harming myself has occurred to me:

( ) Yes, quite often
( ) Sometimes
( ) Hardly ever
( ) Never

Scores 1,2 or 3 on Item 10:
IF ANY THOUGHTS OF SELF HARM ENQUIRE FURTHER and ensure SAFETY

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The Edinburgh Postnatal Depression Scale

Scoring

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5¬10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Range of EPDS Scores

Scores

0-9 : Scores in this range may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with day to day ability to function at home or at work. However if these symptoms have persisted more than a week or two further enquiry is warranted.

10-12 : Scores within this range indicate presence of symptoms of distress that may be discomforting. Repeat the EDS in 2 weeks time and continue monitoring progress regularly. If the scores increase to above 12 assess further and consider referral as needed.

13 +: Scores above 12 require further assessment and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary.

Item 10: Any woman who scores 1, 2 or 3 on item 10 requires further evaluation before leaving the office to ensure her own safety and that of her baby.

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