



BLACK DOG INSTITUTE

## 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.

**EDINBURGH POSTNATAL DEPRESSION SCALE**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Weeks pregnant: \_\_\_\_ or weeks postnatal: \_\_\_\_

Surname: \_\_\_\_\_ Given Name(s): \_\_\_\_\_ TOTAL SCORE **INSTRUCTIONS:**Please colour in one circle 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

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

Comments

\* Murray and Cox 1990 \* Cox, Holden &amp; Sagovsky 1987

## CLINICIAN SCORING GUIDE

BLACK DOG INSTITUTE



### EDINBURGH POSTNATAL DEPRESSION SCALE

#### INSTRUCTIONS:

TOTAL  
SCORE

ADD THE NUMBER NEXT TO EACH CIRCLE THAT HAS BEEN FILLED IN. THIS IS THE TOTAL SCORE.  
SEE ALSO RANGE OF SCORES ON THE EDS.

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

- { 0 As much as I always could
- { 1 Not quite as much now
- { 2 Definitely not so much now
- { 3 Not at all

#### 2. I have looked forward with enjoyment to things:

- { 0 As much as I ever did
- { 1 Rather less than I used to
- { 2 Definitely less than I used to
- { 3 Hardly at all

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

- { 3 Yes, most of the time
- { 2 Yes, some of the time
- { 1 Not very often
- { 0 No, never

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

- { 0 No, not at all
- { 1 Hardly ever
- { 2 Yes, sometimes
- { 3 Yes, very often

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

- { 3 Yes, quite a lot
- { 2 Yes, sometimes
- { 1 No, not much
- { 0 No, not at all

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

- { 3 Yes, most of the time I haven't been able to cope at all
- { 2 Yes, sometimes I haven't been coping as well as usual
- { 1 No, most of the time I have coped quite well
- { 0 No, I have been coping as well as ever

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

- { 3 Yes, most of the time
- { 2 Yes, sometimes
- { 1 Not very often
- { 0 No, not at all

#### 8. I have felt sad or miserable:

- { 3 Yes, most of the time
- { 2 Yes, quite often
- { 1 Not very often
- { 0 No, not at all

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

- { 3 Yes, most of the time
- { 2 Yes, quite often
- { 1 Only occasionally
- { 0 No, never

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

- { 3 Yes, quite often
- { 2 Sometimes
- { 1 Hardly ever
- { 0 Never

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

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

## EDINBURGH POSTNATAL DEPRESSION SCALE

### 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.**

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