



Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark “X” in the box next to the answer which comes closest to how you have felt in the **past 7 days**—not just how you feel today.

In the past 7 days:

- | | |
|--|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <p>0 <input type="checkbox"/> As much as I always could</p> <p>1 <input type="checkbox"/> Not quite so much now</p> <p>2 <input type="checkbox"/> Definitely not so much now</p> <p>3 <input type="checkbox"/> Not at all</p> | <p>6. Things have been getting on top of me</p> <p>3 <input type="checkbox"/> Yes, most of the time I haven't been able to cope</p> <p>2 <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</p> <p>1 <input type="checkbox"/> No, most of the time I have coped quite well</p> <p>0 <input type="checkbox"/> No, I have been coping as well as ever</p> |
| <p>2. I have looked forward with enjoyment to things</p> <p>0 <input type="checkbox"/> As much as I ever did</p> <p>1 <input type="checkbox"/> Rather less than I used to</p> <p>2 <input type="checkbox"/> Definitely less than I used to</p> <p>3 <input type="checkbox"/> Hardly at all</p> | <p>7. I have been so unhappy that I have had difficulty sleeping</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> |
| <p>3. I have blamed myself unnecessarily when things went wrong</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, some of the time</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, never</p> | <p>8. I have felt sad or miserable</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> |
| <p>4. I have been anxious or worried for no good reason</p> <p>0 <input type="checkbox"/> No, not at all</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>3 <input type="checkbox"/> Yes, very often</p> | <p>9. I have been so unhappy that I have been crying</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Only occasionally</p> <p>0 <input type="checkbox"/> No, never</p> |
| <p>5. I have felt scared or panicky for no very good reason</p> <p>3 <input type="checkbox"/> Yes, quite a lot</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> No, not much</p> <p>0 <input type="checkbox"/> No, not at all</p> | <p>10. The thought of harming myself has occurred to me</p> <p>3 <input type="checkbox"/> Yes, quite often</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>0 <input type="checkbox"/> Never</p> |

Total Score

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.

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SCORING GUIDE

- | | |
|--|--|
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|--|--|

EPDS Score	Interpretation	Action
Less than 8	Depression not likely	Continue support
9–11	Depression possible	Support, re-screen in 2–4 weeks. Consider referral to primary care provider (PCP).
12–13	Fairly high possibility of depression	Monitor, support and offer education. Refer to PCP.
14 and higher (positive screen)	Probable depression	Diagnostic assessment and treatment by PCP and/or specialist.
Positive score (1, 2 or 3) on question 10 (suicidality risk)		Immediate discussion required. Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby.

References:

Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*. 1987; 150(6):782-786.

BC Reproductive Mental Health Program and Perinatal Services BC. (2014), *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period*. Available at: <http://tiny.cc/MHGuidelines>