

## California Home Visiting Program Edinburgh Postnatal Depression Scale (EPDS) Instructions (For FSW Use Only)

### What is the Edinburgh Postnatal Depression Scale (EPDS)?

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool used to identify participants at risk for postpartum depression. The EPDS was developed for screening postpartum women in clinical or home visit settings (preferably in the presence of a FSW). The test includes 10 questions and can usually be completed in less than 5 minutes.

### Instructions for users

1. Ask the participant to choose the response that best describes how she has been feeling in the previous 7 days.
2. Have the participant complete the scale herself; if she has limited English or difficulty with reading, the FSW may assist her.
3. Do your best to ensure that the participant does not discuss her answers with anyone else.
4. Make sure the participant completes all ten items.

### Assessment frequency

Administer the EPDS 6-8 weeks after the participant gives birth. The EPDS can be administered at additional time periods if the FSW suspects postpartum depression. Since the EPDS is meant to measure the participant's symptoms during the previous week, administering the questions again after 2 weeks may be useful.

### Scoring

**Questions 1, 2, & 4:** Response categories are scored 0, 1, 2, or 3 from top to bottom, corresponding to increasing severity of the symptom (i.e., top box is scored as 0 and the bottom box is scored as 3).

**Questions 3 & 5-10 (labeled with an \*):** Response categories are reversed and scored 3, 2, 1, 0 from top to bottom, corresponding to increasing severity of the symptom (i.e., top box is scored as 3 and the bottom box is scored as 0).

Calculate the total score by adding the scores for each of the ten items. Write this score in the space provided at the bottom of the screening form.

**Maximum score: 30**

**Possible depression: Score of 10 or greater**

**Always look at item #10 (suicidal thoughts)**

**If the client scores a total of 10 or more points OR scores 1 or higher on question #10 (indicating that she may harm herself), refer her immediately for follow-up by a mental health professional.** If the client has a total score below 10 but the FSW feels she may be experiencing depression, an appropriate referral should be made.

### Data Source

Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-78

# California Home Visiting Program Edinburgh Postnatal Depression Scale (EPDS)



Participant Name: \_\_\_\_\_ Participant ID: \_\_\_\_\_ Date: \_\_\_\_\_

As you have recently had a baby, we would like to know how you are feeling now. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Please complete all questions.

### In the past 7 days:

1. I have been able to laugh and see the funny side of things
  - As much as I always could
  - Not quite so 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

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*For FSW use only*

Total Score: \_\_\_\_\_