The Edinburgh Depression Scale (EDS).

(L. Murray and J. L. Cox 1990)

Also known as 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.

A score above 10 requires a repeat of the EDS within 2 weeks.

Two scores above 12 require further assessment to establish if a clinical disorder is present.

The EDS 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.

Downloadable version

EDINBURGH DEPRESSION SCALE*

Also known as the Edinburgh Postnatal Depression Scale (EPDS)*

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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 & Sagovsky 1987

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CLINICIAN SCORING GUIDE

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EDINBURGH DEPRESSION SCALE*

Also known as the Edinburgh Postnatal Depression Scale (EPDS)*

TOTAL SCORE ☐

INSTRUCTIONS:

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 & Cox 1990 * Cox, Holden & Sagovsky 1987

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Range of EDS Scores

CLINICIANS PLEASE NOTE:

This information is offered as a guide only. Clinical judgement forms an important part of any assessment and care planning process.

Remember that the EDS scores apply to the ***last seven days.*** Use the guide below in relation to the most recent EDS.

Scores

0-9 When scores are in this range this may indicate the presence of some symptoms of distress that may be short-lived and are not 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 as to the cause

10-12 Scores within this range indicate presence of symptoms of distress that may be discomforting. We suggest that you repeat the EDS in 1- 2 weeks time for women scoring in this range and if the scores increase to above 12 assess further and consider referral to a mental health specialist or general practitioner for review.

13 + Scores above 12 require further evaluation and possible referral to a perinatal mental health specialist. Repeat the EDS at intervals top monitor progress.

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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