USING THE EDINBURGH SCALE

Instructions for Users

- The mother is asked to underline the response that comes closest to how she has been feeling in the previous 7 days.
- All ten items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others.
- The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

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.
Individual items are totaled to give an overall score.

Evaluating Results

- A score of **10 or greater** indicates the likelihood of depression.
- A score of **13 or greater** indicates very high likelihood of depression.
- If any number other than “0” is picked for Question 10, further assessment is required right away.

The EPDS Score is designated to assist, not replace, clinical judgment. Women should be further assessed before deciding on treatment. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders. Good clinical care also involves asking if the mother has fears about hurting the baby or fears of the baby coming to harm.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150*, 782-786.

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Perinatal Depression Screening and Intervention