

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

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

Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.

No, not very often Please complete the other questions in the same way.

No, not at all

In the past 7 days:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="radio"/> As much as I always could<input type="radio"/> Not quite so much now<input type="radio"/> Definitely not so much now<input type="radio"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="radio"/> As much as I ever did<input type="radio"/> Rather less than I used to<input type="radio"/> Definitely less than I used to<input type="radio"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="radio"/> Yes, most of the time<input type="radio"/> Yes, some of the time<input type="radio"/> Not very often<input type="radio"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="radio"/> No, not at all<input type="radio"/> Hardly ever<input type="radio"/> Yes, sometimes<input type="radio"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="radio"/> Yes, quite a lot<input type="radio"/> Yes, sometimes<input type="radio"/> No, not much<input type="radio"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="radio"/> Yes, most of the time I haven't been able to cope at all<input type="radio"/> Yes, sometimes I haven't been coping as well as usual<input type="radio"/> No, most of the time I have coped quite well<input type="radio"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="radio"/> Yes, most of the time<input type="radio"/> Yes, sometimes<input type="radio"/> Not very often<input type="radio"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="radio"/> Yes, most of the time<input type="radio"/> Yes, quite often<input type="radio"/> Not very often<input type="radio"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="radio"/> Yes, most of the time<input type="radio"/> Yes, quite often<input type="radio"/> Only occasionally<input type="radio"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="radio"/> Yes, quite often<input type="radio"/> Sometimes<input type="radio"/> Hardly ever<input type="radio"/> Never |
|--|--|

Administered/Reviewed by _____ Date _____

¹Source: 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* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt **during the previous week**. 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.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

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.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: 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* 150:782-786.

²Source: K. L. Wisner, B. L. Pary, C. M. Plontek, Postpartum Depression. *N Engl J Med* vol. 347, No 3, July 16, 2002, 194-199

PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

a. Little interest or pleasure in doing things

Not at all **Several days** **More than half the days** **Nearly every day**

b. Feeling down, depressed, or hopeless

Not at all **Several days** **More than half the days** **Nearly every day**

c. Trouble falling asleep, staying asleep, or sleeping too much

Not at all **Several days** **More than half the days** **Nearly every day**

d. Feeling tired or having little energy

Not at all **Several days** **More than half the days** **Nearly every day**

e. Poor appetite or overeating

Not at all **Several days** **More than half the days** **Nearly every day**

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

Not at all **Several days** **More than half the days** **Nearly every day**

g. Trouble concentrating on things such as reading the newspaper or watching television

Not at all **Several days** **More than half the days** **Nearly every day**

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

Not at all **Several days** **More than half the days** **Nearly every day**

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

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PHQ-9 — Scoring Tally Sheet

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

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How to Score PHQ-9

Scoring Method For Diagnosis

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring Method For Planning And Monitoring Treatment

Question One

- To score the first question, tally each response by the number value of each response:

Not at all = 0

Several days = 1

More than half the days = 2

Nearly every day = 3

- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤ 4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥ 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult.

The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

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