PHN-PREP
Public Health Nursing Practice, Research & Education Program

Professional Resource

Administration, Scoring & Interpretation of the Edinburgh Postnatal Depression Scale (EPDS)

When a client presents with signs of depression, the recommendation within the *Public Health Nursing Care Plans for Supporting Perinatal Clients at Risk of Depression* is that either the EPDS or the Patient Health Questionnaire-9 (PHQ-9) tool is administered to screen for risk of perinatal depression. This Practice Guidance Resource provides information on how to introduce, administer, score and interpret the **EPDS** screening tool during the postpartum period.

What is Depression?

Depression is more than just feeling sad or experiencing temporary "blues." Clinical depression, sometimes called major depressive disorder, is a complex mood disorder caused by various factors, including genetic predisposition, personality, stress and brain chemistry.[1]

Perinatal Depression

Perinatal depression refers to depressive symptoms that occur during pregnancy or within the first year postpartum. It can affect any parent, including biological parents, adoptive parents, and partners.[2]

For additional information on how to recognize, assess, and respond to perinatal mental health concerns in practice, refer to the Public Health Nursing Care Plans for Supporting Perinatal Mental Health Practice Guidance document.

Signs and Symptoms of Depression & Perinatal Depression

Depression[3]	Perinatal Depression[2]
For both depression and perinatal depression, a person must present with a five (or more) symptoms that have been present nearly every day during the same 2-week period, and at least one of the symptoms is either: **Depressed mood (e.g., feels sad, empty, hopeless)** OR **Loss of interest in activities that would have previously been pleasurable**	
Other symptoms: • Changes in appetite (increase or decrease) or unintended weight loss/gain • Sleep disturbances (difficulty sleeping or excessive sleep) • Fatigue or loss of energy	**Symptoms of perinatal depression include all of those identified with depression, as well as:** • Lack of interest in the baby, not feeling bonded to the baby, or feeling very anxious about/around the baby • Feelings of being a bad mother/caregiver • Fear of harming the baby or oneself

- Increase in purposeless physical activity (e.g., inability to sit still, pacing, handwringing) or slowed movements or speech [these actions must be severe enough to be observable by others]
- Feelings of worthlessness, excessive or inappropriate guilt
- Trouble thinking or concentrating, and difficulty making decisions
- Recurrent thoughts of death/suicide

- Early cessation of breastfeeding*[4]

**The relationship between breastfeeding and postpartum depression has been found to be bidirectional. While early cessation of breastfeeding has been identified as a symptom of postpartum depression, breastfeeding appears to reduce the incidence of postpartum depression.*[4]

Depression occurs on a **spectrum** from mild to severe. At the "severe" end of the spectrum, individuals may develop suicidal thoughts or intent (e.g., plans) and/or psychotic symptoms.[3]

Screening for Risk of Depression

If signs of depression are observed during the client interaction or the client shares their experiences of symptoms that may be suggestive of depression, begin to ask open-ended questions that invite the client to further elaborate on their experiences.

Can you tell me about any changes in your mood or emotions since your baby arrived?

How has your energy level / sleep patterns / appetite been lately?

I heard you mention that things are really hard / overwhelming. Can you tell me more about that?

I've noticed that you seem to be tearing up when we talk. Can you tell me more about what is going on for you right now? What are some of your feelings or thoughts?

Using Plain Language in Client Conversations

When discussing depression with a client, it's important to use clear, supportive language and define potentially unfamiliar terms. Some individuals may not identify with the term "depression" but may relate more to:

- Feeling down or stuck
- Having a hard time enjoying things
- Feeling exhausted all the time or struggling to find energy
- Struggling with motivation or focus
- Feeling disconnected from their baby
- Having negative thoughts about themselves

When a client is presenting with **signs of depression or perinatal depression**, it is recommended in the Public Health Nursing Care Plans for Supporting Perinatal Clients at Risk for Depression that a nurse consider administering one of two tools to screen for risk of depression, the PHQ-9 or the EPDS.

CRITICAL PRACTICE NOTE:

If a client is around two weeks postpartum, they may be experiencing a normal transition to parenting, even possibly in the form of the "baby blues."* It is important not to pathologize normal maternal adjustment. Use nursing judgement based on your client's history to determine whether or not to utilize screening tools at this time. Explore with your client if further assessment is warranted during follow-up appointment.

* For more information, refer to the ***Understanding and Supporting Emotional Changes in the Early Postpartum Period ("The Baby Blues")*** practice guidance resource.

What is the EPDS?

The EPDS is a validated tool that, unlike other depression screening tools, is designed specifically for perinatal individuals who may be at risk of, or experiencing, perinatal depression.[5] It is also validated for use in diverse populations, including fathers, adoptive parents, and partners. It is not a diagnostic tool however information gained from completion of the tool helps guide further assessment and intervention. It is brief, easy to administer, and suitable for use in the perinatal period.

Features of the EPDS

- 10 questions assessing mood and emotional well-being over the past 7 days.
- Focuses on core depressive symptoms, including:
  - Feelings of sadness, guilt, or hopelessness.
  - Enjoyment of activities.
  - Anxiety and ability to cope.
  - Sleep disturbance.
  - Suicidal thoughts (last question).
- Each question has four response options:
  - For questions 1, 2, and 4, responses are scored from 0 (least severe) to 3 (most severe).
  - For the remaining questions, responses are reverse-scored, with answers listed from 3 (least severe) to 0 (most severe).
  - The score is listed next to each response for easy and quick tabulation.

Introducing the EPDS to a Client

When a public health nurse introduces a mental health screening tool like the EPDS to a client, it is important to do so utilizing a trauma- and violence-informed (TVIC) approach to care.

Key Principle	Why It Matters	How to Apply It in Practice
Create a safe and supportive environment	Clients experiencing depression may feel isolated, vulnerable, or ashamed of their feelings. A safe space fosters trust and openness.	Choose a **private, quiet space** where the client feels comfortable. Use **open body language** and a **calm, supportive tone** to reduce distress.

Key Principle	Why It Matters	How to Apply It in Practice
Normalize and validate the experience	Many parents struggle with guilt or shame around feeling low, exhausted, or disconnected from their baby. Validating their feelings reduces stigma.	Use **non-pathologizing language**. *"Many parents feel overwhelmed, exhausted, or disconnected in the postpartum period. You're not alone in this."*
Explain the purpose clearly	If the tool feels like a test, clients may **minimize their responses** out of fear of judgement. Explaining its purpose reassures them.	Introduce the EPDS as a **way to explore emotions**, not a diagnosis. *"This tool helps guide our conversation so we can understand what support might be helpful for you."*
Give the client choice and control	Trauma survivors and individuals experiencing perinatal depression may feel **powerless**. Offering choice promotes a sense of control.	Always **ask permission** before administering the PHQ-9. *"Would you be open to going through these questions together?"* Allow the client to **opt out** or **take breaks.** Ensure the client knows they can skip questions or ask for clarification.
Use plain language and avoid jargon	Clients may not identify with the term **"depression"**, but may relate to feeling **drained, hopeless, or disconnected**.	Frame questions in **everyday language.** *"Some people describe feeling numb or like they're just going through the motions. Have you felt that way?"*
Frame it as a collaborative conversation	Builds **trust and partnership**, making the client more likely to engage meaningfully.	Reinforce that **the client is the expert** on their experience. *"This tool helps me understand what you've been feeling so we can explore what might be most helpful for you."*
Acknowledge strengths and offer reassurance	Clients with depression often experience **self-doubt** or **guilt about not feeling happy.** Reassurance helps counter these feelings.	Normalize their experience and **highlight resilience**. *"You're doing a lot right now, and it's okay to ask for support."*
Discuss next steps together	A rigid or prescriptive approach can make clients feel powerless or dismissed.	After completing the PHQ-9, **ask how they feel about their responses** and explore **next steps collaboratively.** *"Is there anything from these questions that stood out to you?"*

Options for Administering the EPDS

The EPDS can be administered in different ways. It is essential to provide the client with a choice related to administration.

Consider how clients might be given a choice in how they complete the EPDS to promote comfort and autonomy. Use clinical judgement to determine client literacy level, comfort etc.

"Would you prefer that I ask these questions aloud, or would you rather fill them out yourself?"

- **Self-completion:** the client is handed the EPDS and completes the screening tool on paper or electronically. This offers them privacy in responding to the questions. If the client is unable to answer all questions independently, offer assistance to aid in its completion - which may include reading or explaining the question. Ensure a non-judgemental tone and space when reviewing responses with the client.
- **Side-by-side administration (collaborative approach):** sit beside the client and read each question aloud while the client marks their own response. This approach reinforces that the client is in control of their responses provided.
- **Verbal administration:** ask each question verbally and record response as client responds.
  - If administered verbally, sit side-by-side with the client and read each question and the subsequent responses exactly as written to maintain tool validity and reliability. For verbal administration, the tool could be introduced as follows:

"I'm going to go through a short set of questions called the Edinburgh Postnatal Depression Scale, or EPDS. This is a tool I use with many of my clients during visits. These questions ask about how you've been feeling over the past seven days, not just today. Each question has four response options, and I'll read them exactly as written."

How the EPDS Can Be Introduced to a Client

Normalize and validate the screening process:

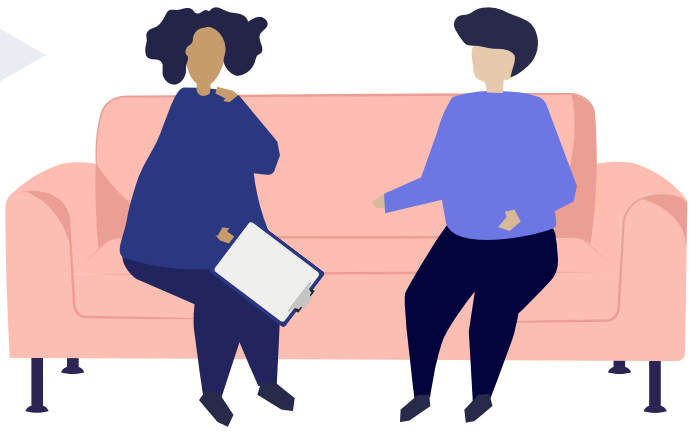
"Many parents experience a mix of emotions in the postpartum period. The postpartum period brings a lot of changes—physically, emotionally, and mentally. As a new parent you might experience moments of joy and connection, but also times of worry, sadness, or feeling overwhelmed. To better understand how you've been feeling over the past week, we have a short set of questions called the Edinburgh Postnatal Depression Scale, or EPDS.

Explain the purpose of the EPDS:

This isn't a test or a diagnosis—it's just a tool with 10 questions to help guide our conversation about your well-being.

Emphasize choice and control:

"I can either ask the questions aloud to you or you can read them on your own, please let me know what you prefer. You can then choose the response that feels most accurate for you. If anything is unclear, just let me know, and we can go through it together at your pace. If there are questions you prefer to not answer, that is okay as well, there are no right or wrong answers. Does that sound okay to you?"



Provide anticipatory guidance and describe how responses will be used:

"Once we have completed the questions, I will add up the score. We will then go over the responses together and I will explain what your scores mean. We can talk about how you've been feeling. If your responses suggested you might be experiencing symptoms of postpartum depression or anxiety, we can discuss next steps, including different types of support available to you. The goal is to make sure you feel heard, supported, and not alone in this."

Provide reassurance and next steps:

"Regardless of your score, we can talk about what you need and what might help you feel supported. Some people appreciate connecting with other parents and talking to other health care professionals. There may also be strategies that we can discuss together on future home visits. I'm here to listen and support you in whatever way you need."

EPDS Scoring, Interpretation and Client Communication

The EPDS is scored by summing the scores of all 10 questions, with a total score range of 0 to 30.

After administering the EPDS, tabulate the score and share the score and interpretation with the client using therapeutic language.

Score	Interpretation	Say...
0 - 9	Low Risk	*"Your responses suggest you may not be experiencing perinatal depression at this time."*
10 - 12	Moderate Risk	*"Your responses suggest you may be experiencing some symptoms of perinatal depression. This is common, and there are supports available if you'd like to explore them."*
13 or more (10+ for male partners)	High Risk	*"Your responses suggest you may be experiencing significant symptoms of perinatal depression. You are not alone, and there are supports that can help."*

Positive response to Question 10* (self-harm thoughts.	Immediate Further Assessment	*"I noticed you indicated that thoughts of harming yourself have occurred to you. I'd like to talk about this further to ensure you have the right support in place."* Inquire if the client has thoughts or intentions of harming themselves, children or someone else. Additional assessments to consider: • Suicide risk assessment** • Assess for signs of perinatal psychosis • Assess for signs of homicide (including infanticide) and intention.

*Positive response is defined as an answer of **Yes, quite often; Sometimes; Hardly ever**

Refer to the **Nursing Care Plans for Supporting Perinatal Mental Health for Suicidal Ideation

Note: *There is variation across organizations in how scores are categorized. The cut-off scores presented here for the EPDS align with the guidance developed by the Healthy Human Development Table.*[6]

After scoring the EPDS, refer to the **Public Health Nursing Care Plan for Supporting Perinatal Clients at Risk of Depression** for guidance on next steps for tailoring care to the client's level of risk.

NOTE

It is important to use clinical judgement when interpreting the score of the EPDS. For instance, there may be situations where the "score" from an assessment tool reflects "low risk" – yet the client and their partner urgently express significant concern about the mother's safety and mental well-being. In this situation, the public health nurse would use all the assessment information available to them and perhaps interpret that the client is at higher risk than what was indicated following completion of the assessment tool alone. The nurse would then choose to respond with interventions appropriate for a higher level of risk.

Communicating Scores to the Client

Remember, it's important to normalize, validate and provide reassurance.

"It looks like your responses indicate significant symptoms of perinatal depression. First, I want to reassure you that you are not alone—many parents experience this, and there are supports available to help. It's okay to ask for help, and I'd like to talk about what might feel supportive for you. Would you be open to exploring some options together?"

An Important Note About Mental Health Screening Tools

Screening tools, like the EPDS:

- Support nursing assessment and intervention by providing structured insight into a client's symptoms.
- Are to be used alongside other tools (e.g., care plans, educational resources, clinical observations).
- Help to identify and monitor symptoms of depression over time.
- Aid in client education by increasing awareness of symptoms and available support.
- Provide an opportunity to strengthen the therapeutic relationship when administered in a supportive, trauma-informed manner.
- **Are to be used in a manner that complements, but does not replace, clinical judgement.**

References

[1] Centre for Addiction and Mental Health (CAMH). (2024). *Depression*. Retrieved February 24, 2025, from https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/depression

[2] American Psychological Association (APA). (2023, October). *What is perinatal depression?* Retrieved February 2, 2024, from https://www.psychiatry.org/patients-families/peripartum-depression/what-is-peripartum-depression

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Citation: Bradley, C., Olarte-Godoy, J., Moisey, L., Strohm, S., Weatherby, J. & Jack, S.M on behalf of the PHN-PREP Project Team [2025]. Administration, Scoring & Interpretation of the Edinburgh Postnatal Depression Scale (EPDS) [Professional Resource]. School of Nursing, McMaster University.