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Citation: Dudeney, E. & Meades, R. (2026). Rethinking the Edinburgh Postnatal Depression Scale: contemporary relevance, validity and implications for future research. *The British Journal of Psychiatry*, doi: 10.1192/bjp.2026.10748

This is the accepted version of the paper.

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Link to published version: <https://doi.org/10.1192/bjp.2026.10748>

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Rethinking the Edinburgh Postnatal Depression Scale (EPDS): Contemporary relevance, validity, and implications for future research

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Keywords: Edinburgh Postnatal Depression Scale; Assessment; Validity; Acceptability;
Perinatal Depression

Declaration of Interest: None.

Funding: This research received no specific grant from any funding agency, commercial or not-for profit sectors.

Acknowledgements: The authors would like to thank Professor John Cox for his insights and support of this Guest Editorial.

Author Contributions: ED and RM jointly conceptualised the Guest Editorial. ED wrote the initial draft. RM contributed substantial revisions. Both authors reviewed and approved the final version.

Transparency Declaration: N/A

Data Availability: N/A

Analytic Code Availability: N/A

Research Material Availability: N/A

Word Count (main body of text): 2010

Summary

The Edinburgh Postnatal Depression Scale has shaped the identification of perinatal depression for four decades, but evolving understandings of distress, comorbidity, and measurement standards challenge its continued adequacy. We argue for rigorous, co-produced revision to enhance validity, inclusivity, and clinical utility, supporting more accurate and meaningful assessment in contemporary care.

The Edinburgh Postnatal Depression Scale (EPDS)¹ is among the most widely used measures for identifying perinatal depression globally. Since its development, the EPDS has been embedded in UK and international clinical guidance, practice and policy, validated in diverse populations and settings, extensively applied in research contexts, and translated into at least 60 languages, underscoring its enduring value and contribution to perinatal mental health. As the EPDS approaches its fortieth anniversary, it is timely to recognise its impact whilst also considering whether it remains adequately aligned with contemporary understandings of perinatal mental health, current service priorities, and the needs of increasingly diverse families, particularly where misalignment may have implications for identification, engagement, and care. Although many established mental health measures may warrant contemporary re-evaluation, the EPDS merits particular consideration because of its exceptional global reach, translation, policy embedding, and influence on how perinatal distress is identified and operationalised across research and clinical settings.

In a recent Guest Editorial in this journal, Professor John Cox revisited the origins of the scale and suggested possible ‘new directions’ for its use in contemporary societies². Here, we consider issues of continued validity, acceptability, and clinical utility in modern contexts, and outline key priorities for its potential revision in light of advances in measurement science, evolving understandings of perinatal mental health, and the realities of implementation within routine care.

Enduring impact

The success of the EPDS reflects several features that have supported its widespread adoption and sustained use. At the time of its inception, valid measures for postnatal depression were limited and the EPDS addressed a clear clinical need. Early piloting suggested strong face validity and acceptability to women and practitioners^{1,2}, and its focus on psychological rather than somatic symptoms marked an important advance in perinatal mental health assessment. Its brevity and ease of administration facilitated early uptake into clinical practice and subsequent inclusion in UK guidelines for the assessment of antenatal and postnatal mental health since their introduction³. In parallel, its extensive use in research has underpinned a substantial international evidence base and developments in digital technologies have further extended its reach and implementation. Together these features have established the EPDS as a central instrument in perinatal mental health research and practice.

Construct validity and measurement implications

The influence and contribution of the EPDS are undeniable. However, longevity and widespread use do not guarantee ongoing relevance or validity, and without rigorous contemporary re-evaluation, the scale's dominant position risks reinforcing conceptual and clinical inertia. The ten items that comprise the EPDS have remained unaltered for four decades, despite substantial shifts in understandings of perinatal mental health and the contexts in which it is experienced. Considerable and recent evidence supports its accuracy in detecting major depression in pregnant and postnatal women⁴.

However, this strong performance does not remove the need to consider broader questions of construct validity, content validity, acceptability, and alignment with contemporary conceptualisations of perinatal mental health. The EPDS was developed as a screening tool rather than a diagnostic instrument and its psychometric performance does not, in itself, clarify the constructs it captures. A growing body of research has proposed a two-or three-factor structure comprising depression, anxiety, and anhedonia, suggesting that the EPDS may reflect a broader spectrum of perinatal distress beyond its original unidimensional purpose⁵. While the sensitivity of a three-item subscale has shown some promise as a discrete measure of perinatal anxiety, it remains unclear whether the EPDS can reliably discriminate between anxious and depressive disorders⁵. These uncertainties have important clinical implications as ambiguity regarding what is being measured may contribute to misclassification and limit the extent to which scores meaningfully inform care. These considerations raise fundamental questions about how well the EPDS aligns with contemporary conceptualisations of perinatal mental health and its application within modern clinical practice.

Comorbidity and complexity in perinatal mental health

Perinatal mental health conditions now affect approximately one in four women and birthing people during pregnancy and/or after birth, and are increasingly understood as complex, overlapping, and heterogeneous rather than restricted to distinct diagnostic categories. Substantial evidence highlights the high prevalence and co-occurrence of anxiety disorders, stress- and trauma-related difficulties and other forms of distress during the perinatal period. Importantly, symptoms that do not meet diagnostic thresholds may nevertheless be highly distressing and impactful for women and families, yet may be less visible within approaches directed towards identifying probable depression. At the same time, conceptualisations of perinatal mental health have expanded beyond biomedical frameworks to incorporate social, cultural, and structural determinants, alongside increasing emphasis on lived experiences and

co-produced research. Likewise, changes in family structures and parental working patterns, increasing ethnic and cultural diversity, advances in Assisted Reproductive Technologies, and a stronger focus on the mental health of fathers, non-birthing partners and babies have transformed the landscape for how perinatal mental health is experienced and understood, emphasising the need for more inclusive approaches to assessment and support. Without acknowledgement or critical exploration of these modern tensions, there is a risk that continued reliance on the current EPDS for identifying and defining perinatal depression will potentially constrain how perinatal distress is conceptualised, what is measured, and whose experiences are captured, thereby shaping the evidence base and care that follows.

Contemporary standards in measurement development

It is equally important to consider the contemporary context of measure development, as current standards now place greater emphasis on content validity, relevance, interpretability, and cultural sensitivity alongside psychometric performance. The COSMIN (COnsensus-based Standards for the selection of health Measurement INstruments) framework prioritises content validity, requiring clearly defined constructs and active involvement of the target population to ensure items are relevant, comprehensive, and comprehensible⁶. Central to this is the embedding of lived experience and co-produced research methodologies that reflect the realities, priorities, and meanings of those the measures are intended to support. Best practice now emphasises a systematic, iterative process of item generation, including qualitative exploration, cognitive testing and stakeholder input to refine items prior to large-scale psychometric validation. Such approaches represent a shift towards more transparent, participatory, and conceptually rigorous measurement development, in which the meaning and interpretation of items are considered as important as their statistical properties. The EPDS was developed within a markedly different era of measurement development that did not foreground these principles. As such, the current scale may not align with contemporary expectations for how constructs are defined, operationalised and interpreted, or resonate with the diverse lived experiences of modern perinatal populations. However, revision is not without challenges. Changes to item wording or content may affect comparability with historical datasets, alter prevalence estimates, and introduce tensions between local relevance and cross-cultural consistency. This tension becomes particularly apparent at the level of item wording, where the language used to operationalise the experience of perinatal depression and/or distress shapes how questions are understood, interpreted, and responded to in

practice. Therefore, any revisions should take place within clear parameters where words reflect the intended meaning of items.

Language, meaning, and interpretation

Contemporary mental health language, idiom, and cultural expressions now reflect more nuanced, destigmatising, and humanising understandings of psychological wellbeing, which may affect how well the EPDS is interpreted and understood. Evidence indicates that some EPDS items may be ambiguous and/or problematic, with women and healthcare professionals reporting the wording as unclear, judgemental, or dismissive. For example, there is concern regarding the ambiguity, acceptability, and utility of item 10 (*“the thought of harming myself has occurred to me”*) which is commonly used in both clinical and research settings as an indicator of suicidal ideation. However, this item does not distinguish between self-harm and suicidal ideation, the term ‘harming’ may be interpreted as unintentional or detrimental harm (e.g., accidental injury or health-compromising behaviours such as smoking during pregnancy), it may not be culturally sensitive or relevant, and it may overestimate the true prevalence of suicidal ideation in epidemiological and other research contexts. Recent qualitative work also suggests that this item is often understood as non-suicidal self-harm, which may compromise the specificity of item 10 for capturing suicidal ideation in the absence of further questions⁷. These linguistic and conceptual issues may have important implications for identification, disclosure, and access to support, again underscoring the need for robust systematic review evidence and co-produced contemporary research of the EPDS’s acceptability and content validity with diverse perinatal populations and healthcare practitioners.

Identification of perinatal mental health in context

The widespread use of the EPDS rests on an implicit assumption that identification leads to improved outcomes. However, evidence suggests that routine enquiry alone, without adequate pathways to care, may have limited impact. This raises a more fundamental question of not only whether we are measuring perinatal distress appropriately, but whether current approaches to identification are fit for purpose within contemporary health systems. Routine enquiry in this context is not a neutral process but a complex intervention, with the potential to facilitate disclosure and access to care, but also to generate anxiety, reinforce stigma, or deter help-seeking if poorly implemented. Routine enquiry using standardised questions can offer a pragmatic approach to identifying women who may require further assessment and

support. Within UK maternity services, identification often includes use of the Whooley questions in accordance with NICE guidelines³, with subsequent assessment using the EPDS and referral processes where concerns are identified⁸. Internationally, screening approaches vary considerably and may involve measures including the EPDS as a first-line approach⁹. However, evidence that routine enquiry alone improves maternal or infant outcomes remains limited and highly contingent on the availability and quality of subsequent care pathways. Recent evidence-based guidance emphasises that identification approaches must be embedded within structured pathways for assessment, intervention, and follow-up⁹ or risk leaving women experiencing postpartum depression unidentified within existing care systems. Poorly administered questionnaires can feel like ‘tick-box’ exercises which depersonalise care, and a lack of information regarding the purpose and outcomes of routine enquiry may inhibit disclosure. There is now clear recognition that measures should not be used as standalone tools but instead form part of a person-centred approach that enables meaningful dialogue and takes account of individual experiences, needs, and circumstances⁸. This has important implications for measurement. If routine enquiry is to function as an entry point to care, tools must do more than identify symptoms, they must support meaningful disclosure, reflect diverse experiences of distress, and be interpretable within the context of individual lives and care pathways. Contemporary perinatal mental health care requires identification approaches that capture the breadth and complexity of distress, including anxiety and comorbidity, while remaining clinically interpretable and feasible within routine care. A focus on elevated EPDS scores may obscure qualitatively different experiences of distress leading to potential misclassification and shaping clinical decision-making and care pathways in ways that do not reflect individuals’ needs.

A case for change

Taken together, these considerations highlight a pressing need for rigorous contemporary re-evaluation of the EPDS to ensure alignment with current understandings of perinatal mental health, lived experiences, cultural relevance, inclusivity, service priorities, and standards of measurement development. This will require systematic, co-produced research involving contemporary item review, cognitive testing, qualitative exploration of interpretation and meaning, and evaluation across diverse cultural and clinical contexts prior to psychometric validation. Such work has the potential to improve the identification of perinatal mental health difficulties, support more timely and appropriate care pathways, and reduce reliance on multiple screening measures, thereby minimising burden for both women and practitioners.

Crucially, any revisions should also strengthen the acceptability and clinical utility of identification approaches by supporting usability and meaningful dialogue, facilitating disclosure, informing decision making, and ensuring care is responsive to individual needs and circumstances. Given the EPDS's established position in current clinical guidance, practice, and research, revision within clear parameters rather than replacement offers a pragmatic and sustainable approach for supporting equitable, person-centred assessment, that better reflects the complexity and diversity of modern perinatal experiences. However, without critical re-evaluation, there is a risk that continued reliance on the current scale may limit how perinatal distress is recognised and addressed in both research and clinical care. Advancing this agenda will require coordinated, interdisciplinary effort and ongoing international dialogue to ensure that future approaches to assessment are equitable, person-centred, and fit for contemporary practice.

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