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Guest Editorial

# Rethinking the Edinburgh Postnatal Depression Scale: contemporary relevance, validity and implications for future research

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**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.

**Keywords**

Edinburgh Postnatal Depression Scale; assessment; validity; acceptability; perinatal depression.

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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 40th anniversary, it is timely to recognise its impact while 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 proposed possible new directions for its use in contemporary practice.[2] Here, we consider its continued validity, acceptability and clinical utility, 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 in 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 introduction.[3] 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 10 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 women.[4]

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 properties alone do not establish the constructs it measures. A growing body of research supports a two- or three-factor structure comprising depression, anxiety and anhedonia, suggesting that the EPDS may capture a broader spectrum of perinatal distress than originally intended.[5] While the sensitivity of a three-item subscale has shown some promise as a discrete measure of perinatal anxiety, it remains uncertain whether the EPDS can reliably distinguish anxiety from depressive disorders.[5] This uncertainty has important clinical implications because ambiguity regarding what is being measured may contribute to misclassification and limit the extent to which scores meaningfully inform clinical decision-making. These considerations raise fundamental questions about how well the EPDS aligns with contemporary conceptualisations of perinatal mental health and its role in 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 after birth



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and are increasingly understood as complex, overlapping and heterogeneous, rather than being restricted to distinct diagnostic categories. Substantial evidence highlights the high prevalence and co-occurrence of anxiety disorders, trauma- and stressor-related difficulties and other forms of psychological 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 acknowledging and critically exploring these contemporary tensions, continued reliance on the current EPDS to identify and define perinatal depression risks constraining how perinatal distress is conceptualised, what is measured and whose experiences are captured, thereby shaping the evidence base and the 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 COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) framework prioritises content validity, requiring clearly defined constructs and active involvement of the target population to ensure that items are relevant, comprehensive and comprehensible.[6] Central to this is the embedding of lived experience and co-produced research methodologies that reflect the realities, priorities and perspectives of those the measures are intended to support. Best practice now emphasises a systematic, iterative process of item development, including qualitative exploration, cognitive testing and stakeholder involvement to refine items before large-scale psychometric validation. Such approaches represent a shift towards more transparent, participatory and conceptually rigorous measurement development, in which the interpretation of items is considered as important as their statistical properties. The EPDS was developed in a markedly different era of measurement development that did not prioritise these principles. As such, the current scale may not align with contemporary expectations for how constructs are defined, operationalised and interpreted, or adequately capture the diverse experiences of contemporary 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. These tensions are particularly evident in item wording, where the language used to operationalise the experience of perinatal depression and distress shapes how questions are understood, interpreted and answered in practice. Any revisions should therefore be undertaken within clearly defined parameters to ensure that item wording accurately reflects the intended construct and meaning.

## Language, meaning and interpretation

Contemporary mental health language, idiom and cultural expressions reflect more nuanced, destigmatising and person-centred understandings of psychological distress, which may influence how EPDS items are interpreted. Evidence suggests that some EPDS items may be ambiguous or problematic, with women and healthcare professionals describing their 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 clinical practice and research as an indicator of suicidal ideation. However, this item does not distinguish between self-harm and suicidal ideation. Furthermore, the term 'harming' may be interpreted as unintentional or detrimental harm (e.g. accidental injury or health-compromising behaviours such as smoking during pregnancy), may not be culturally sensitive or relevant and may overestimate the true prevalence of suicidal ideation in epidemiological and other research settings. Recent qualitative work also suggests that this item is often understood as non-suicidal self-harm, which may compromise its specificity for identifying suicidal ideation in the absence of further questions.[7] These linguistic and conceptual issues may have important implications for identification, disclosure and access to support, reinforcing the need for robust systematic review evidence and co-produced contemporary research evaluating the EPDS's acceptability and content validity across 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: 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 is not a neutral process but a complex intervention, with the potential to facilitate disclosure and access to care, while also generating anxiety, reinforcing stigma or deterring 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 National Institute for Health and Care Excellence (NICE) guidelines,[3] followed by assessment with the EPDS and referral where concerns are identified.[8] Internationally, screening approaches vary considerably and may use the EPDS as a first-line approach.[9] 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 should be embedded within structured pathways for assessment, intervention and follow-up[9] or risk leaving women experiencing postpartum depression unidentified within existing care systems. Poorly administered questionnaires may feel like 'tick-box' exercises that depersonalise care, while a lack of information regarding the purpose and outcomes of routine enquiry may inhibit disclosure. There is now broad recognition that 'screening' measures should not be used as standalone tools but should form part of a person-centred approach that facilitates



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meaningful dialogue and takes account of individual experiences, needs and circumstances.[8] This has important implications for measurement. If routine enquiry is to function as an effective entry point to care, tools must do more than identify symptoms; they must facilitate meaningful disclosure, reflect diverse experiences of distress and be interpretable within the context of individuals' lives and care pathways. Contemporary perinatal mental health-care therefore requires identification approaches that capture the breadth and complexity of distress, including anxiety and comorbidity, while remaining clinically interpretable and feasible for routine practice. A focus on elevated EPDS scores may obscure qualitatively different experiences of distress, leading to mis-classification 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, facilitate 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 improving usability, facilitating meaningful dialogue, encouraging disclosure, informing clinical decision-making and ensuring care is responsive to individual needs and circumstances. Given the EPDS's established role in clinical guidance, practice and research, revision within clearly defined parameters, rather than replacement, offers a pragmatic and sustainable approach to supporting equitable, person-centred assessment that better reflects the complexity and diversity of contemporary perinatal experiences. However, without critical re-evaluation, continued reliance on the current scale risks limiting 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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## Data availability

This study did not involve the novel creation, generation or analysis of primary research materials. All relevant literature is cited in the References.

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E.D. and R.M. jointly conceptualised the Guest Editorial. E.D. wrote the initial draft. R.M. contributed substantial revisions. Both authors reviewed and approved the final version.

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## Declaration of interest

None.

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