Bozo Lugonja: Hello, and welcome to the very first ever Piece of Mind podcast. So this is a brand new podcast that will talk about mental health and psychiatric conditions and the research and science behind these conditions, and we'll bring you conversations with patients affected by these conditions alongside researchers who are working at the very cutting edge of understanding an incredibly complex area of psychology and biology.

So this podcast is brought to you by people working at the National Centre for Mental Health, which I will now refer to as the NCMH, and the MRC Centre for Neuropsychiatric Genetics and Genomics, which I will refer to as the MRC Centre, just because they're both mouthfuls and it is easier to talk in abbreviations. So I am the research coordinator for the NCMH, which is actually spread across Cardiff University, Swansea University and Bangor University, and it brings together world-leading researchers looking at the triggers/causes of mental health problems and aims to improve diagnosis, treatment and support for millions of people affected by mental ill health every year. As well as this, it aims to tackle stigma faced by many. The key to achieving this is to engaging with the service and the users, so working with NHS, working with charities and their companies and the wider public to increase understanding on mental illness, and by supporting and undertaking mental health research, and one of the things we thought will be good would be to bring a podcast to you to directly bring you stories from our participants and from our researchers so you have an idea of what we are doing and how you can get involved. We are also part of the MRC Centre here in Cardiff, which is the largest psychiatric genetics group in the UK and it was established in 2009. It uses clinical, genomic, statistical and bioinformatic expertise to tackle the challenges posed by psychiatric, neurodevelopmental and neurodegenerative disorders, with the aim of informing better diagnosis and treatment for the future.

So, how would this podcast work? Well, we're hoping to bring you a range of different formats across the podcast series, but for our very first episode, one of the things we thought would be a good idea to do is to bring together a participant and a researcher, and for our very first podcast, we are going to be focusing on postnatal depression. So with that, I would like to introduce Laura Dearney and Professor Ian Jones.

So, Laura, I was going to introduce you both, but I think it is better if we get you to introduce yourselves. So, Laura, if you could introduce yourself, that would be fantastic.

Laura Dearney: Hi, I am Laura. I am 34. I am a mum of two little monsters. One is 7 and one is 4. Don't be deceived by Poppy's blonde curly hair, she is demonic. I had peri, so during and postnatal on both my children, but was mainly diagnosed with Poppy because I had many complications during both pregnancies, so with my first pregnancy, a lot of my mental health issues were missed. I got involved with the National Centre of Mental Health when I was involved with the Depressed Cake Shop Cumrae and I was

sat next to the National Centre of Mental Health guys at an event, and it just made sense with what they do, and I think they have been trying to get rid of me ever since but I have kind of adopted them as my family and especially Prof who is sat with us here. He is never going to get rid of me, so yeah.

Bozo Lugonja: It is a wonderful relationship.

Laura Dearney: It is. I love him to pieces.

Bozo Lugonja: And on my left hand side, I have got Professor Ian Jones. So Ian, if you'd like to introduce…

Professor Ian Jones: Hi, so I'm Ian. I'm not going to tell you how old I am because I'm far, far too old, but I'm a psychiatrist. So I trained in medicine and did psychiatry training, but for many years, primarily I've been involved in doing research. I'm director of the National Centre for Mental Health and we're absolutely delighted to have Laura working with us to do what's such important work actually, what's really… the experience of Laura and meeting and talking through with Laura really emphasises why what we're doing is really important, I think.

Laura Dearney: He always says the nice things.

Bozo Lugonja: A charmer.

Laura Dearney: I know.

Bozo Lugonja: I think the best place to start is… obviously we have people who know about postnatal depression, perinatal depression, but there's going to be people who are also listening who might not know as much and hopefully will be using this as a resource to learn a little bit more about it. So Ian, could you explain to us what is postnatal depression? And I'll be quite interested to find out why it's an area that you find so interesting and how it is so unique as a disease group?

Professor Ian Jones: Okay, so what do we mean when we use the term postnatal depression? Well, postnatal depression – postnatal or postpartum means following child birth. So when we use that label, we are talking about episodes of illness, episodes of depression that come on after having a baby. Very simply that's what we mean. I suppose there's a bigger question then about what do we mean by depression actually? Because, and probably

what I'd want to say about that is that when we talk about depression as an illness, as a clinical condition, we're not talking about just feeling sad. We're not just talking about the ups and downs that we all experience in life. We're talking about something that can be incredibly serious, incredibly severe, and can really be some of the most devastating health conditions that people can experience. So very simply, we're talking about depression as an illness, we're talking about these significant episodes of illness, and we're talking about those episodes that come on after having a baby.

Bozo Lugonja: So, Laura, could you tell us a little bit more about how you came to be diagnosed with postnatal depression and experiences behind it?

Laura Dearney: Yeah. When I was… let me take you back many years to when I was pregnant with Jack. I had extreme morning sickness but it was missed. So I was lighter giving birth than when I found out I was pregnant, and I was really scared throughout the entire time and I was having all these silly little — they're not silly but OCD things where I had to have a separate fridge, because I was worried to being sick so much, so what if I got ill? What if — it sounds horrible when you say it out loud, doesn't it — and if Henry had made me poorly – it's my husband. I couldn't afford to be sick on top of being sick. And I was so skinny, not in a good way, that I just looked like I had a beach ball on my front, like no one knew I was pregnant unless I kind of turned around and they that "whoa" thing because I was big at the front. But I also then started to have these night episodes of vomiting and kind of fitting, and initially when we had them we thought I was miscarrying, so an ambulance was called. By the time my two amazing ambulance men, which we call Bert and Ernie, and we've actually seen them recently when my son had concussion and we went into the Children's Hospital, not in an ambulance but they were outside, they don't remember me, I remember them… but by the time they arrived, I was more concerned with like how was the cat? If he had enough food when we were in hospital? So they were like, what's wrong with you? Forward then 3 months, I'm still having these fits. They just say it was the baby lying on your sciatic nerve, that's why you can't walk, that's why you can't sleep, you're just being sick, don't worry about it, first child, you're being over the top… had Jack, and the midwife said at the time "she's not right, somebody should've picked up on something." Amazing midwives in the hospital. Then I went home and my cousin had had postnatal, and we had moved house at 8-1/2 months pregnant. If you're listening to this and you're considering moving house and you're pregnant, don't do it. So Jack had a bed when he was born, I didn't because we had just moved into the house, we were still rebuilding everything, and I got home and I just wasn't right. Everyone then says it's baby blues, you're going to be fine, you have to give it 10 days. The health visitor walked in and took one look at me and said "you need to speak to the Mental Health Team" and I just went "go away" and I didn't talk to her for about 2 weeks. My cousin, Tara, who had suffered with mental health issues having had here son, she rang me and told me if no uncertain terms that if I didn't go to the

doctor that day she would drive down from Oxford and she would take me to the doctor. My doctor was like an old school mum. She was amazing. But what she said you did. So she gave me antidepressants after talking to me and I was sat in a car park with them and I didn't want to take them and I rang her and her exact words to me were "I'll ring your mother if you don't take them" so I reverted to being about 13 and I ended up taking… it works seriously, you don't want to mess with a short west _____ woman. So I took my tablets. They then found out the reason that I was still being sick and having night-time fits was my gallbladder had failed but I didn't fit any of the profile because I was 24 — I think I've just made myself younger actually in my pregnancy, because that would make him 10 and he's not 10, so we'll just let everyone else do the maths, but I didn't fit in the age bracket which is I think fat, fair, 40, and female — well, I was female but that was about it. And also I was tiny after giving birth, but they found out it was my gallbladder. Nearly kissed the ultrasound technician who was like "whoa, that's really messed up," had my gallbladder out, my surgeon went "oh, that was the reason you were depressed, it was because you parent" and he threw my tablets in the bin, and that started probably the worst 3 years of my life where I had been told by someone that was a lot clever than me, that was a surgeon, that I wasn't ill and I wasn't mentally ill but I started sleeping in separate bedroom. I would watch Jack sleep. It was horrendous. I was on edge, I was snappy. My husband is an ex-Scottish rugby player — don't get too excited, it was like under 18s — and he's quite squat and like solid. I reduced him to tears on the floor. And then for some brilliant reason – well, brilliant because she I wonderful even though she is a spawn of Beelzebub, we got pregnant with Poppy and she… well, I was really sick during pregnancy but luckily my midwife picked up on it and sent me to the hospital. It was very fine. I had conversation, I lied, you know, like you do. "How are you doing?" "Fine." But then one day, my mother-in-law came down. It's completely unrelated but she made a cup of tea and that, for some reason, just triggered me off and I had s complete mental breakdown. I walked into the doctors. My doctor had retired. She had been replaced by someone that was my age. I was petrified that I would've knew her or that she'd be younger than me and I'd be like "you know nothing about life." And instead she took one look at me, sat me down and she… when things are just meant to be it's really weird. She had just come into the GP surgery but her last rotation in hospital had been with my consultant who I was under for my pregnancy. So she rang her while I was in the room and they put me on like their watch list, so to speak as well. She met with me once a week to check how I was doing because I couldn't take meds because I was pregnant. I was already on anti-sickness meds because I was throwing up again. It was a brilliant diet. She met with Henry once every 3 weeks because he was basically a carer to a child and a pregnant woman who completely couldn't cope with anything and then she met with the most honest person in our family regularly as well, which was Jack, because he was 4 at the time and she would just play blocks with him in the corner and ask how mummy was doing. Now I know a lot of people say a lot of negative things about doctors but she genuinely saved my life by taking the time out to listen to me, to let me talk, and that talking therapy really kept me as sane as I

was going to be during my pregnancy. After I had Poppy, obviously I knew more than the doctors, and I refused to take my mental health tablets. See, looking back, I just think "you're a blithering idiot" because I'd been on sickness meds, I just wanted 2 weeks medicine free. Those 2 weeks, the brain is an amazing thing, I have very little recollection of those first 2 weeks. I do have a recollection of Henry's first day back at work where I rang him at about 1:00 and said "I need to see Dr Clements, I need to see her now" and he rang the surgery and they were like "no, I'm sorry, she doesn't take phone calls on a Tuesday." He said, "No, she'll take this one, just tell her Henry Dearney's on the phone." "No, I'm really sorry." So we argued with the receptionist for 20 minutes. Pretty sure he's blacklisted now. And they mentioned Henry's name to her and I got into the surgery. She just walked me, basically frogmarched me down, and she had my tablets there. And she was like "you know that you're not nuts, you're not crazy," people can't see I'm doing air quotes. "You're not insane, you've got a chemical imbalance in your brain and you just try it. What's the worst that can happen?" And I guess I've been… no, I have… I've been amazing ever since taking them. I've had the best 4 years. The kids are… Jack plays on it. Like, if he doesn't get pudding, he asks if I've taken my crazy lady pill. He'll go into the doctors and like say "she needs her nut pills." But we're really open and honest with it as a family now because we kind of had to be. Jack lived through it.

Bozo Lugonja: Absolutely, yeah.

Laura Dearney: And it's just made other things a lot easier where, you know, stuff happens at school. We're quite an open family, and I think I've spoken to Prof when Jack sadly lost a friend through a car accident and I was like, "what am I doing?" And it was really reassuring with the fact, they're like "well, you're a very open family, you talk about lots of things" and it's quite a two-way street. But yeah, it's an interesting tale of two pregnancies that kind of merged into one mass breakdown at 20 weeks pregnant with Poppy.

Bozo Lugonja: I think there's quite a lot of things there that you've mentioned…

Laura Dearney: There's a lot.

Bozo Lugonja: …that are really interesting. But the first one I'd quite like to go back… obviously, I mean, how does this… no, I'd quite like to ask you this, how does this chime with your experience of treating other patients? How typical or atypical would Laura's experience be?

Professor Ian Jones: Well, I think everybody's got their own story and their own experiences, and every woman's experience is different. But I suppose a couple of

things I'd pick out of there is pregnancy is difficult. Having kids is a massive change in your life. It can affect your physical health and actually that's one thing that came out of what Laura's just been saying, is that she had physical health problems and that can increase risk of having mental health problems as well. Having a baby is a time where joy is the expectation. It's almost the given. This is a time where women must be shining and blooming and glowing…

Laura Dearney: …an everglow…

Professor Ian Jones: But the actually the experience of many women is that… you know, but the postpartum and pregnancy related mood episodes, postnatal depression, postpartum depression, isn't something that's just been thought up in the last 5 or 10 years as a new way to sell drugs to women. These are conditions that have been written about for hundreds, if not thousands of years. We know that there are accounts even in the writings of the ancient Greeks where women experienced mood episodes in relation to childbirth. So yeah, everyone's experience is different but we do know that for some women this can be a particularly difficult life transition. And actually if we think about what are the causes of what can trigger off an illness, I think it's… you know, as human beings we are that complex interaction of our biology, of our psychology, of our social, you know, even the political, and actually when we think about post partum illness, that's no better illustration of that because there are very big hormonal changes that happen in pregnancy in the post partum period that are undoubtedly important, that major life transition to being a parent is undoubtedly important, the changes in the other relationships that you have, the relationship with your partner and your family… all of that is going to be important and what motivates our research to try and understand that is that very strong belief that actually we'll only really understand these conditions by understanding these illnesses and all of these different levels.

Bozo Lugonja: One of the things I want to ask you both about is this key difference between the "baby blues" and postnatal depression. There's a lot of people who tend to say, well, there is a general thought by some people to say, "Oh, it's just baby blues" or would have been previously. The baby blues is a thing, but it's not postnatal depression. Could you just, like, differentiate between them?

Professor Ian Jones: Yeah, when you think about the kind of mood conditions that occur in relation to childbirth. We do think about the baby blues, about postpartum depression, and actually something else called postpartum psychosis, I'll say something about. As far as the baby blues is concerned, this is a way of describing a very, very common experience that many women have. Some studies suggest 50%, some even as high as 60%, 80%. Those days in that week after a having baby, women can have very

changeable moods, and actually the blues is probably a misnomer actually, because for many women it's not even low mood that they have, but they can just have very labile moods, moods that change all over the place. An important point to make with the baby blues is it is not an illness, it is not a condition, it shouldn't be treated as such. By definition, it passes, it doesn't last a long time, but the important point is to make sure that those people that are looking after women at this time are aware that for some women it goes beyond that. For some women, it becomes more severe, and for some women, it can be much more long lasting. So picking up between those episodes of what we'd call clinical depression that can occur in those times and differentiating that from those kind of minor mood changes that happen to many women, if not most women, is really important, I think.

Bozo Lugonja: Laura, did you ever have any kind of difficulties in explaining your condition to friends or family who might have misinterpreted it, like Ian says, about as the baby blues or as something that is not postnatal depression or what was the effect in speaking to those who were close to you?

Laura Dearney: I think the hardest thing was telling my parents because it feels… it's so unspoken about and the more you speak about it the more people come out and say things like, "oh, actually… actually I've had this… I've done that… I know this person." Telling my mum was really hard, I remember. I can actually be there now. If I shut my eyes, I'm in my parents' kitchen, and my mum stood up next to me and my dad sat on the chair, and I remember her saying, "John, I think this is serious." And she automatically, and it could be many reasons, as I'd walked in with their first grandson, my child in my arms, or she automatically wanted to protect Jack from those words of postnatal depression, but the hardest thing was sitting down and explaining to them that I didn't hate Jack. Because that's what people assume. They think postnatal depression, you've rejected the child, you hate the child, and it wasn't… I hated me. I couldn't stand me. I couldn't function. I didn't like me. He was pretty awesome. Like, how did I create that thing? Like, look at him, he's alive. That is my victory, both children are still alive to date. But that was the hardest thing, because people assume you hate your child and you hear that word postnatal and they assume that you are going to try and **kill** your child off.

Professor Ian Jones: Is that a worry, do you think, Laura? Do you think people… do you think women are still not talking about the emotional symptoms…

Laura Dearney: Yeah, I think they're still scared.

Professor

Ian Jones: …that you experience because they're scared of having the baby taken away from them.

Laura Dearney: Yeah.

Professor Ian Jones: Is that a real… is the stigma still there…?

Laura Dearney: I think so, yeah.

Professor Ian Jones: …to that level that that's a worry?

Laura Dearney: I was involved in a perinatal discussion with the government recently and every single woman on the table all said the same thing. That apart from that we need a mother and baby unit in Wales, it was… we were all scared that people had written us off as loony, unable to take care of our child, and they'll take the child away. And it's things like that that stop women speaking about it until year afterwards, and that's brilliant that people are starting to talk about it and there are famous people starting to talk about it, but all the children now are like 7, 9, and I know I'm just as… I'm putting myself in that box, but if you can speak about it when you're in… like I did when I had Poppy and I stood up and I remember being in like a mother and baby group and I was like "I'm not coping" (I hated mother and baby groups). I remember just being like, "I'm not coping. My child is not sleeping through the night. My child is not impeccably dressed. I am not here with my hair done. I'm here and I'm not coping. I've got postnatal." And about three other mums just went "oh, my God, us too. This is the first time that we've put on, like, clothes in 4 days." And talking about it then, that's when like the camaraderie needs to happen. Like it's all lovely that we're being reflective and it's amazing that it's being put in the press, but the fear is real once you have a child. Like, for starters, you're trying to keep a small person alive. You are on sleep deprivation and you are just… it's the hardest… it's the most wonderful and hardest time. It's the most wonderful when I've got my tablets, but it's hard. And people are scared because it's so not spoken about. They don't what the repercussions are.

Professor Ian Jones: And it sounds to me from the moving story you told before was it was only when you could talk to somebody you can tell your doctors and, you know, that you got the help that you needed, and that help. The other thing that was really interesting from what you were saying, I think, is that that help wasn't just medication. That, from what you're saying, sounds like medication was a help for you, but it was somebody to listen to you, somebody to be there…

Laura Dearney: Somebody to tell you you're not… you are, but you're not crazy, kind of like the whole "it's okay, you're one in four." It was that conversation. There's what, three of us in the studio. One in four is like… it's a huge figure. Jack says it perfectly. We've all got brains.

Professor Ian Jones: So what's your message to women that are worried about admitting that they're not…

Laura Dearney: It's stronger to talk about it than to hide it.

Professor Ian Jones: Okay.

Laura Dearney: You're not weak. You're pretty kickass. Because if you're struggling with your brain and your, like, child is still there functioning and you are being a mum and everyone things that you are completely coping and you feel like inside you're falling apart, you're like an ultimate warrior. You've got like 100% success rate of your really bad days. It's really strong what you're doing, but it's not weakness to ask for help.

Bozo Lugonja: Do you have any ideas on how we could encourage women to speak out? I mean, the things that you do, I mean, Laura's helped NCMH out at countless event and is actually one of our research champions, we could ask you about that in a second as well. How can we get more women to speak about these things? And I think it is interesting point as well for Ian to perhaps say something as to how can we get people to speak more about their mental health, and whether they've had mental health conditions or not, how can we get the conversation going? Are we anywhere near beating the stigma associated with the mental health conditions? Do we still have a lot of work to do? Is postnatal depression one of the areas in which we're making more strides than other areas perhaps?

Laura Dearney: I think I'm going to hand most of this off to Ian, but one of the things that a mental health organisation and what no one here probably saw was when Ian was talking about it not being an emotion, of being an illness, I kind of put my arms in the air and did a bit of like a "yay" because we used the #SickNotSad for that very reason. I find myself saying that continually. Like this is not an emotion, it's not a choice, it's an illness. If it was an emotion, I would be, like, I would snap out of it. I never want to feel like I feel on my bad days. I think we still got a big fight because people still… I've got an amazing goddaughter, she is 16, and I'm like her allocated adult friend on Facebook, and there's things that go up like "Oh my, God, she was so bipolar last night" and it's like "hmm, really?" Like, bipolar is a serious illness, it's not the fact that one minute she's changed her mind to

that and the other. But I think with the work that Ian has done with people like EastEnders, where they portrayed Stacy's postnatal psychosis, was beyond helpful. I remember watching it and just being in tears. I've got a friend, a very close friend that had postnatal psychosis, and it was just… it could've been done really badly. I've seen many a soap where they've done something like postnatal depression or depression, and I've just gone like "oh, what are you doing? You're reinforcing some of these." I've had an argument with a magazine editor who wanted to change my story to be that I didn't like the kids, and I was like "no, no, I'm not getting involved with you. No, I'm not fitting your mould." We will never be doing work them because I ended up saying that they were reinforcing the stigma rather than doing what they wanted to do, which was fight it. But with EastEnders, Ian was involved in the script, so I'm going to hand over, and it was… she's an amazing actress, is it Lacey Turner?

Professor Ian Jones: Yeah.

Bozo Lugonja: Lacey.

Laura Dearney: She portrayed it wonderfully. There was no am-dram, and the fact that they got someone… a couple of people that are specialists in that area to help write it just that… that soap, the fact that… I very rarely watch soaps, but I sat down and watched that with my mum, and the fact that you got women and families all around the country talking about it, you know, there's the #RealLifeStacey that went on social media, the amount of women who suffered… I need a little soap box to stand on… who had postnatal psychosis, which is even less talked about that postnatal depression, was unbelievable. So I'm going to look up to Ian because it was spectacular. And Lacey, she won an award for it, didn't she?

Professor Ian Jones: Yeah.

Laura Dearney: Well deserved.

Professor Ian Jones: Actually, I think, working with EastEnders, coming back to that issue about stigma, one of the key people that really drove this was a woman called Clare Dolman, who is a woman with bipolar disorder who has got lived experience herself of postpartum psychosis. She, along with myself, went up and pitched the idea to EastEnders and then Clare sorted out for a number of women with lived experience of this condition to come and talk to the writers and the producers. And I think the BBC actually took a lot of credit and the producers of EastEnders because they really did take the importance of listening to help who had gone through this on board, and I think at the end of the day they're about doing a drama but they did take it incredibly seriously. I do think that in the area of perinatal mental

health that we are doing some really excellent work here, dealing with stigma. I've worked with the Maternal Mental Health Alliance in the UK who are doing some fantastic work to push for better services for women at this time and an incredibly key component of what they do, including Emily Slater who has been the director and is leading that, is it is women with lived experience. Emily has had a severe postpartum depression herself. What working with those women has taught me, what working with Laura has taught me and other research champion is the incredible importance of people who have lived through these conditions, the power of lived experience is massively higher than people like me, clinicians, researchers. We can waffle on all we like, but actually it's the real stories of real people that get through to people, that help people understand that actually this is not something to be ashamed of. That this isn't any different from any other health condition. And that's where we need to get to. That's where we need to be. You know, we sometimes use this term _____ with physical conditions. We have to get to that. I just give a clap back to Laura because I think that actually it's people like Laura who are prepared to talk about their experiences in a way that shows that this isn't something to be ashamed of that has a massive impact, so well done.

Laura Dearney: Thank you. We've started with the organisation I run. We only use real people. And it's always nice to hear someone that — I don't need anything when I say this — but someone that I completely respect, not only in your field but as a person, we've done quite a lot of work together, to reinforce that. We've been collating their stories and we only use their words because it is much… a stat is wonderful but you know what? Giving someone a face is even more powerful, because it shows that it's not a random person.

Bozo Lugonja: Do you also think that it's about perhaps changing the language behind mental health and changing the terminology behind mental health to make it more acceptable as part of becoming more of kind of like wider social topic? We could do away with terms and things like crazy or nuts or…

Laura Dearney: I think we own them.

Bozo Lugonja: Yeah.

Laura Dearney: Like I'm happy… I randomly am like "I'm nuts." And especially at the school gate, if they don't know me, they go like "heh" and I'm like "oh no, I've got the prescription to prove it" and what's brilliant is my doctor, his son is in the class next door to mine, and he sometimes goes "she has." I think the thing that need to be is that people need to realise it's just health, and as Jack, he is 7, he's like "you've got a brain, it's part of your

body. You've got a heart, it's part of your body. You've got a knee, it's part of your body. You don't sit there and go 'I've got bad knee health today.'" And he's 7. And you sit there going "how does he get it and so many don't?" It should just be health. They're learning in schools to look after their bodies, why aren't we looking at looking after their brains.

Professor Ian Jones: Actually, the rest of medicine can learn a lot from mental health as well. There are psychological, there are social, there are political impacts on health across the spectrum, whether what we feed our kids, the school dinners, what we advertiser, all of these have impact on people's cardiovascular health. It's not just mental health. It's this kind of left field thing where all of these things are important. And that's my… I do think sometimes we get… and I know language can be important, and people can take offence and things, and we need to get these things right, but actually we need to move beyond that because it is more important than just the language we use.

Laura Dearney: Yeah, I'm okay if somebody calls me crazy.

Professor Ian Jones: You have to get to the stage where mental illness, mental health conditions, however, we want to, whatever label we want to use, where they're seen as problems that we can understand better, and actually that's where it comes to research, that's where the research we're doing is so important, I think, because actually we really are only going to really change attitudes when we can show that these are conditions that we can understand and that we can do something about, we can prevent and we can treat. And so the more research that we do along that line, for me, that's the key to take this going forward.

Bozo Lugonja: So talking about treatments and research, two really obviously important topics, very interesting topics. If we talk briefly about treatments, you said that you are on medications…

Laura Dearney: Yes.

Bozo Lugonja: There are other treatments available, obviously for different people…

Laura Dearney: There are.

Bozo Lugonja: There is unfortunately still stigma around taking so-called pills or whatever…

Laura Dearney: Oh yeah. You take tablets, you're a bad guy. You don't take tablets, you're a bad guy. You do CBT, you're a bad guy. You don't do CBT, you're a bad guy. You do talking therapy, you're a bad guy. You don't talk to… I get so frustrated because… and I can say this as I've checked this out with one of my friends who has a diabetic child, but you don't judge someone for taking insulin.

Bozo Lugonja: Yeah.

Laura Dearney: You don't judge someone going "I don't want to do radiotherapy, I want to do palliative care." So why do you judge me for trying to treat my chemical imbalance through tablets? Because it's not just tablets. I actually… I don't look it, but I go to the gym, and when I don't go to the gym, my mental health wavers. And it's because it's illness, it's not mental, it's not physical, it just happens to be that the imbalance portrays itself as depression. And if I had an insulin imbalance and I didn't take my insulin because it was frowned upon, people would be up in arms, so why are people up in arms when I take a tablet? I always say that medication isn't for everybody because there are levels of… I'm looking at Prof and hopefully… the thing is, the brain is complex, so some medicines work for some people and some don't, and you shouldn't just go… I agree sometimes tablets are handed out easy, but work out what works for you. If I feel really good, I forget to take my tablet and then I go on a downer. And my husband can read it, like within seconds, he's like "you didn't take your tablet for the last 2 days, did you?" And I'll go "I'm sure I did, I'm sure did." They need to have all mental health treatment as tablets needs to have the days on because I forget. He'll know if haven't been to the gym and if I haven't taken my tablet because I'll just go downhill. So it's something that I can record that it helps, if I make sense. But if someone else takes the same medication as me, it might not help them because our brains are different. And that's the thing that people need to remember, in the same way that if we had the same… we both wear glasses, just because you can't see us, I've taken mine off, we need different lenses. It's just because it's the eye it doesn't mean that it's the same.

Bozo Lugonja: One size fits all.

Laura Dearney: Yeah.

Professor Ian Jones: Yeah, I think the important thing is what works, yeah, and we know that there's really good evidence that medication can help some people with some conditions, and there shouldn't be a stigma involved. I'm really pleased to hear Laura saying that. On the other hand, we need better treatments. We need treatments that don't have as much side effects as

we have at the moment. And the other thing we need is ways better of predicting who is going to respond to what treatments because sometimes in mental health, in psychiatry, it's just a long case of trying different things. Actually the area of pregnancy and childbirth is an area where there are particular issues with taking medication. It's an area where…

Laura Dearney: It's really complex.

Professor Ian Jones: …where there are some really difficult decisions that some women have to face about whether to carry on or to stop medication in pregnancy with some unknown impact.

Laura Dearney: And then afterwards with breast-feeding because some tablets go through to milk and some don't and you can get… one of my friends taw told by the drugs council that it didn't go through and her doctor said it did, and then she just had an appointment where she was like "I don't want to but for my own health" because if she is not healthy, the baby is not going to be healthy. She stopped breast-feeding early and it had a massive effect on her.

Professor Ian Jones: So I think there are some really difficult decisions to make and it is a matter of weighing up those risks, those benefits, and looking at all the options available because we know that there are medications that can be really helpful for depression but there are other treatments as well. There are talking treatments. There is CBT and other things that can help. The other thing I feel very strongly about is that often pregnancy and breast-feeding are reasons to take women out of studies, their exclusion criteria for studies, and actually there's not much work done specifically looking at these conditions and what treatments can help. So I think that's a real area. There's been a very encouraging study just recently published, very small study, that looked at postpartum depression and looked at giving kind of hormonal infusion and it was in very small numbers and it needs to be replicated and further work needs to be done, but I was really encouraged by that, was that there were researchers out there that were targeting… saying actually not postnatal depression, something that will take out of our studies but actually will do some research specifically to try and understand what can help treat this particular condition.

Laura Dearney: Wow. Because it's a long 9 months, 10 months, 14.

Professor Ian Jones: It's difficult. And these are very difficult decisions that clinicians and women have to make about carrying on stopping treatment.

Bozo Lugonja: I think that's a really good point to talk about research. Obviously if we talk about any papers during this podcast we will try and make them available to anyone who's interested. You can get in touch with us by going to the NCMH website, ncmh.info, or checking this out on Twitter or Facebook, again just type in NCMH or MRC Centre Cardiff. The NCMH is actively involved in research. We are actively collecting and recruiting participants. Laura is one of our awesome participants, as is one of your children.

Laura Dearney: And my dad.

Bozo Lugonja: And your dad.

Laura Dearney: I think we were the first three-generation family.

Professor Ian Jones: Fantastic.

Bozo Lugonja: Fantastic. That's a total family affair.

Laura Dearney: And I've just found out Poppy's allowed to done DNA, so she'll be down next week, I'm sure.

Bozo Lugonja: So, Ian, if you could tell us a little bit about some of the work that NCMH is doing and if anyone is interested as a result of this podcast to become a volunteer or a participant or is just interested in collaborating with us as a researcher, we're more than open for that so…

Professor Ian Jones: So in NCMH, one of the most important things that we're doing is to build a group of people with mental health conditions who are working with us to try and understand these conditions better. In NCMH, we are interested in hearing from people who've had any mental health condition or even no mental health conditions because it's actually it's very useful for us to have the help of people who may be have not suffered themselves and to have them available for controls for study. We have recruited in now well over 7000. 7500 or more, it goes up all the time, which is fantastic, as well as hugely thanking Laura who is sitting here as a representative of all those people. I just really want to thank all of those people because it is something that we are strongly believing in the NCMH is that it's only through research that we're really going to make the major advances that we can to make things better.

Bozo Lugonja: Absolutely.

Laura Dearney: Completely.

Professor Ian Jones: The help that we ask for people, people can sign up on our website, they can give consent to be part of our NCMH family and they can fill out some questions and give some details about their mental health, and then for certain people we'll contact them if there are particular conditions that we're researching at the time, for example postpartum mood disorders is one of those at the moment, that we'd be very interested to hear people from, then perhaps a member of our research team would come out, who are a lovely bunch of people, and Laura can confirm that…

Laura Dearney: They are lovely.

Professor Ian Jones: … and can see people in their own home, can take a fuller, more information. One of the things that we talked about before and one of the things I was very keen to point out was that we need to understand these conditions at all levels, from the biological, the psychological and the social, so we do a lot of kind of psychological assessments and ask questions about social factors, but also we take blood at the moment for…

Laura Dearney: …and spit.

Professor Ian Jones: …or saliva so that we can look at, as Laura was saying about it, to collect DNA from so we can look at the role that genetic factors undoubtedly play in making some people more vulnerable or less vulnerable to these conditions. So we're taking that kind of holistic approach. We're asking for the help of anybody, but there are some particular conditions that we are very interested in, and postpartum mood disorders are ones that if people have suffered postpartum psychosis or postnatal depression want to get in touch, we'd be really interested to hear from them.

Bozo Lugonja: Fantastic. And as Ian says, we are looking for samples from participants and I'm actually the person that handles those samples so I can say it's handled very, very to the highest standard going.

Professor Ian Jones: That is true.

Laura Dearney: Your boss is sat next to you.

Bozo Lugonja: My boss is sat next to me here. He also knows what I'm doing today. So I think a lot of what we've spoken about is great. I mean, one of the things… last couple of questions I suppose I'd like to ask is in regard to the genetics, because of what we do with NCMH and the MRC Centre is whether there's anything being uncovered with regard to genetics in postnatal depression. And secondly to ask you both where you see the field of postnatal depression going? Are we on an up? Is it an optimistic future that we can hopefully beat some of these stigmas, get more people involved in research?

Laura Dearney: I always think it's on an up. We're talking about it, so…

Professor Ian Jones: …which is very good.

Laura Dearney: Like how many years ago this wouldn't have happened.

Bozo Lugonja: Exactly.

Laura Dearney: This is going to be available for anyone to download and that's huge. I also think that one of the many reasons I think it is on the up is I spoke at the midwifery conference recently and they're realising what they've known for ages. People underestimate the fact that midwives know this stuff. But they are starting to get the support to be able to do more mental health training as midwives, because having that support earlier will help so many women. Because the midwife is the port of call. I think we're heading in the right direction. I'd like to think we're heading in the right direction. I'm going to keep standing on my soapbox until we're going in the right direction.

Bozo Lugonja: We'll keep giving you microphones.

Laura Dearney: Yes, I love a microphone.

Professor Ian Jones: So taking those two questions, I'll come back to what Laura just said then, but just questions about the genetics.

Bozo Lugonja: Shoot.

Laura Dearney: That's got to be you.

Professor Ian Jones: One of the things that we can have a world reputation in Cardiff and in Wales is that doing genetic research. In some areas of psychiatry, in schizophrenia, bipolar disorder, ADHD, and others, there have been some really incredible advances and we are identifying those genetic factors. You know, individually only nudge risk up or nudge risk down a little bit, but identifying those is helping in giving us an understanding of what the biology of some of these conditions is. So it's really exciting time in psychiatric genetics. What's been clear is because of the complex nature of this, as we've talked about, because everybody is different, we need incredibly big numbers of people in studies. One of the benefits that has been in recent years is that we've linked up with research groups around the world doing this work, and that's been a fantastic example of how researchers are not competing with each other but researchers coming together and has really advanced things. It takes samples of tens of thousands in order to be big enough as to be really confident that we can identify these genes. We have those samples for some conditions. For the postpartum conditions, for postnatal depression, for postpartum psychosis, we don't at the moment, but we are putting those samples together. We're collaborating as part of what is called a pact consortium. We're working with groups around the world to try and build those samples. So I can only emphasise again, if people listening have experience of postpartum illness, of postnatal depression or postpartum psychosis, then to get in touch with us in NCMH and become part of this family that's trying to do the work and we really will try and build that sample.

Bozo Lugonja: Yeah, so just to reiterate what Ian is saying, if you are interested in any of the work we do, get in touch with us, @NCMH or @MRCCentreCardiff on Twitter. Facebook and Twitter pages. Email us as well, ncmh.info. We will have a few more faces. Our communications guy, Paul, is looking at me through the glasses and he is the one who will answer your emails as well. So you can get in touch with us about anything that you hear or if you're interested in any of the work that we do. We can only read you the work that we do with our participants. If it wasn't for our participants, we would not have a centre to be able to do any of the research that we want to do. I think now is a great time to end things. Just to say a huge thank you to both Laura and to Ian for taking time out of their very busy schedules to actually sit down and have this conversation. I really hope that it's given whoever is listening or anyone an opportunity to learn a little bit more about postnatal depression and learn about some of the work that NCMH does and hear Laura's story as well. And ultimately, if it's broken a stigma down or it's enabled anyone to come out and speak about their experiences, I think that'll be a fantastic achievement for everyone. So again, if you're interested, if you want to get in touch with us, please do. There are other charities, Mind, _____. There's lots of resources on our website. Thank you very much for listening and hopefully you hear from us soon.