Introduction to Women's Health

[music] >> Welcome to The Trip Lab, kitchen table conversations about integrative medicine and psychedelics. [music] I'm your host and attending physician, Dr. Mariella Wood.

Hi everyone. Welcome back to another episode of The Trip Lab. In today's episode, we're diving into a topic that I am personally very passionate about and that a lot of my day-to-day work centers on. But surprisingly, I have not devoted a full episode to this area yet. And that's women's health. It is a fascinating, beautiful, and obviously important area of medicine. And today, I want to explore it through a lens that gives it its true justice.

So yes, we are going to talk about hormones because hormones are essential. They play a huge role, but they are only one part of the story. And I think one of the biggest problems in women's health is that we have far too often just stopped there. So what I want to do in this episode is sketch a broader model. So a model of women's health that is not just hormonal, but also neuroendocrine, immune, metabolic, mind-body, and really just deeply connected to the rhythms of our lived experience.

So for a very long time, and truly still today actually, women were underrepresented in medical research, in many cases actually excluded from it altogether. So for decades, that left a huge blind spot in how women's health was studied, understood, and treated. So male physiology was often treated as the default. Drugs were studied in them and then broadly applied to women.

Additionally, the menstrual cycle was seen almost as a confounder rather than something worth understanding. So the result of that was generations of women that were left with a medical model that did not fully reflect the complexity of their bodies. Another key thing that I want to talk about, and I think no women's health podcast is complete in this day and age without discussing the hormone replacement therapy arc or HRT.

So hormone replacement therapy for perimenopause and menopause was used widely. Then, almost overnight actually, the conversation completely flipped. So after the Women's Health Initiative came out, fear around HRT spread quickly, and for years, many women were told that hormones were simply too dangerous. Now, thankfully, we are in a much more nuanced moment.

We understand that the story is more complex than that, and HRT has rightfully reentered the conversation as an important and often very helpful tool when used thoughtfully and responsibly. A quick side note though on that Women's Health Initiative that essentially blacklisted HRT. So the major data driving that initiative's conclusion was flawed.

So the average participant was 63 years old, which A is well past the onset of menopause, and we know that many risks naturally increase with age alone.

The formulations of HRT that they were using were also synthetic, so conjugated estrogens and medroxyprogesterone. So those are very different from the bioidentical hormone regimens and transdermal routes that are used more commonly by clinicians today. So because of those differences in age, timing, formulation, the risks were likely due in part to those confounding variables rather than the HRT itself. At least that's what we're now thinking. So now the black box warning has lifted, and we do now take a much more thoughtful approach. So HRT is definitely used more widely now.

But we also use more risk stratification, too. So we look at risks like estrogen-sensitive cancer and other factors, clotting disorders, and so on, so on.

So this is great. We need more talk on hormones, and I personally do prescribe them every day.

Hormones Beyond Reproduction

But I also want to invite us to take it one step further because women's health is not just a story of estrogen and progesterone. It is also a story of how hormones shape the brain, how they influence neurotransmitters, mood, sleep, cognition, pain, and emotional regulation. It's also a story of inflammation and metabolic function. So conditions like endometriosis, PCOS, IBS, and autoimmune diseases, and why so many of these conditions show up more commonly in women. I also want to talk about the mind-body connection and the ways that stress, trauma, rhythm, and physiology all interact. And I think thinking about women's health this way is an especially important framework when we talk about women who can't take hormones. So whether that's because of estrogen-sensitive cancers, blood clotting disorders, or other reasons, there are plenty of ways we can support peri- and postmenopausal women without HRT. So if they're not able to take it or just don't want to take it, there's lots that we can do. HRT certainly is a great option. I use it daily. But in this podcast, I want to talk about those other things. So we'll talk about all of that, and then we'll zoom out a little bit, look back in time a little bit, and think through how women have always been associated with intuition, cycles, the moon even. And we'll ask whether some of those older symbolic frameworks were, in their own way, pointing towards something really real about the rhythmic nature of the female body. And of course, we will briefly mention psychedelics, too, because there's some interesting aspects with women's hormones and psychedelics. But overall, what we're really going to talk about today is the complexity and beauty of the female body, mind, and spirit. So this episode is really an invitation. An invitation to think about women's health more broadly, more deeply, and more honestly. So let's just get into it. To start, I do think we have to talk about the hormones themselves because obviously they do matter a lot. So let's first get acquainted with some of the key players here. And I'm going to try to keep this high-level because as you can probably imagine, hormones can get really complicated. So I'm just going to give a little snippet of each major hormone so you can understand the landscape a little bit more before we go beyond hormones. So the first misconception that I want to bring up is when people only talk about estrogen and progesterone when it comes to women's health. Yes, they are important. They are major players here. But they're not the only ones that matter. Women's health is also shaped by testosterone, DHEA, thyroid hormones, cortisol and stress hormones, and also metabolic hormones like insulin. So even at just the hormone level, this is already a much bigger story than most people realize. So first, of course, estrogen. >> [clears throat] >> So it's not just a reproductive hormone. It influences the menstrual cycle and ovulation, yes, but it also supports bone health, brain function, skin, cardiovascular health, and even aspects of mood and cognition. So during the menstrual cycle, estrogen tends to rise in the first half of the cycle. It'll peak around ovulation, which is in the middle of the cycle, and then it does have a smaller rise again in the luteal phase before it drops off before the period starts. So what I really want to highlight is that rise and fall. That's the key with this one because estrogen interacts with neurotransmitters, affects serotonin and dopamine signaling, and can influence energy, mood, focus, and even pain sensitivity. So we'll get more into that later, but but that's estrogen. Next, of course, is progesterone. So this hormone rises after ovulation in the second half of the cycle. So progesterone is often thought of as the calming, stabilizing counterpart to estrogen, though of course the biology is not actually that simple.

So one of its core features is that it supports the uterine lining in case of pregnancy. So it's preparing the body for pregnancy to come. When a pregnancy doesn't happen, your uterus sheds its lining, which is your period.

But beyond that, progesterone also has important effects on the brain, especially through GABA-related pathways, which is one reason that it can influence calm, sleep, anxiety, and emotional steadiness. So if progesterone is low, whether due to anovulation, so not ovulating, or luteal phase dysfunction, which is essentially another term for progesterone dysfunction, women may notice more cycle-related anxiety, insomnia, mood changes, or PMS symptoms.

So estrogen and progesterone, of course, are two key players. And after menopause, they both decline significantly as the ovaries transition out of their reproductive years and are no longer the primary source of cyclic hormone production. But another misconception here is that these hormones drop to absolute zero. They actually do not. The body still produces small amounts of estrogen in peripheral tissues, particularly through conversion in adipose tissue and other extraovarian sites. So the postmenopausal state is actually not a no-estrogen state. It's just a different hormonal landscape with much lower and noncyclic hormone production. Next, we have testosterone, which I think is often underappreciated in women's health.

So women actually make testosterone, too, just in lower amounts than men do. And it plays a role in libido, motivation, energy, muscle mass, confidence, and overall vitality. So too much androgens, which testosterone is an androgen, signaling can contribute to acne, hair growth in unwanted areas, PCOS-type patterns, while too little can show up as low libido, low drive, or reduced resilience. Related to that is DHEA, which is an adrenal hormone and also a precursor hormone, which means that it can be converted downstream into androgens and estrogens.

So it sits at an interesting crossroads between adrenal function, aging, and sex hormone production. It does a lot, so we don't need to get overly technical here, but it is one more example of how reproductive hormones are connected to the adrenal system and the broader endocrine story.

Next, we have our thyroid hormones, which are incredibly important and often not emphasized enough in conversations about women's health. So the thyroid hormones regulate metabolic rate, energy, temperature regulation, hair, skin, bowel function, and menstrual health.

So, if thyroid function is off, women can experience fatigue, weight changes, constipation, hair loss, cycle irregularity, mood symptoms, fertility issues, and more. Next, we have cortisol and other stress hormones. So, cortisol is not actually inherently bad. It is actually essential for life. It helps regulate our stress response, blood sugar, inflammation, energy availability, and our circadian rhythm. >> [clears throat] >> But, when stress physiology becomes chronically dysregulated, it can start to influence reproductive hormones, ovulation, sleep, insulin sensitivity, inflammation, and mood. So, this is where stress comes in and can worsen PMS, contribute to hypothalamic dysfunction, aggravate perimenopause symptoms, and generally just make everything feel more volatile.

Last, just a brief mention of the metabolic hormones, so especially insulin. So, insulin is often thought of only in the diabetes conversation, but it's actually deeply relevant to women's health. So, insulin regulates blood sugar and energy storage, but if insulin resistance develops, it can also influence ovarian function, androgen production, inflammation, and weight regulation. So, one reason that insulin plays such a central role in PCOS and other metabolic patterns that overlap with hormone symptoms.

Neuroendocrine Signaling and Mood

So, just a brief overview here, there certainly are more hormones that we could talk about, peptide hormones, and a lot more, but I just want to give a small snippet here and really point out that hormones are not just about reproduction. They shape mood, energy, cognition, inflammation, metabolism, libido, sleep, and just overall resilience, and they don't act in isolation. They all move in relationship with one another and in relationship with the brain, the immune system, and the rest of the body. So, that's where we're going to go next because once we understand the hormones themselves, the next step is realizing that they are not just affecting the ovaries or the uterus. They are helping regulate the brain along with the body.

So, I think we far too often classify medicine in general into boxes. So, we have the endocrine system, which is hormones, the nervous system and neurology, but in reality, the endocrine system and the nervous system are in constant conversation. So, we call that to the neuroendocrine system. So, it's a whole slew of things that involves an ongoing dialogue between hormones, the brain, neurotransmitters, stress signals, and the rest of the physical body. So, just as we did a little overview of the hormones, I do want to give an overview of some neurotransmitters. So, first to define that term, neurotransmitters are chemical messengers that help nerve cells communicate with each other. So, they help shape mood, motivation, reward, calmness, alertness, learning, pain perception, and just the overall tone of our internal experience, and hormones influence neurotransmitters, sometimes by changing how much is made, sometimes by affecting the receptors, and sometimes by changing how responsive the brain is to them. So, we'll just define a couple here. Want to talk about serotonin, dopamine, GABA, and glutamate. So, we'll start with probably the most well-known one, which is serotonin. So, this is often called the {quote} "happy molecule", but really that is far too simple. Serotonin is really helping regulate the brain's emotional volume control.

It stabilizes brain regions involved in threat detection, emotional salience, and helps us keep stress and emotional pain in proportion, and estrogen supports this system by upregulating serotonin receptors and strengthening serotonin signaling. So, this is one reason that many women may feel more like themselves after their period as

estrogen is rising. It also helps start to explain why in the luteal phase, so the second half of the cycle when estrogen is dropping, many women can feel emotionally sensitive. Next, we have dopamine. So, dopamine is often thought of as the neurotransmitter of pleasure and reward, but of course, like serotonin, that really is only part of the story. I think dopamine is really about drive.

So, it helps regulate motivation, focus, interest, reward, and that sense of energy that makes you want to engage with life. So, if dopamine signaling is supported, many women may feel more motivated, more mentally sharp, more confident, and more interested in connection, work, movement, or sex.

Estrogen helps support dopamine signaling as well, which is another reason why rising estrogen can sometimes feel energizing, clarifying, or even socially activating, and of course, when estrogen drops, some women notice the opposite. So, less drive, less focus, and a general sense of feeling flatter or just less engaged with life. Next, we have GABA.

So, GABA is the brain's main calming neurotransmitter. It helps quiet neural activity, settle the nervous system, and create that feeling of exhale. So, the sense that you can soften, rest, and not be so on edge. So, this is where progesterone enters the picture.

So, as progesterone rises after ovulation, it is actually metabolized into compounds that enhance GABA signaling, which is one reason why progesterone can feel calming and why many women taking progesterone on HRT notice better sleep. But, I do want to point something out. So, as we talked about previously, progesterone rises in the luteal phase, so that's second half of the cycle before you get your period, and even though progesterone is rising, which ultimately enhances GABA signaling, many women actually feel more anxious, irritable, or emotionally reactive in the luteal phase. So, that may be due to low progesterone.

It could also be that the brain responds abnormally to otherwise normal hormonal shifts, especially as progesterone metabolites change and estrogen support begins to fall.

So, my point with all of that is that most of these hormones are not just a story about high or low progesterone, high or low estrogen. It's really about how the brain is responding to the changing hormonal environment. So, with all that, let's take those neurotransmitters, let's take those hormones, and let's look at some actual conditions that women experience. So, first we'll chat about PMDD, or premenstrual dysphoric disorder. So, I think this one is a perfect example of how the story is not just high or low hormones.

So, PMDD is characterized by severe mood changes in the weeks prior to the period. So, often severe depression, severe anxiety, so much more than the mild mood swings we expect with just regular PMS.

So, in some women, this may be a hormone imbalance. It may be poor ovulation, a weaker progesterone rise, or broader hormonal imbalance, but what we actually see in clinical practice is that many women with PMDD actually have hormone levels in the normal range.

So, in those cases, the issue is often that the brain is unusually sensitive to the hormonal transition itself, especially in that luteal phase. So, again, as progesterone rises, we expect GABA signaling to increase, but in PMDD, that might not be happening.

So, instead of creating calm, the receptor system appears to respond abnormally, and emotional circuits in the areas of the brain like the amygdala may actually become more reactive, while frontal regulatory control is less effective. That means that the brain is more likely to register stress as threatening, emotions as intense, and small frustrations as disproportionately big. At the same time, estrogen support is shifting, too, which can reduce some of the serotonin stabilizing effect.

So, if the problem is actually weak ovulation or a poor progesterone rise, then supporting ovulation or giving progesterone can help. But, if it's more of a neuroendocrine disruption, then we need to look at reducing other factors that make the nervous system more reactive and less resilient to hormonal shifts. So, things like blood sugar instability, inflammation, poor sleep, chronic stress.

Magnesium is a great supplement that may help because it supports nervous system regulation and actually has evidence for improving premenstrual symptoms. SSRIs, the medications, can also help many women with PMDD because they rapidly improve serotonergic signaling and also appear to affect neurosteroid signaling.

So, some people will be on these just during the luteal phase, so the second half of the cycle, and then of course, the mind-body piece matters, too.

PMDD and Perimenopause

When the autonomic nervous system is chronically activated, the brain is already closer to that threat mode, so normal hormonal fluctuations are more likely to feel intolerable. Next, perimenopause is another perfect example of why women's health has to be understood through a neuroendocrine full-body lens. So, people often talk about it as simply a low estrogen state, but again, of course, that's not the whole story. Perimenopause is actually a state of hormonal unpredictability. So, estrogen does not just quietly decline in a straight line as we go from our cycle years to our postmenopausal years. It actually swings, and it can swing very rapidly, which is what causes a lot of the symptoms.

So, ovulation starts to become less consistent, which means progesterone can become less reliable, too. So, essentially, the brain is no longer getting that same steady, rhythmic hormonal signaling it had been used to for years. So, that means that estrogen, which supports serotonin and dopamine signaling, and progesterone, which helps shape GABA, also fluctuate, which really impacts mood, sleep, anxiety, focus, motivation, and stress tolerance in very, very real ways. So, perimenopause, menopause is so much more than just hot flashes.

For many women, it feels like their emotional wiring, resilience, and even sense of self has become very less predictable. And then, of course, the rest of the body gets pulled into the story, too.

So, vasomotor symptoms can disrupt sleep, and poor sleep by itself makes the brain more emotionally reactive, less resilient, and more sensitive to stress. These fluctuating ovarian hormones can also interact with the HPA axis. So, essentially, our stress system is becoming less stable at exactly the same time the brain is losing some of its familiar hormonal buffering. So, if we can target much more than just hormones for perimenopause and menopausal women, we can start to treat the system and get them feeling a lot better. So, those were just a couple of examples of how women's health can really be seen through a neuroendocrine lens.

But next, and certainly related, is another major player, and that is inflammation. So, inflammation, I feel like that word is everywhere now, but I really want to slow down and talk about what it actually is. Inflammation is part of the body's protective response. So, if you get a cut, catch a virus, sprain your ankle, or have any kind of infection, the immune system activates and sends out signaling molecules, which then recruits immune cells, which then help repair the tissue. So, this acute inflammation is not bad. It's actually essential. But, inflammation can also become chronic and low-grade. So, instead of being a short, targeted response, the immune system stays slightly activated in the background, and we see this with chronic stress, poor sleep, metabolic dysfunction, repeated environmental exposures, visceral adiposity, which is internal fat in the abdominal region, persistent gut barrier disruption, ongoing infections, or just a lot of other signals that the body interprets as danger or imbalance. And chronic low-grade inflammation is now actually understood to play a role in a wide array of diseases, including cardiovascular disease and neurodegenerative disease. So, other things that aren't, you know, overtly inflammatory illnesses like inflammatory disease, for example. And even in cardiology, markers like high-sensitivity CRP are used now to look at inflammatory cardiovascular risk, which I think tells you how mainstream this idea has become. So, bringing back inflammation into women's health, chronic inflammation can alter insulin signaling, ovarian function, pain pathways, immune behavior, neurotransmitter function, and tissue level signaling. So, it can amplify symptoms, worsen metabolic dysfunction, and make hormone-sensitive systems much more unstable.

So, we'll look at a couple examples here. We'll start with PCOS, or polycystic ovarian syndrome. So, to start off, that name tells us something important. So, this is a syndrome, not just one single disease process. So, clinically, PCOS is diagnosed when a woman meets two out of three criteria: irregular or absent ovulation or periods, signs of excess androgens like acne, hirsutism, or elevated testosterone, and polycystic appearing ovaries on the ultrasound. So, if you have two out of those three categories of criteria, you technically meet the diagnosis for

PCOS. But, I want to pause there, because what I think is so interesting is that if we treat PCOS too rigidly as a fixed diagnosis, we're actually missing the deeper physiology.

Again, remember it's a syndrome, because very frequently, a woman may have irregular cycles and acne, so technically meeting the criteria at one point, and then later have regular cycles. So, technically, if they were evaluated at that point in time, they wouldn't, quote unquote, fit the diagnosis in the same way. We also see ultrasounds looking different at different points in life, too. So, I think that doesn't mean the underlying physiology has disappeared, but I think we really need to look at PCOS as a broader hormonal, metabolic, and inflammatory pattern that can express itself differently over time. So, again, that word syndrome is getting at a lot. It's a cluster of tendencies and signals, so not just a static state.

Inflammation, PCOS, and Endometriosis

And actually, the international PCOS guidelines also describe PCOS as a heterogeneous condition, which I think fits that more dynamic view. So, at its core, PCOS is often a hormone story, a metabolic story, and an inflammation story all at once. One of the biggest drivers we've discovered is insulin resistance. So, when the body is less responsive to insulin and insulin levels are rising, that higher insulin signaling can push the ovaries to make more androgens, while also interfering with follicle development and ovulation. And at the same time, many women with PCOS also have chronic low-grade inflammation, which can further worsen insulin resistance, amplify androgen signaling, and just reinforce that whole cycle. So, conventional treatment often uses oral contraceptives to override the system to regulate bleeding and to reduce androgen symptoms.

And that can be really helpful for a lot of women. But, if we just stop there, I think we miss a lot of the deeper drivers. I think it's really important to dig deeper, ask more questions. Which one of those factors is pushing patterns in the first place? Is it the insulin resistance, chronic inflammation, going further back, is it sleep disruption, high stress load, excess visceral adiposity, poor nutrition, sedentary lifestyle? So, lots and lots that we can look into. So, many integrative treatments will certainly incorporate things that traditional medicine does, like like oral birth control pills, metformin, or spironolactone, but we also look deeper into nutrition, movement, sleep, weight management when appropriate, reducing inflammatory burden, possibly using targeted supplements like anositol in selected patients, and supporting the broader metabolic environment, so the ovaries are no longer operating inside that same dysfunctional signal. Next, we have endometriosis.

So, this is a condition in which tissue, endometrial tissue, which that is the lining of the uterus, is found outside of the uterus, often somewhere in the pelvis, but it can be anywhere. It can be on the bowel. There's been case reports of it being in the lungs. It can really be anywhere. So, essentially, any endometrial tissue that is outside of the uterus. So, that's the technical definition, but I want to talk about it a little bit deeper, because it's not just a structural or gynecological problem. It's also inflammatory, immune, hormonal, and neurological. So, a lot of systems start interacting in the wrong way at once, which causes that endometrial tissue to grow where it's not supposed to grow. So, estrogen is stimulating the growth and survival of those endometriosis lesions. We have the immune system that does not clear that tissue as effectively as it should. Inflammatory cytokines start to build up in the pelvic region. Immune cells like macrophages stay activated rather than go away.

And over time, that inflammatory environment can promote pain, scarring, fibrosis, and ongoing tissue irritation. So, it really is not just the uterine tissue is in the wrong place. It's a chronic inflammatory microenvironment shaped by abnormal immune surveillance, estrogen-responsive tissue behavior, and persistent pain signaling. So, that broader way of thinking about it also helps explain why endometriosis is often so much bigger than just pelvic pain alone. Many women also experience bloating, bowel symptoms, fatigue, infertility issues, pain with sex, low back pain, and a kind of whole-body strain. So, if we think in systems, this makes a whole lot more sense. Chronic inflammation affects more than just one tissue. Ongoing pain can sensitize the nervous system. The immune system, the gut, the endocrine system, and the brain all start getting pulled into the picture here. So, that's why endometriosis often feels like a whole-body condition to many women, because it really is. And so, just like with PCOS, treatment can be approached at different levels.

Conventional treatment may involve hormonal suppression or surgery, both which can be incredibly important. We can also look at what else is driving the inflammatory terrain. How can we reduce inflammatory burden?

How do we support gut health, pain regulation, sleep, and nervous system resilience? How else can we think about estrogen signaling, immune activation, and the chronic stress of living in pain? And there's a lot that we can do for those things. So, naturally, what comes next from inflammation is to think about autoimmune disease, because autoimmune conditions are much more common in women than in men. So, female physiology is not just hormonally distinct, but immunologically distinct, too. Women tend to mount much stronger and more responsive immune reactions, which can be protective in some contexts, but that same responsiveness may also make the immune system more likely to lose tolerance and start reacting to the self, which is what autoimmune disease So, estrogen can amplify certain immune pathways, and the X chromosome carries a high density of immune-related genes, some of which can be more active in women. But, I think when we ask why autoimmune disease is more common in women, the answer is probably not just one isolated cause. Really, the female body is built around a more dynamic, responsive immune terrain, and that responsiveness comes with both strengths and vulnerabilities. So, I think this should change how we think about the treatment, too. If women are more prone to immune dysregulation, we have to think about what impacts that immune system. And that would be hormones, stress physiology, gut integrity, environmental exposures, and a lot more.

Autoimmune Disease and IBS

So, when we treat autoimmune disease, of course, we have our conventional treatments like immunosuppressive therapy, that can be absolutely life-changing. But, what I want to invite is what else can we be doing alongside of that? So, not in replace of it, but alongside of that. And I think overall, that's one of the deeper themes of women's health that I want to really get across. Women are often treated through isolated categories. Hormones over here, immune over there, anxiety in another box, IBS somewhere else.

But the body is not actually organized that way. All of the systems are talking together. So, we really need to look at the whole woman body as a beautiful intertwined system. So, I briefly mentioned IBS. So, let's talk about that one, cuz that's another that is more common in women. So, we now consider IBS, so irritable bowel syndrome, different than irritable bowel disease, which is an autoimmune condition. So, IBS, irritable bowel syndrome, is a functional GI disorder. So, we can really think about it as a disorder of gut-brain interaction. So, this means that the problem is real, but it's not always a structural problem. So, it lives in signaling between the nervous system, the gut, the immune system, the microbiome, and the brain.

And this is not just an integrative lens. The Rome criteria and the American College of Gastroenterology now frames IBS this way. So, a biopsychosocial model rather than just a structural one. So, let's chat a little bit about that gut-brain axis. The gut is not just a passive tube.

It actually has its own nervous system. And it communicates through the vagus nerve and other neural pathways. And it actually shares chemical messengers like serotonin. And it's constantly exchanging information with the brain through hormones, immune signals, microbes, and the autonomic nervous system. And normally, the brain filters most of that communication out, so it doesn't go to your conscious awareness. Otherwise, we would feel every contraction, every shift in the gut, every meal moving through us.

But in IBS, that relationship, that connection, actually becomes dysregulated. The gut actually becomes more sensitive. Motility can change. Pain signaling is amplified. And stress can start to show up in the gut in a very real and actually physiological way. This is why IBS is such a mind-body condition. Not because it's imaginary, but because the mind and the body are genuinely interacting there all the time. And we have mind-body treatments like gut-directed hypnotherapy and other gut-directed psychotherapies that are actually now in mainstream GI guidelines, because they have been shown to meaningfully improve IBS symptoms.

So, of course, bringing this back to women's health a little bit more, we already mentioned that IBS is more common in women. So, of course, we want to ask bigger questions. How are our hormones affecting gut motility and visceral sensitivity? Again, we have stress, the immune system, the microbiome. Again, everything connecting together. And when we start asking these questions, we start to see why gut-directed hypnotherapy, nervous system regulation, trauma-informed care when relevant, and mind-body practices can be so powerful. So, with all that being said, I do want to shift the conversation a little bit here. I want to soften a little here, because women have always understood themselves through rhythm, long before medicine tried to understand them through lab

values. So, long before we had hormone panels or cycle tracking apps or even language for that neuroendocrine system, women were already living inside a wisdom of phases, rising, blooming, releasing, withdrawing, and beginning again. The menstrual cycle was not just seen as biology, but as rhythm, as relationship to nature, as an inner calendar. And I think it's pretty fascinating that the average cycle mirrors the moon more closely than the modern calendar does. The average cycle is not 30 days, it's 28 to 29 days. It's not neat and linear, but rather, it's cyclical, shifting, and alive. And there's something about that that just feels deeply feminine to me.

And across time, women have also been understood through archetypal phases.

Cycles, Archetypes, and Psychedelics

One of my personal favorites is the maiden, the mother, and the crone. Not as rigid roles, but as different expressions of feminine power. So, the maiden as the becoming, curiosity, and emergence. Then we have the mother as creation, devotion, fullness, and holding. And then the crone as wisdom, discernment, and inner authority. The woman who has passed through fire and no longer needs to explain herself. So, whether or not we take these literally, they really speak to something that modern life often forgets. Women are not meant to be static. We are rhythmic. We are seasonal. We are intuitive. We are always moving through small deaths and rebirths and beginning again. And I really want to honor that and think about that as part of healing women's health. So, not just regulating symptoms, not just {quote} {unquote} balancing our hormones, but remembering that there is always something sacred in the cyclical nature of the female body.

And I think this is where psychedelics can start to enter the picture, too. Psychedelics can open altered states. They heighten sensitivity, deepen embodiment, and bring people into contact with emotion, memory, intuition, and meaning in a completely different way. And when you think about women as already being cyclical, relational, and deeply responsive beings, it raises so many fascinating questions.

How might different phases of the menstrual cycle shape a psychedelic experience? Because as we talked about, we know that estrogen increases serotonin receptors, the very receptors that psychedelics act on. We can also start to dig deeper into perimenopause, menopause, or other shifts in the hormonal terrain, and how those changes may change the way these medicines, these psychedelics, are felt in the body and the mind. There's also a role in how psychedelics intersect with healing around sexuality, body image, motherhood, grief, trauma, and identity. And really, we are only at the beginning of this conversation. And I think that's a really exciting place to be. There's still so much that we don't know. And so much beauty that may still emerge for us to discover. I'm definitely going to do a full episode on women's health and psychedelics specifically.

But for now, if there's one thing that I hope this episode leaves you with, it's that women's health deserves a more complex framework. One that honors hormones, yes, but also the brain, the immune system, inflammation, metabolism, rhythm, and lived experience.

Women are beautifully complex. And I think the future of women's health will be shaped for the better by clinicians, researchers, healers, educators, and women themselves who are willing to think in systems, trust complexity, >> [snorts] >> and build a framework spacious enough to hold the full intelligence of the female body. Thanks for listening to The Trip Lab. If you liked this episode, please subscribe and share, so we can get the conversation started about integrative medicine and psychedelics, to destigmatize it and fully explore what this could mean in the world.

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