Introduction and Cynthia Thurlowu2019s Background

Thanks. I have, Cynthia Thurlow here, who is, one of the world's experts in intermittent fasting and has been, really instrumental in, you know, making it accessible for people.

Or, you know, she's writing a great book about it. She had a very, popular, early on, I guess. And you had a very popular TEDx channel, and there was really not much information out there.

So thanks for, coming. And, maybe we can start with, sort of your journey, to where you are, because I actually think is probably, you know, it was very similar to mine and that you are also sort of, trained very traditionally.

And we're really in that sort of, whole medical thing until you saw. Hey, wait, there's like something not not exactly, you know, kosher and going on here, so.

But why don't you why don't you tell us your story? Absolutely. Thank you. And I have to give credit to the fact that your book really, for me, reaffirmed that you could be a traditionally trained health care professional and be able to integrate this because there is so much solid research.

And so just to give listeners a bit of perspective, I am a traditional allopathic trained as well as functionally trained nurse practitioner. But for 16 years I was in clinical cardiology, and I think for so many different reasons, I started seeing patterns with my patients, a lot of lifestyle mediated diseases that I felt like just throwing more medication at it, doing more surgical interventions was not per se really addressing the root issue.

And I became quite passionate at talking about initially nutrition, where a lot of my colleagues thought it was funny and quaint and they would kind of, you know, tease me gently about why I was so interested in talking to patients about nutrition as being the kind of foundational practice to really health and longevity and then, you know, I really stumbled upon intermittent fasting as a perimenopausal woman that was struggling with a bit of weight loss resistance and every bit of information that I used to give to my patients about counting calories and trying to exercise to outdo the amount of caloric intake you had really wasn't working.

And so I stumbled upon intermittent fasting and had tremendous success personally, and then started speaking to my patients about it. And those that were open and receptive to the message of eating less often started to have pretty phenomenal improvement in, you know, objective metrics, blood pressure, lipids, etc..

And then I honestly, eight years ago got to a point where I was so frustrated with just writing prescriptions. And you can imagine in clinical cardiology, we have quite a few of very sick, oftentimes vascular Pathak patients, patients that have carotid artery disease.

You know, they have cardiovascular disease. They peripheral vascular disease, they have diabetes. They've got a lot of metabolic disease. And I felt very encumbered by this traditional model where I was just writing prescriptions for many things that I felt lifestyle could really, be improved upon.

And I felt so strongly about this that I left clinical medicine without an A plan initially, and went on to great programs and started working with patients in different capacities, and then had an opportunity to do not one, but two Ted talks, the second one being the one that you were alluding to, not realizing that intermittent fasting in 2019 was going to be the most searched nutritional paradigm.

That was out there. And so that gave a lot of interest to learning more about fasting. And so obviously very humbling. I always say that that was the, the impetus to kind of validate that leaving traditional allopathic medicine for me was the right decision at that time.

And now I've gone on to teach thousands and thousands of women how to implement very successfully based on their physiology, you know, whether they're still in their peak fertile years, they're in perimenopause or menopause, and allowing them to think about fasting is one strategy of many that they can utilize to improve their metabolic health.

Yeah. And, there's always a lot of questions. And I think you are really the world expert in sort of intermittent fasting for, for women because there's a lot of sort of nuances.

Intermittent Fasting for Women Across Life Stages

I mean, certainly back in 2019, there wasn't a lot of information in general. So it was fine to, to give information. But now we're sort of getting a little bit more sophisticated.

Right? You see that a lot of people are talking about what the sort of regimens, what can be used, but there's also a lot of, a lot of sort of, questions about what?

About women like, and, I you know, I'd love to, for you to talk a little bit more about sort of the, the sort of nuances for women, how to make it easier, like, what's the best strategies?

Because I'll tell you that I get asked this a lot. And I've looked in the literature and there really is almost nothing. So I always say that, you know, I've used it for a lot of people, but I can't say very much because it's not actually, there's not actually a lot of literature.

So your sort of clinical expertise would probably be, you know, very valuable here for, for women. So maybe, you know, people like it sort of in terms of their life stages.

So there's a lot of women who ask about, you know, what about, you know, through the through the period, like, what's the best time? And then in the perimenopausal and then, you know, the age, what's the sort of best what's your sort of, you know, best advice at that point?

Yeah. And it's such an important way of just kind of looking at women depending on what life stage they're in. So we have, let's say, 35 and younger women that are still on their peak fertile years, helping them understand and think back to the fact that even as a nurse and a nurse practitioner, I knew very little about the menstrual cycle.

We got a very cursory overview. I'm sure you probably got a very cursory overview in med school. And so really understanding that there is a time to optimally utilize this strategy, and it's typically and I'll just use a broad overgeneralization if we're looking at a 28 or 30 day menstrual cycle, understanding that the first day of bleeding up until about day 14, so that predominant kind of follicular phase when this hormone estrogen predominates and estrogen is, I jokingly refer to it, it's our superpower.

It's this hormone that allows us to get away with a bit of fasting, allows us to get away with more intense exercise if we want to be lower carbohydrate, if we're lowering our carbs, that's the time to really maximize this.

And the little caveat I have is that if you are a very lean, athletic woman, I think a bit of intermittent fasting is okay. But that is not that is not the time to overdo it.

I think I see a lot of well-meaning individuals who will say, well, you know, I, I'm, I played college level athletics and my desire to do fasting is because I want to optimize blood sugar and metabolic health, and that's great.

But sometimes younger women, if they're in too much of a compressed feeding window and they are very, very lean to begin with, that can be problematic.

And this is when I will oftentimes suggest to them that use your menstrual cycle as a barometer of how much or medic stress, so beneficial stress and the right amount at the right time.

If your menstrual cycle is remaining, you know, regular and regular flow and you're not having too much cramping and you feel good, then intermittent fasting during that follicular phase up until ovulation is certainly reasonable.

If you're a woman, however, that has PCOS and we know this is the most common endocrine disorder in women, not actually a thyroid disease, as is oftentimes thought to be the case if you have polycystic ovarian syndrome.

We already know that you've got a metabolic health issue. And so women that fall into that category 25% of whom are thin phenotype, so they are thin or women to begin with, they're oftentimes not properly diagnosed.

But healthy women that have PCOS understand that utilizing a bit of intermittent fasting in that follicular phase can be helpful. And then after ovulation, this is again oversimplification.

We're looking at the luteal phase when the hormone progesterone predominates. And this is when I find for a lot of women, they may have a harder time, especially the week preceding their menstrual cycle, to get away with a bit of fasting.

So helping them understand maybe we do 12 to 13 hours of digestive rest. Maybe that is completely reasonable and feasible that week preceding the menstrual cycle, because we know physiologically women need about 100 150 additional calories.

And I always prefer that they get that from high quality carbohydrates as opposed to the processed ones topping them. Understand that, you know, the week preceding the menstrual cycle, probably the time to not do the intense exercise, probably not push the carbohydrates to too low.

And we can speak to, you know, how do we define that. And then helping them understand that, that 12 to 13 hours of digestive rest can be very beneficial.

The other piece about women still on that peak fertile year, even if they're choosing not to have children, their bodies are exquisitely attuned to stress and sleep and, you know, food intake.

And so even if they're choosing at that point in time not to have children as an example, you know, losing your menstrual cycle if you're at this stage of life is a sign that it's too much stress.

I mean, I more often than not take women or have them take a break from intermittent fasting if they say, you know, I lost my period for a few months while fasting, I'm like, okay, that's a sign that we need to back off versus looking at women in middle age.

So north of 35, you know, we understand now the perimenopause can be ten plus years preceding menopause. The average age of menopause is 51. And so helping women understand if you're in your late 30s or early 40s, you're already there.

And some of the changes that are going on physiologically, including, you know, we have this, ovarian senescence, you know, we have the circadian clocks in our ovaries that kind of, are intricately involved in the aging process, helping women understand that as our ovaries are producing less progesterone, that may show up, as, you know, sleep issues, anxiety and depression.

And again, going back to this model of helping women understand where in their cycle should they be fasting? Because women in perimenopause have a tendency because there's issue with weight loss, resistance can sometimes be magnified at this point in time.

For many, and in many instances, they may feel like more fasting is better, more food restriction is better. You know, more exercise is better. And I'm here to remind people that perimenopause and menopause are opportunities for we as women to understand the, interrelationship between managing our stress, getting enough sleep.

So I usually will say, if I can't get you to sleep through the night, it's not the time to add more gasoline to the fire. This is a time to not be doing too much fasting, or to be conscientious about when you fast.

So women in perimenopause, it's asleep. Are you sleeping 7 to 8 hours a night? Are you managing your stress and what does that represent that represents that you are doing more than five minutes of meditation once a week.

You know, it's helping to kind of quiet that over activation of the hypothalamic pituitary adrenal ovarian access. It's helping women understand that, you know, the way we ate at 18 and 25 is not the way that we can continue eating into our 40s, 50s and beyond, you know, the inflammation that we can, you know, kind of become succumb to by consuming ultra processed foods, too many processed carbohydrates, not enough protein, too much of the wrong types of fats.

Really helping women understand that we need more protein, not less, as we're making this transitional period. So talking to them about nutrition, talking them about an intermittent fasting regimen that is aligned with their menstrual cycle, again, so secular phase. Yes.

Luteal phase backing off. And then the beautiful thing is women kind of navigate perimenopause where we have some of the highest fluctuations. And estradiol, which is our predominant form of Western prior to going into menopause, helping people understand that these wild fluctuations.

And then there's this drop off at the end of perimenopause, as I said, average age of menopause in the US and most westernized countries is 5152. By the time women are in their late 40s or early 50s, they're very close to menopause.

And that's 12 months of that a menstrual cycle. The great thing about menopause, amongst a myriad of other things, is that women start to be able to get away with a bit more fasting.

I find that, you know, they're not encumbered by the hormonal fluctuations that they get day to day, week to week when they're younger. I usually say, I think men and menopausal women generally have the easiest time with intermittent fasting.

The caveat with menopausal women is the sleep, the stress, the anti-inflammatory nutrition. The exercise keys like strength training all remain very important for them.

And I would echo what I said earlier, that women come to intermittent fasting in many instances because they have a desire to lose weight, which I respect.

I understand I've been there, but they will generally stay because they feel so much better. All of a sudden their hot flashes and vasomotor symptoms are improved.

All of a sudden they have less inflammation, their clothes don't feel as tight, the rings aren't tight anymore. All of a sudden they have less aches and pains in their joints.

And this is even preceding ever having a discussion about hormone replacement therapy for a lot of women, those lifestyle measures make such an enormous difference in their quality of life that I think that that is a foundational approach to the aging process for all of us, that intermittent fasting can be one of many strategies that we use.

But for women in particular, really being mindful about where they are on their cycle, if they're still getting a cycle and using their menstrual cycle as a barometer of whether or not they're doing too much fasting.

As I stated previously, if you lose your menstrual cycle, that's a sign that you may need to back off on the intensity. And I'm sure you see this in your own patients that, if a little bit of fasting is good, more is better.

And so I see women regularly that will say, well, if 24 hours is good, I want to do a five day fast. I'm like, well, hold on a second. Let's dial in on some of these other things that we need to look at in terms of lifestyle.

First. Yeah, yeah. So many great things. There I just want to back up a little bit into some of them. And let's start with that. That notion, which I think is nuts, that oh, if it's a little bit, it's good.

A lot is really good. Right. And yes, we saw this all the time at the beginning, it was sort of like, okay, you have to see where you are. Like you said, some people are quite lean, in which case you don't want to over do it.

And we saw this in I saw it in all kinds of people who are like mean. They they heard about it in sort of 2016 to 2020 sort of thing in the earlier days.

And so then they're like, I'm going to do a five day fast every month. And then they felt like crap. Because again, you got to remember that fasting is a stress on the body, which is not a bad thing.

Exercise is a stress on the body too. But the point is that that will help. If you know stress stresses your body, it takes it to the edge and then you get stronger. That's the whole point.

So there's all these people who sort of turned against fasting. And I kept thinking, but you did it all wrong. And then you blame the fasting. And it's like, you know, it's like having a sharp knife.

It's a tool. But if you cut yourself, it's your own damn fault. It's and you didn't use it properly. It's not the knife's fault. The knife is just a tool. Right.

So we had all these people, you know, some very prominent people who are very into fasting, who then went like, oh, fasting is terrible. I'm like, oh, God.

Like you just didn't use it, right? So, you know, that's important because if you're, you know, younger, you're saying, you know, for these women who are mean, who are younger, who are maybe, you know, they're they're losing their period and so you kind of know when to back off.

And that's when it's great to have a professional to say, okay, I've done this in lots of people. Right. Same as, you know, this guy, very prominent sort of internet guru, if you will, who is like sort of super into fasting, then I think way overdid it and then was super against fasting and it's like, okay, but you're not like the typical 400 pound type two diabetic that I'm working with, right?

So you can't take what I say for that and say, oh, okay, well, well, maybe I'm going to do it because he is a lean guy, is an athletic guy, like you shouldn't have been fasting that much.

And that's the point. The the other, point about PCOS is, very good too, because, you know, maybe we can talk a bit about PCOS because I don't think people talk about it enough.

It's actually super, super common. And it's it's actually one of the metabolic diseases.

PCOS, Insulin Resistance, and Metabolic Health

And so it's strange because if you look at medical school, PCOS is, you know, thought about as this really important disease because it causes a lot of an ovulation.

That is the the ovaries don't produce their eggs. And they treat it with all kinds of metabolic treatments like drugs. Right. Because doctors are great at giving drugs.

But then when you talk about diet and your metabolism, the doctors are all of a sudden just shut off, right? It's like, okay, well, you know that you're treating it with metabolic drugs and, you know, things that can impact that.

But, you know, maybe you can talk a little bit about sort of what it is, how it affects women, just so that they know what it is, because I think it is actually a really important thing that we don't talk enough about, for, for young women.

No, I agree, and for full disclosure, I didn't realize that I had PCOS until I went to a fertility doctor because I, I realized I was not ovulating. I think it's important just to share with listeners, because I was.

Then no one ever thought to diagnose me or even consider that I had this an ovulation relative to a progesterone deficiency. So there are many there's many constellation of symptoms that come along with polycystic ovarian syndrome.

And, you know, it starts with at the basis is insulin resistance. Although none of my markers would ever have supported that. We talked about inflammation and oxidative stress.

And so at the basis of these changes, some women there's varying degrees. I look at it as a syndrome. Some women can be an obvious dietary. So they're not ovulating.

They don't know that they're an illiterate because more often than not, they've been put on oral contraceptives to fix their menstrual cycle without realizing it, but also helping people understand that along with this continuum of this syndrome, many people, they can deal with, you know, a degree of being overweight or obesity.

They can deal with, many instances. People can have problems with inappropriate hair distributions or hirsutism. Not every person who's diagnosed with PCOS has to have classic cysts on their ovaries.

That used to be a misnomer that many clinicians say, well, this person definitely does not have, PCOS because they don't have these. There's like a cystic like pattern that you will see on the ovaries.

You can make that diagnosis without an ultrasound. That confirms a cystic pattern. And I never had that either. So when I look at what's going on really at the basis, you have an ovulation generally of high androgen.

So generally high testosterone and generally speaking you'll have a degree of insulin resistance. And what many women will report is, you know, they have irregular cycles.

They're dealing with weight loss resistance. In many instances they may have a carbohydrate addiction. They may be driven to consume quite a bit of carbohydrates.

They may have a significant blood sugar dysregulation. So if I'm looking at continuous glucose monitors of these patients, it's not just where they are in their cycle.

They have a degree and a propensity of dysregulation of their blood glucose. And so that then drives this carbohydrate need. And so for me, when I'm when I'm looking at patients that have PCOS, it's helping them understand it is the most common endocrine disorder that we know of.

That's number one. So I think many, many women are never diagnosed properly. And so maybe they're trying to get pregnant and they realize their inability and helping patients understand if at the basis for most patients, they're insulin resistant and their weight loss resistant, helping them hone in on meal frequency, the proper amount of carbohydrates to consume, along with protein and healthy fats, helping them understand the role of physical activity.

And I'm not even saying that we have to get into strength training, but helping people understand, like walking after a meal can help with blood sugar regulation before we ever even get to looking at things like metformin, Clomid, some of these drugs that are utilized to treat well.

Clomid more for the fertility piece because it helps with ovulation, but other people understand like glucose in metformin. These drugs per se are not without side effects.

So when we're when we're talking about PCOS, using this as a strategy to help women improve their metabolic health in a way where they feel like they are actively involved in their care is huge.

Because the drugs that we use to treat PCOS like that for men are not without side effects. I think a great deal about the degree of nausea. I have some patients that cannot even tolerate one 500 milligram tablet of metformin every day to help manage their blood glucose, so giving them opportunities where they can utilize a strategy like fasting, combined with a bit of exercise combined with some carbohydrate restriction in in many ways can be hugely impactful.

And then, you know, helping them understand that they do have the ability to proactively support their health care outcomes. I mean, that to me is huge.

And and also the other pieces, you know, when we think about PCOS, it's helping to educate these female patients that this puts them at greater likelihood of going on to develop, you know, full blown diabetes.

So helping them understand like what that involves. And the the targets in their body that are impacted by diabetes is significant and profound. And so I find that once I start kind of painting a clinical picture where they can see the benefits of improving their insulin and their glucose control, losing weight, using this as a strategy along with their menstrual cycle, to really improve things.

I mean, the beautiful thing is I've had patients that have been diagnosed with PCOS that using intermittent fasting is one of many strategies have gone on to have successful and healthy pregnancies.

And that, to me is a sign that we're improving their metabolic health and, you know, proactively improving their child's health and their family's health.

And so PCOS is not talked about enough. And as I stated earlier, because 25% of these women are thin, they're not diagnosed. They're misdiagnosed since they're the women that are going on into perimenopause that unfortunately are, you know, getting earlier diagnoses of insulin resistance or maybe even going on to develop type two diabetes.

And so we want to do everything we can to leverage, not ever getting to that point. Because I know for both of us clinically, you know, especially in cardiology, seeing the end stage manifestations of metabolic disease, we want to do everything we can to educate our patients so that they never get to that point.

Yeah, absolutely. And, one of the early descriptions of PCOS was diabetes appeared in women, which was very interesting because it sort of hits all the highlights and it's very sort of a graphical way.

Yeah, well, you get the diabetes, which is the. Yeah, the hirsutism. And then, you know, the, the, the point is that it is a metabolic disease in the same spectrum of diabetes because you really have that insulin resistance.

Hyperinsulinemia. And what I always found strange was when I actually, looked at it because I looked at the path of physiology a bit because, you know, so Megan Ramos, who I work with, closely, she also was the same, right?

Relatively thin at the time, but still had PCOS. Whereas you think about it more in the sort of, overweight obese category. It's not it's really the hyperinsulinemia and insulin resistance that's the problem.

And I remember giving a talk a few, years ago to a group of ob gyn doctors, and I was talking about PCOS, and I went over the path of physiology and it was strange because these are specialists, like specialists in this, and they really had no idea that if you trace it all back, it was the hyperinsulinemia, the excess insulin that was actually driving everything.

So you could trace it back. You could see how the insulin was leading to the and all the elation which was leading to this cyst formation, which was leading to the excess androgens, which was causing the hirsutism.

So the whole thing was actually caused by excess insulin. And even though they had been treating people with, say, weight loss and that for they never really connected it.

And like I'm thinking you guys are specialists, man. It's like, how can you not even know what's causing this super common disease? Because if you don't know what's causing it, how are you going to treat it?

Like you can't just keep giving drugs? I'm I'm reading review articles in like, you know, about PCOS and they never even mention that. Hey, it's it's actually a metabolic disease.

So it's it's it's it's quite interesting that, you know, there's, there's almost this mental block in medicine, whether it's cardiology or nephrology or Gyn, where you just don't think that the diet is it matters and a great deal.

Like, yes, they give lip service to it. But then I think as, as physicians and medical professionals, as you start training, you get into this idea that, hey, I'm here to give you the best drug.

It's like, no, no, no, that's not because it's supposed to make people better. Whether it's drugs or whether it's diet, it doesn't matter. But there's this whole sort of, you know, stay in your lane, sort of don't talk about nutrition because you're the drug guy or drug girl.

And it's so wrong because it's like if you have a disease that is ultimately about metabolism, about hyperinsulinemia, well, you can impact that with your diet.

So we should be talking to people about the diet as opposed to sort of here's metformin, here's this year's that. Right. So that that was very interesting because, you know, the fasting method, we also had this other doctor, doctor, Pagano who also, treated people with, carbohydrate restriction, as you did, and intermittent fasting.

And she was like, you know, and she said, oh, yeah, they call me the baby doctor because and so many of her patients were getting pregnant. And it's like, okay, well, instead of spending thousands of dollars on IVF and all this other stuff, you could start with the appropriate things for your metabolic health, which includes fasting.

I also want to talk about the carbs, because the carbs are always a sort of interesting point, because there's, you know, there's a difference between carbs, like sometimes we call carbs.

It's like, oh, all carbs. Then you get this big debate about, oh, well, you need carbs, you don't actually need carbs. But on the other hand, they're not like all evil either, right?

There's a huge distinction between the ultra processed carbs and sort of the carbs you might get with grains and stuff, right? There's a huge difference.

And it's it's you sometimes get into this point like, and you can see it physiologically because you can do something like a glycemic index. And there's a massive difference between sort of white bread and broccoli.

Right. So broccoli has some carbs. Right. But clearly the effect is much less but sometimes it gets demonized as, oh, you should eat zero carbs, which is a strategy, but it's not.

You don't necessarily have to do it if you don't want to. So I love the fact that you're saying, like, you know, let's not be, you know, so absolute on everything.

Sometimes you need to adjust, sometimes you have to maintain. But, you know, the one thing most people agree on is that that ultra processed, sort of foods in general, and it typically is carbs are probably on the, you know, first things that you should probably think about cutting down or cutting it out.

Ultra-Processed Foods and the Limits of Calorie Counting

And I think that's, that's a great that's a great point that you make about it because I think people are getting more are realizing more that there's there's more.

It's not all, you know, because sometimes they fight about low carb, low fat, high protein, this and that. And that's

talking about the, the macros. But there's actually something very profound that happens when you change a food.

Right. Whether it's, it's you know, carbs. So you could also talk about processed meats, some of which are not very good for you, like hot dogs, a lot of hot dogs are not good for you at all.

But also there's there's ultra processed oils too, right? So a lot of the seed oils are highly, highly processed. And it's questionable whether or not they're good for you.

So maybe if you could talk a little bit about that, because I feel that that's that's sort of the next step in sort of really talking about it's cutting carbs.

Like, you know, if you think about the the nutritional transition we've seen in the last ten years, you know, we've seen low carb, low carb has been around quite a long time.

But not all carbs are actually that bad for you. So then we talked about fasting, which was a, you know, important thing. And then now I think the next step and I think that, you know, you've brought up a couple times, maybe talk a little bit about the ultra processed foods and why that's really probably as important as thinking about carbs, proteins, fats, sort of thing.

Now, it's such a good point. And I think when we're looking at lifestyle changes that people can make, and I know here in the United States, I think the latest statistic was 70% of us eat predominantly ultra processed foods.

And the greatest concerns I have about ultra processed foods is not just that they're full of adulterated seed oils and oftentimes, you know, highly inflammatory fillers and and additives.

But it's we know that the processed food industry has food scientists that design these foods to be as addictive as possible. There's something called the bliss point where food scientists will actually bring in, outside individuals to test products to see at what point how much sugar they need to add to a drink as an example, or a food that people will continue eating it although they're filled up or they're filling up.

They just don't register that they are full like their it obliterates their ability to acknowledge that there's a degree of satiety. There is no satiety. That's the bliss point.

And so when I think about the addictive qualities of processed foods, this is where I get concerned, because we don't have the same control mechanisms as if you sat down and had a steak and broccoli, and maybe you had part of a sweet potato, you have stretch receptors in your stomach that will tell your brain, okay, we're full.

You know, we've had enough fiber and protein and carbohydrate and healthy fats and now we're full. But if you sit down and eat a bag of Doritos or a bag of Cheetos or, you know, these highly processed Lunchables and other products that unfortunately get marketed towards children, what ends up happening is that same brain does not get the same information from that load of food or food like substances.

And so I think the ultra processed foods I acknowledge I'm a realist. This is not to suggest that I have never eaten, a clean protein powder or had a protein bar, but it does acknowledge that for those of us that are looking or endeavoring to help our patients live healthier lives, it's educating them that there might be a time and a place, but the bulk of what we are consuming should be as akin to what it looked like when it was pulled off a bush or pulled out of the ground, or, you know, an animal that was taken to slaughter, you know, looking at meat or poultry or fish, helping people understand that the more nutrient dense food you consume, the more full you are going to be, the less likely you are to overeat and so I think that that distinction, helping people understand that ultra processed foods, yes, they're convenient.

But ultimately, you know, if we look at the research, we know that they are more likely to dis regulate our hunger and satiety cues. They're more likely to just regulate our blood glucose.

They are more likely to encourage us to continue eating. And we know the average individual that eats ultra

processed foods continues. On average, an additional 500 or 2000 calories a day.

Now, I don't know about you, but if at the stage of life that I'm in, that can make a big difference for me or for my patients, and health outcomes. And so I think that ultra processed foods, it's building awareness about what they do in the body. I know they can be delicious.

I have teenagers, you know, I start to get a little bit of pushback now because they realize there's a whole world out there that they were less familiarized with being predominantly at home, but helping them understand how to make good choices and helping our patients to do the same.

Again, I think, yeah. I think that's a good point, because we're not trying to say is eat zero processed foods right? Because that's not realist, but you don't want to don't want to be eating 70% either. Right?

There's got to be a mix in there where you know, you're going to still be able to be metabolically healthy, and still, you know, have some once in a while, some ultra processed foods.

Because, again, that's the world we live in. We're not living in the 1500s. Right? So, yeah, we're not going to go kill all our own food sort of thing.

Right. So so the point is that we're just so far on that spectrum in the United States. And I have to say that if you look at other countries in the world, and this was, you know, brought up, you know, I think Cali means and some of these people are bringing up this exact point.

Other countries have more rules regarding a lot of the stuff and have a lot less health problems than the United States. Right. So it's not that it's not that, you know, it's everybody's it's your own fault.

And stuff. Like, you have to have some kind of regulation because it's like if if you have all these ultra processed foods that lead to food addiction, therefore, like, you got to treat it like an addiction.

That's that's the whole point. And I think this is where it always makes me a little bit sort of like these calories. People drive me crazy, right? Because they're all like, it's all about calories.

It's all about calorie. I'm like, you're so stupid, right? Because it's like, think about, you know, what's causing. It's not that you're not eating more calories than you're losing.

That's not the point. The point is that what is driving that excess calorie, you know, calories and greater than calories out? It's not. We're not arguing that calories in is greater than calories, that we're saying that there's something that's causing it.

So if you have an ultra processed food which is designed to make you addicted, which is causing you right to to eat and excess of what you're burning, which is causing obesity, you can't just say it's all about the calories.

No, because it's about the ultra processed food which was driving the calories. That's the point. You have to you have to keep going back to the root, cause then you say, okay, how are we going to deal with the ultra processed foods?

Whereas the calories people are like, it's all about the calories, which is so stupid because it's like a, you know, any addiction. It's like, oh, you have a morphine addiction.

Just take less morphine. It's like, thanks. That's the worst advice I've ever heard. It's the same thing. It's like you have a food addiction which is leading you to take too many calories, just like you might have a heroin addiction, which is leading you to take too much heroin, it is not helpful to say take less heroin.

Thanks. Now please go away. Like. And the crazy part about the calories people is that they always think they're right. But in every other field where you say, okay, well, it's it's, you know, it's it's not that we're arguing that calories

are not in excess.

We're saying that it's either it could be ultra processed foods, it could be food addictions that could be driving the excess. It could be eating too frequently, eating out too much, too much sugar, too much refined carbohydrates.

So there's all these issues that can lead you to have access calories. So fix that issue. Whether it's eating too often, then maybe fasting, right? Maybe it's too much ultra processed food. Fix that.

Maybe it's too much refined carbs. Hey, change your carbs, right? Those are all strategies that are going to fix the issue. The root cause, which is going to fix the calorie problem, which is going to fix the weight gain problem or metabolic problem for PCOS.

And then and then you always have like ten different, usually doctors and academic doctors who are like, it's all about the calories, fasting, work. It's all because of the calories.

I'm like, I'm thinking, wow, that's crazy how stupid that is. Like, it's just crazy. It's a very reductionistic way of thinking. And I certainly when I see patterns of people talking about that, they generally are of a certain age.

And this is not, an ages comment because I think that when I was probably in my 20s, I thought it was just about the calories. That's what I've been trained in, and I'm sure I probably propagated that as a young nurse practitioner.

Having said that, it is so much more nuanced and so much more complicated than just that. If it were just about the calories and everyone would be able to lose weight easily, right?

I think we do a disservice when we don't help them understand that it is more nuanced. I think I have had women cry when we start talking about the nuance around weight loss, resistance and hunger and satiety, like true satiety, and then, you know, helping patients get the right resources.

Because if someone has a food addiction, that's that's one thing. But there are many people that are using food as a source of comfort. And so that requires a different strategy.

And oftentimes looping in a specialist, you can talk to them about, just like their shopping addiction, food addiction. There's so many things, but food is the one thing we have to continue eating.

So it's not like you can just say, I'm not going to go shopping when someone has a food addiction. I mean, that is that is I always look at it as a multi processed support system because it is not just one intervention that will fix that.

That is many different things dealing with uncomfortable feelings. All of us deal with it in different ways. So one might exercise am I might go cry? Someone may read a book, someone else may self-soothe with food.

And so I think that we're not ultimately helping our patients. If we reduce things to saying, just count your calories, that will fix the problem. So I 100% agree with you.

And when you hear it from from multiple people, right, to virtually every newspaper, which is always saying, oh, it's all about the calories and all the special lists and all the sort of obesity experts.

And I always think that again, think about it as you're saying, we know that highly processed carbs are going to spike your dopamine. Sugar will spike your dopamine, right?

Which is our reward system. I mean, that's not controversial. We've we have clear evidence that if you eat a, you know, very highly refined, like a donut, lots of sugar or lots of refined carbs, then it's going to spike your glucose, which is going to make you feel good in the short term sometimes, but also spike your dopamine.

So if you're depressed and I have actually had I was just speaking to a doctor yesterday who is like, oh, during Covid, he got super depressed and gained like 30 pounds, right?

I'm like, yeah, because what's happening here is that you have depression. So you're basically trying to self-medicate. You're trying to spike that dopamine that you used to get from going out with your friends and playing pickleball and doing all this stuff, stuff that used to fill your life.

Now you don't have that, so you're depressed, you don't have any dopamine spikes, so you decide to self-medicate with donuts and alcohol or, you know, whatever else your drug of choice is, and you're going to spike that dopamine because you're depressed.

The answer is not count your calories. The answer is deal with that depression. Maybe you need therapy. Maybe you need to talk to somebody. Maybe you need to have friends.

That is what's going to work, not count your calories. It's as stupid as saying that, oh, you have depression, which is leading you to drink more alcohol.

So the answer is drink less alcohol. It's like, okay, alcoholics anonymous does not ever say drink less alcohol because that's not the point. The point is, you have to deal with the things that are leading you to drink too much alcohol, right.

So there there's a whole 12 step program that's been around for God knows how long, but it's probably one of the most effective ways. And it's not drink less alcohol, right.

But then you transform that into waves and so on. And it's just and it's all of a sudden just eat fewer calories, which is again, just so simplistic, like, I can't believe that people even believe it anymore.

Like it's so simplistic as to be stupid and useless, right? Just like saying just drink less alcohol, just take less heroin, just take less morphine. Like tell Michael Jackson, just take less morphine.

That'll solve your problems. And if you can't do it, it's a lack of willpower. Like, no, that's not understanding people. That's not having compassion for people.

And that's why I always get so upset about this whole sort of issue is because we're focused on that wrong thing. You gotta focus on, you know, what is the actual problem?

You know? And it doesn't necessarily mean cutting all carbs, right? It may mean switching to healthier carbs and maybe, getting that ultra processed foods, down.

And fasting is a part of that too, because fasting is, is one of those, sort of things that really helps because it sort of helps you sort of clear out a lot of the those, sort of issues because, well, it's really, you know, it's low in everything.

So therefore it's really going to help. But it's not purely about the calories. It's actually about a lot more than that. And I appreciate you saying that, you know, there's there's a whole lot more nuance to this, because that's not the message that most people get.

Most people get the message that just eat 500 fewer calories, you'll lose a pound a week. It's like, you know, that works for like zero people, right?

It's like almost never works. And yet. As a physician, that's what you're taught. This is how to get people to lose weight. Just tell them to eat less.

It's like that's that's that's terrible advice. And the problem is that it's terrible in a way that impacts people's health very profoundly. So, you know, I said thanks.

Thanks for for bringing that all. And then maybe we just close off. Maybe you can tell us a bit about your book and, how people can reach you and, you know, your great programs.

Thank you. So, thank you. And this has been a wonderful discussion. I always enjoy connecting with you. So my first book was written about, women in fasting.

So it's the intermittent fasting transformation. And that is actually based on a program that I've run for the last six years. So I've had thousands and thousands of patients, go through that and successfully go on to improve their health, along a continuum of many metrics.

I have a podcast called Everyday Wellness. And you've been a guest on there multiple times. You can find me across social media. I do have to for more people on Twitter.

I can be a little bit snarky, but I have a free Facebook group called, the Midlife Pause backslash. My name. I'm active on Instagram. I am on TikTok, but you know that it's only because of my team, who are all 20 and 30 somethings are trying to get me to be there, but working on my second book, which will actually not be about fasting but will be devoted to women in perimenopause and menopause.

Books, Programs, and Closing Remarks

Oh very interesting. I look forward to that discussion. And actually, again, one of the things that I think really people need to focus a lot more on, I love that, just, just I just want to throw one last thing in is that for perimenopause is actually a huge problem.

And this is actually been well documented. There are periods in people's lives where you gain more weight, like weight gain is not it's not constant. It's not like 1 pound a year sort of thing.

It's actually concentrated in certain parts, certain not just not only proteins of the calendar, parts of their life. So if you look at the calendar years, it's it's actually weight gain is concentrated between Thanksgiving and Christmas, for certain, you know, for reasons we can probably all acknowledge too much cake and too many parties. Right.

So that's fine. That's understandable. But if you look over, a person's life, they're in a man. There's actually the one period of time where they actually get a concentrated weight gain.

It's after marriage, which is funny. And also. Yeah, and also having kids. But in a woman's life, perimenopause is actually one of the those periods of time that it's actually where you see this little spike up in.

Yeah. Before the three PS of puberty, pregnancy and perimenopause, those three times a woman is most susceptible to weight gain. So yeah. And I think so most of us do not do a good job preparing our patients for that.

I don't think I spoke to anyone, at any time prior to leaving clinical medicine about perimenopause, because I myself had no experience to draw upon. But now I make sure that everyone I talk to is aware of that, because with knowledge comes power.

Oh, totally. If you warn somebody, hey, this is you're entering a period of time where you need to really focus on this. Then they know, right? And it's like we're not saying like it's just like anything else.

Like if you're getting older, then you know, you have to be a little bit more careful. Like, don't you know, you don't want to slip, you could fall and break your hip.

Right? It's it's it's just common sense. So if people don't know, they can't put the attention that they need on it. And the perimenopause period is a period where the actually people just don't know at all.

They just mean it's all calories. Right? But it's not. It's the hormones that are changing in that perimenopausal period that are leading to weight gain.

And it's, it's, it's it's great that you're you're going to focus on that because I think that's, that's certainly one of the things I, I actually haven't, I actually haven't I don't even can't even think of another book that really talks much

about it.

So I'm looking forward to that. Thank you. Yeah, I'm very excited. Although as you know, when you're in the throes of book writing, you, it's kind of like having a baby. That's always the analogy.

At the time you have your baby, you're excited to have your baby, and then you think too, you're going to do it again. And then you start the whole process over and you're like, labor is not fun.

What was I thinking? But then you get through it again. I think I'll maybe I'll write a third book. So yeah. So I mean, I'm in the throes of it, but it'll ultimately be, I think, very, very helpful.

Thank you so much. Thank thank you. Thanks for your time.