

Nutrition: Women's Health, Part 3

Let's talk a little bit about menopause. The average age of menopause is 51 years old in the United States. It can start in the early 40s for some women, or it can be later than 51 in others. Family history plays a role, as do many other factors. Menopause is defined as twelve months with no menstruation. It's caused by a natural decline in the output of estrogen, progesterone, and testosterone, and common symptoms of menopause, which I'm sure you're familiar with, include hot flashes, night sweats, waking insomnia, vaginal dryness, and decreased libido.

Many women gain belly fat during menopause and are not able to lose it just simply using diet and exercise strategies that worked for them in the past. Weight gain is most likely related to slowed metabolic rate rather than menopause itself, and fat gain around the midsection can be due to a drop in estrogen. Recommendations for the symptoms of menopause might include strength training, which prevents loss of muscle mass and bone density and may help to prevent weight and belly fat gain; reduce the intake of caffeine, alcohol, and sugar, which can exacerbate hot flashes; and manage cortisol levels, which we'll be talking a lot more about in the HPA axis unit. High cortisol is associated with perimenopausal insomnia, weight gain, especially belly fat, and hot flashes. And stress management, blood sugar control, and good social support can help keep cortisol from spiking. So one thing that's important to understand as a clinician is that during menopause, the production of sex hormones, the burden of that production shifts from the ovaries primarily to the adrenal glands, and supporting women's HPA axis and adrenal function during perimenopause is one way that you can really help them to make that transition more smoothly.

Hormone replacement therapy can significantly reduce perimenopausal symptoms. You have to consider the family history of hormone-related cancers, like breast cancer, though, and as I'm sure you know, there are some possible risks of HRT (hormone replacement therapy), including heart disease, stroke, blood clots, and breast cancer. This is a very controversial area, strong opinions on both sides, the jury is still out in my opinion, and I think caution is warranted. Some clinicians do consider bioidentical hormones to be safer than synthetic hormones, but there's not a lot of data on that either, so this is a fairly murky area, and one of the reasons I've chosen not to include male and female hormone balancing in this initial ADAPT training is that I think more research needs to be done here, and I feel like I'm still figuring this out. The second reason is that I believe focusing on HPA axis regulation is the most important thing to do when it comes to endocrine balancing, and if you look at the endocrine system from a functional medicine perspective, you can see that the most important things to do in order to support normal endocrine function are to promote healthy blood sugar regulation, gut function, liver and gall bladder detoxification capacity, to reduce inflammation and to support the HPA axis. And of course, those are all the things that we are focusing on during this first level of the ADAPT training, and if you do that in most women, you may not even have to tinker with the hormones directly because just supporting the body from a functional perspective will be enough to realign sex hormone production.

Weight loss can be more challenging for women than men, just observed that clinically. You hear a common complaint from women: my husband lost tons of weight and did great on Paleo, but I didn't. The basic principles of weight loss, of course, are helpful for most women, which is that some calorie deficit will lead to weight loss, but if the woman voluntarily restricts calories, that can paradoxically stall weight loss. We'll talk about this more in the particular presentation on weight loss. This could likely be related to changes in metabolic rate and hormone balance that occur in a severe calorie deficit. So for women in particular, I recommend no more than a 20 percent calorie deficit for weight loss. Exercise is essential, you want to do a combination of long, steady-state cardio, like walking, weight resistance training, and then high-intensity training like sprints or explosive weightlifting. That's the most effective for weight loss and improved body composition for women.

What about carbohydrates? Should it be a low-carb diet for weight loss, or a high-carb, low-fat diet? Very-low-carb diet is more effective for women who are sedentary or significantly overweight with significant blood sugar issues, so that might be 7 to 20 percent of calories from carbohydrate. But other women do better on a moderate- or even high-carbohydrate intake, especially if they're exercising regularly. Actually, varying between the two can be helpful sometimes, when weight loss is stalled, so if a woman has been on a low-carb diet and she plateaus, adding carbohydrates in might actually kick-start the weight loss again, and that can seem counterintuitive when they've had success on a low-carb diet previously, but we've seen that happen over and over again, and the converse is true as well. So for women who are super-active, exercising regularly, the ideal range of carbohydrate might be more like 25, even 50 percent of calories from carbohydrate, and some women may just do better, they may lose more weight that way and they may feel better. As you may have read in my e-book on low-carb diets, some women will experience insomnia and anxiety, depression, fatigue, and other symptoms like that on a very-low-carb or even low-carb diet.

Let's talk about intermittent fasting. Some evidence suggests that intermittent fasting's not appropriate for women; it can cause hormonal disruption and lead to mood swings, fatigue, and insomnia and possibly decrease glucose tolerance, whereas men generally experience better glucose tolerance and greater insulin sensitivity when they're intermittent fasting. Women of reproductive age seem to be most sensitive to the negative effects of IF, intermittent fasting. There's not really a lot of research available, but there's a lot of anecdotal evidence from patients. I've definitely seen intermittent fasting work with some women, there's no question about that. Typically, it works better in women who are significantly overweight, and who are somewhat sedentary, and who do have insulin resistance, despite what I mentioned a little earlier on this slide, about some studies showing decreased glucose tolerance in women with IF. But we've also seen many women and maybe a majority who are not significantly overweight, who are exercising, who are really kind of burning the candle at both ends, they're busy moms, they have jobs, they have jobs as moms, they're not getting enough sleep, and when they add intermittent fasting, which is basically a stressor, I mean that's one of the ways that it provides its benefit, is by acting a hermetic stressor, something that causes positive adaptation, ideally. But if a woman is already under a huge amount of stress, which many women are, and they're exercising, which is another form of stress, again positive stress ideally, but if the overall load of stress, the allostatic load,

which we'll be talking about in the HPA axis unit, is high, adding another stressor like intermittent fasting can really push them over the top and can lead to some undesirable outcomes, so you really once again need to consider the individual patient when you're making these decisions.

Eating disorders are more common in women than they are in men. You want to always address body image concerns with weight loss clients, and that very well may not be within your training or scope of practice, so having a skilled therapist that specializes in these things that you can refer patients or clients to is really important. The desire for weight loss can often mask underlying emotional or mental issues, and weight loss won't fix that problem. So if you kind of think about it from a mental health, from a functional perspective here, these emotional and mental issues are what drive the obsession with weight loss, and that obsession with weight loss is a symptom of the deeper problem, and so even if they lose weight, it doesn't deal with that underlying problem, and that's what can lead to disorders like anorexia and bulimia, because weight loss is never enough. Too much weight loss, as I mentioned, can lead to hormonal imbalances, which raises the question of whether it's worth it. There's a question in the scientific literature about whether being 10 or 15 pounds overweight is as much of a health concern as was once believed. In some cases, just adjusting expectation and body image may be the best way that you can support a patient. Healthy body weight in women will vary. The weight goal needs to be appropriate given their circumstances, and then of course you have to pay attention to menstrual function. If a woman starts having an irregular period or goes into complete amenorrhea, that can be the body telling you that the calorie intake is too low or the weight loss has been excessive.

The basics of hormone balancing from a nutritional perspective, you want to promote healthy liver function because the liver processes excess hormones. Poor liver health leads to hormonal imbalance, so you want to emphasize things like eating leafy greens, healthy fats and cholesterol, especially egg yolks and liver, fresh herbs, plenty of fruits and vegetables; minimizing alcohol intake; and consider some liver-boosting supplements, which we'll talk about elsewhere in the program if necessary.