Jen: Steph, welcome back to Sparta Chicks Radio.

Steph: Thank you for having me. It's great to be back.

Jen: Well, it's great to have you back. Not only because our last conversation, which was in August 2018, six months ago now, was so popular. It turned out to be the fifth most popular episode of the entire year.

Steph: I saw that on Instagram. That's wonderful. I'm glad everyone's loving what we're chatting about.

Jen: I've had so many questions following up from that conversation, both of what you shared in the conversation and from what people have gleaned from my experience over the last six weeks as well.

Steph: Love it.

Jen: Yeah. I think we're changing lives.

Steph: So good. So good to hear.

Jen: Now that first conversation was pretty wide ranging, and we covered ... I guess in some ways, it was a high level discussion around nutrition and gut health, and their impact on everything from your hormonal cycle and PMS and your immune system, and even 3:30-itis, which I'm happy to say I no longer suffer from. But what I wanted to do this time is to dive into one specific health issue that affects a lot of women. A lot of my clients struggle with this, and that is polycystic ovarian syndrome, or PCOS.

Steph: Yeah. Let's call it PCOS, shall we?

Jen: Let's call in PCOS, and the impact that nutrition can have on it. Because I was at the Living Low Carb event back in December, at which you were speaking. One of the other speakers just made a passing remark about how this was something that nutrition was one of the main ways to treat it. I thought ... I almost got whiplashed at how quickly my head bolts it up, and I was like, "What? Really?"

Steph: Oh, no.

Jen: Yeah.

Steph: I know. That's a really important conversation to have because it's not what people are taught, if that's your experience. There are other people, yeah, that are thinking there's either no cure or it's only medical in nature.

Jen: Yeah. Now, this is something I have not experienced before, so some of my questions are going to be pretty basic and going back to fundamentals. But I thought it'd be a good way also to set the foundations for some women who might be suffering some of these symptoms and perhaps have not put the pieces together yet. But what is POCOS?

Steph: PCOS, yeah.

Jen: PCOS, sorry.

Steph: It's actually diagnosed as a metabolic condition, which we'll start to unpack how of course nutrition will play a role there. But to actually get the diagnosis, you need to meet two of the following criteria. So you've had an ultrasound, where there's polycystic ovaries that appear. They're not cysts, they're actually ovaries that contain a high density of partially mature follicles. That's visible via an ultrasound, but it often comes with an irregular menstrual cycle, and/or increased male hormones such as testosterone on a blood test, which can come with symptoms such as hair growth on the face or breasts or acne, so skin issues as well. You've got to have the ultrasound, but it can definitely come with a number of factors. But yeah, the diagnosis will be given when you've got at least two of the above.

Jen: Okay. Then there's a difference between PCOS, which is the metabolic condition, and simply, and I don't mean simply by simply, I mean separately, having polycystic ovaries?

Steph: Yeah. That's a really important clarification because you might say PICO or PCO, which is not the actual syndrome. It's not a disease, but it is a variant of having “normal ovaries.” What we would see on an ultrasound is still the high density of ovaries ... sorry, pardon me, the ovaries containing the high density of the follicles, but often there's no other symptoms associated with that.

PCO or PICO is definitely more prevalent, but PCOS, I think it's affecting about 12 to 18% of women, which is still pretty high, especially considering that a lot are undiagnosed because you might have the symptoms of an irregular period and you might not do any further investigation, or you might get some extra hair growth but not actually get your

testosterone levels tested. So you don't actually get the criteria to be diagnosed with that metabolic condition. I think the stats are often a little bit incorrect because of the undiagnosed cases that we see as well.

Jen: But even running from that 10 to 12% of women, assuming our population's at 24 million in Australia so far, that's a hell of a lot of women who are suffering from this.

Steph: It is. Yeah, absolutely, it is. There are some ... there's short and longterm effects, which we'll talk about. It is important, I actually think, to use our menstrual cycle as a barometer. We aren't taught this in high school, which I think should be hopefully changing soon. We, most of us, I think, would go to a doctor and if we had any conversation around our period or any PMS or pain, we would have been prescribed or at least offered the pill. What we weren't taught is how to understand our own hormonal cycle and learn about our menstrual cycle. I'm teaching women of all ages this at The Natural Nutritionist, and I love that we have that conversation because a normal menstrual cycle is a huge barometer of overall health, and we don't talk about it.

Jen: No, we don't. We assume that if our menstrual cycle is all over the shop, then that's just our hormones and that's just what we're stuck with.

Steph: Yeah, or we're told to deal with it later if we're a little bit younger, or, yeah, we only look at a western route, which don't get me wrong. The medical world exists for very good reason, but there's so much more to it than maybe just using the pill as a bandaid because that's what we see. If there is an irregular periods, which we've discussed is one of the criteria that needs to be met to be diagnosed with PCOS, then the fair solution is not to take a pill and put a bandaid over the problem. There's so many more things we can do to regulate the menstrual cycle, which is a huge part of managing and even reversing PCOS.

Jen: It's quite amazing. This is a slight side transition, but I was only thinking this morning that in my own instance, I know I've learned the moods and the signs and the symptoms that ... I mean that PMS phase, even now no longer having a period because I've had the hysterectomy. But I couldn't tell you what happens the rest of the month. I couldn't tell you how ... I've never tracked, yet, mood changes and energy changes and all those other things that are a byproduct of our cycle.

Steph: Well, I think if there's one takeaway that everybody starts doing that, because there are apps these days, like the one that I normally suggest, is Clue, C-L-U-E, but there are many versions of that these days. Even if you're not actually having a regular menstrual cycle, you are having hormonal fluctuations. You are a woman, so you have full seasons in a month. Obviously when you have the actual period, it's easier to track things because everything revolves around that day or those days at the start of your cycle. But even without that, you can still observe commonalities that you feel always tired mid month, or always craving chocolate at around about this time of the month.

That's not a coincidence. If you map that, you can start to see. You can actually start to work out what imbalances might exist. I think it's actually a really great barometer. So

taking just a little bit of time to log any symptoms, but also to understand if you are ovulating, which we can talk about, is very important for women of, that what we say, fertile or childbearing age.

Jen: I still can't believe that we're not taught this-

Steph: No.

Jen: ... and women, many of us we're in our 30s, 40s, even later, are just learning about this stuff.

Steph: Totally. It's mind blowing. It really is.

Jen: Yeah. That's a whole another tension we could go down [inaudible 00:09:02] range.

Steph: Stay on track.

Jen: Okay. Getting back to PCOS, you mentioned some of the criteria, the two criteria that are necessary for diagnosis. But are there any other signs or symptoms that one should look out for or what all that might indicate that you have this condition?

Steph: I think actually a big one is weight gain or challenges with weight loss. This is where we start to look at that metabolic nature of the condition or the disease essentially, because the underlying condition is insulin resistance. If our body is in that state of insulin resistance, then we are naturally going to be in a fat storage mode, not a fat burning mode. Unfortunately, the body is stuck in this vicious cycle because the high insulin that's present in that situation also then interferes with our hormonal balance, which then continues to contribute to PCOS, and the insulin ... pardon me, the insulin resistance is also going to make it quite challenging for us to make the right food choices, which are part of the nutritional strategy to treat insulin resistance, which is essentially low carb healthy fat.

That is why we actually use low carb healthy fat in cases of PCOS, because it actually reverses the underlying insulin resistance. That space at the moment is largely in the type 2 diabetes conversation. People are finally learning that low carb healthy fat can be used to reverse type 2, and that's because it gets rid of the underlying insulin resistance, but it's actually very similar in the case of PCOS because you've got to get rid of the insulin resistance to start to rebalance the hormones and to be able to shift the weight. Then, that's a really positive cycle where without insulin resistance, you aren't necessarily going to be craving the foods that have partly contributed to where you've gotten to in the first place.

Jen: It just becomes a vicious cycle, doesn't it?

Steph: Mm-hmm (affirmative) Absolutely. Cravings aren't ... they don't come out of the blue. They aren't just there for no reason. As you learnt with 3:30-itis, it's not a dissimilar conversation. You were experiencing 3:30-itis because of your previous food choices.

Cravings, yes, they are hormonal in nature but they largely come from the carbs that we have eaten and the poor blood sugar that results. That is the start of developing insulin resistance. It's absolutely going to come back to addressing that as one of the largest areas to help, yeah as I said, manage, reverse or even put PCOS into remission.

Jen: It's fascinating to me that insulin resistance can cause such a ... can cause this condition or disease. I think we all understand the link between insulin resistance and diabetes, for example, these days. But these other conditions, we're now recognizing that have this underlying thread of insulin resistance, is quite amazing.

Steph: Yeah. There's lots of mechanisms, and with PCOS, it's slightly different. As I mentioned, the insulin stimulates the production of the androgens, which disturb things like ovulation and the entire cycle. But really, if we look top level, it's inflammation. That is what insulin is going to cause in excess, it's in inflammation. Which is why we also see those short and longterm risks of PCOS looking like diabetes, gestational diabetes, cardiovascular disease, obesity. They're all inflammatory-related conditions that start and have ... part of the disease development is with that high insulin and the inflammatory cascade that follows.

Jen: Is there anyone who's particularly high at risk of PCOS?

Steph: Yeah, that's a really good question actually. There is a genetic component, which I think does need to be acknowledged, but we can't blame our genes. There's definitely a genetic component that we would then say, "All right, the environment pulls the trigger." Yeah? If you've got family history of hormonal imbalances or fertility issues, or if someone in your immediate family has been diagnosed with polycystic ovaries, then if you follow a very western diet and ate a lot of refined carbohydrates, you definitely have or you may create the ability where you turn on those genes. We say the environment pulls the trigger. That's something that you might not know about. You don't run the risk. I mean, there's lots of reasons why you would move away from refined carbohydrates, right? As we discussed last time?

Jen: Yes.

Steph: Other risk factor is definitely an imbalanced gut, which again, we briefly touched on last time. But the unfortunate irony, if I circle back to what I discussed before about what most of us have probably been through, is the suggestion or the prescription to take the pill. Now we know, unfortunately, the oral contraceptive is one of the main reasons that starts to interrupt our gut health and interfere with our balance of beneficial flora or bacteria. That's going to impair your gut health, which actually stops to predispose you to that disregulation of hormones that we see in a PCOS situation.

Jen: Wow. It just puts you on the downward spiral towards it?

Steph: Yeah. I mean I-

Jen: That's a bit dramatic.

Steph: Well, sorry. Unfortunately, we can't ... I mean, it's a tricky conversation to have because a lot of us just have been taking the pill as a way to regulate our cycle, or to avoid having a family at this point in time. It's kind of an easy solution but we haven't acknowledged the side effects. I think this is a conversation that's coming, that we're having a lot more frequently, and I think it is really important. Because there's a lot of women that find out, many, many years after being on the pill, that they've got all this work to do from a fertility and hormonal point of view, which I believe they should have been informed of initially so they could have made a much more informed decision.

Jen: Yeah, definitely.

Steph: Yeah, we need to speak about it.

Jen: Yeah. Now, I was just thinking back when I was on the pill, 20 something years ago, and there were no discussion about side effects whatsoever. My one concern was putting weight on. I was like, "Is this going to make me put on weight?" But the doctor certainly didn't discuss any side effects with me at the time.

Steph: No, I don't remember that either. I'm just lucky that I was terrible at taking consistently, but I'd never did. I must have known deep down, but I never actually took it. Whereas I've got women, my female clients, that are coming in. Probably the most common scenario now is, now that I'm pregnant, I'm attracting all these women that are wanting to have a baby, as it so happens. Yeah, they just really like having this massive realization that 20 years on the pill is often going to mean way more time than you predicted to be able to conceive naturally. Yeah.

Jen: Yeah, it's a bit scary. I was just thinking, as you were talking then, I mean, who knows about the link between the pill and ... For example, I had to have a hysterectomy because of very active fibroids. I know, maybe that was a factor. Who knows?

Steph: Yeah, absolutely. The other risk factor I did want to mention though, just to go back to your question, is actually stress. This is something that I know that we speak about, but psychological stress is definitely part of the equation. Because, obviously PCOS is a stressor itself, which is that chronic cycle of then contributing more so to the hormonal and metabolic imbalances, that stress has a huge role in chronic inflammation which causes things like weight gain, or challenges with fertility or acne.

Then we are in that vicious cycle where we're actually promoting the contributing factors to actually achieve that diagnosis, which is obviously not what we're trying to achieve. We talk about insulin resistance and inflammation, but it's also really acknowledging the significance of stress and inflammation, and why we have to then address both as part of the natural treatment protocol.

Jen: I was going to ask you later on if stress management and rejuvenation practices, especially those recommended by our friend, Katie-

Steph: Of course.

Jen: [crosstalk 00:18:39] we're going to come in?

Steph: Yeah. They're all linked, because you can't go low cab healthy fat or you can't control your blood sugar or become a fat burner, and ignore stress, because it has the opposite desired effect. Now, I'm not saying that everyone that stress gets PCOS, or everyone that has insulin resistance gets PCOS or vice versa. That's not how it works. But it just means that there's a greater risk factor, and that if you've been diagnosed with PCOS, then yeah, make your first two goals to solve or to at least find out if you have got insulin resistance, which we can talk about how you would do that, but also to acknowledge that stress management is going to be part of the equation.

Jen: Okay. What's the traditional conventional, western typical GP doctor approach to treating or managing PCOS?

Steph: Sometimes it is the pill.

Jen: Okay.

Steph: Yeah.

Jen: What's the purpose of putting on the pill? Is that the theory being that it regulates hormone?

Steph: And the period, which is obviously one of the symptoms, the irregular cycle.

Jen: Got it.

Steph: Definitely.

Jen: Yeah. So it's treating one of the symptoms rather than the cause?

Steph: Yeah. Yep. Other people, some people have surgery to remove the cysts.

Jen: Whoa, that's big.

Steph: Yeah, absolutely. In general though, hopefully, you are seeing someone that's a little bit less pharmaceutical-orientated because if there is insulin resistance, you're likely going to be prescribed metformin, which is a drug that's used in diabetes. Then associated insulin resistance, sometimes there's testosterone lowering drugs, even some antidepressants are prescribed. Most western options are definitely pharmaceutical, which is again not dissimilar to what we're talking about with the pill. It's a bandaid solution. If one of your symptoms is high testosterone, which is causing the PCOS, taking a drug to lower that testosterone is masking the issue. As an nutritionist, you would always go deeper, and what is the root cause? Why do I have high testosterone, and let me address that, not just hide the symptom or the expression.

Jen: Yes.

Steph: That's again why we would look deeper and look at a really holistic approach, which largely includes diet and lifestyle.

Jen: Yeah. Yeah, that is such a bandaid approach to things, isn't it? Because even if you take the pill to regulate the cycle, you may still have insulin resistance underneath that, which is going to cause you other health issues.

Steph: Oh yeah. I mean, insulin resistance is a progressive disease that is a pretty horrific way to shorten your life span.

Jen: Going back to that question, we might as well touch on it now going ... You posted slightly earlier. How do you diagnose for insulin resistance?

Steph: Yeah. There's lots of different blood tests you can do. But, I mean, really the gold standard would be to measure your HbA1C. It stands for your glycated hemoglobin, which is a three month measurement of the sugar that's essentially stuck to your red blood cells. Someone of a healthy metabolic profile would have a HbA1C of 5.3%, and then insulin resistance starts to be diagnosed towards ... it's really 6.5%, but we see the precursors at around about 6%. The blood test, any GP can do for you. They can also test your fasting insulin. The reference ranges are unfortunately not amazing in the West. We like to see an insulin of around about three or five, at three to five. Just be mindful of when you get that test, who interprets it for you because not having a disease is very different to optimal.

Again, I don't want to sound like I'm criticizing the medical model. I think there's lifesaving benefits of that. But I don't want to be told that I just don't have a disease, I want to be optimally healthy. That's why reference ranges can be quite skewed because they have been collected over decades, from an average of the people that go to the doctors. Now, you visualize the last time you were at a doctor's clinic, who's in the room with you? Are they optimally healthy, and the kind of people that you aspire to replicate their health? Very rarely is that the case. The average is a quiet average. I say HbA1C of 5.3%, and an insulin of three to five. Any higher than that, and you're on the pathway towards insulin resistance, and then there's the official diagnosis at 6.5%.

Jen: Okay. Right. We're all running off to get our blood tests this afternoon.

Steph: People are rewinding the interview to write down the numbers and the HbA1C. I get it. Good place to take those notes.

Jen: Actually, well, that's a good point. I will take the notes and I will put them in the show notes for this episode, including-

Steph: Right.

Jen: ... the numbers. Just go-

Steph: [crosstalk 00:24:21]

Jen: ... check out the show notes. What can be done? You've already alluded to how nutrition plays a big role. Well, [crosstalk 00:24:31]

Steph: Yeah, I think it's number one. I think number one, is to stabilize your blood sugar, and how do we do that? Well, it's going to be your version of LCHF. Now, to recap that stands for lower carbohydrate healthy fat. So it's not zero carbs, and it's not drowning your food in oil. It's really just moving to a real food template. Most of your plate comes from plants or non-starchy veggies, there's a small amount of high quality protein, and then we get lots of fats from both Omega 3s, which are nuts seeds, olive oil, avocado, free range eggs, grass-fed meat, and then small amounts of saturated fats from things like grass-fed butter, buying the chicken fines, so the breast or getting our grass-fed steaks, if that's the way we choose to eat, and a little bit of coconut oil or medium chain triglyceride oil.

Then, as we would have discussed last time, just being really mindful of what sort of complex carbohydrate you do consume. If you've been diagnosed with insulin resistance, then to reverse that, I'd be cutting out most complex carbohydrates other than resistant starch. But if you're quite lean and you've got a fairly good metabolic profile, then you need to be including your sweet potato or your potato or a little bit of white rice, especially post-training, to help with that muscle glycogen replenishment. But it's only a very small part of the equation. It's mostly plant proteins and healthy fats, and that stabilizes your blood sugar. That's going to help me everyone, regardless of PCOS or PICO or whatever it might be. It's actually all about nutrient density, and that's ultimately what we should be striving for when we look at food and how it impacts our health but also our longevity.

Jen: Yeah. You're preaching to the converted. [crosstalk 00:26:30] What about supplements? I have a client ... well, I have multiple clients who have PCOS, and I asked one of them what I should ask you. She had two questions. One of them was about supplements, and that she had heard something called-

Steph: Inositol.

Jen: Inositol. Had some decent evidence behind it. What's your view?

Steph: I mean, first and foremost, I would make sure that before you're buying anything that is a supplement, you've addressed nutrition because that is the lifelong strategy. I think that we are very pill for an ale, whether it's pharmaceutical or natural, and it annoys me that we go there first. I'll just get that off my chest. The Inositol conversation is quite interesting when it comes to PCOS, because they're is some pretty much ... pretty good research that is showing the right type of Inositol supplement can really help manage PCOS. But we need to be able to separate, I guess, fact from fiction in the supplement industry.

There are a couple of different types of Inositol. There's Myo and Di-Chiro, and it's actually important that the Inositol supplement contains both forms so that it actually is more absorbed, and the research shows it's much more effective in helping to manage

PCOS. Some of the issues that I have with the research though is that the research is quoted all the time, but they're actually quite small studies. I believe they're about an N of 50, which is 50 subjects, and maybe there is one that was up to about a 100 objects. Now, we can't really use that as a extrapolation to the entire population, so I'll be waiting to see much greater clinical trial with a much larger subject number before we spend all of that money and expect amazing results.

But when we talk about supplements, it's going to come back to quality. This is a little bit of a side note, but a lot of the Inositol supplements also contain folic acid. Now, folic acid is that preconception nutrient that we hear all about in countries like Australia, that our grains and cereals have been fortified with to avoid birth defects and spinal bifida, and it's products elevate that are recommended preconception. But there is actually quite a high percentage of women that don't tolerate folic acid in its most synthetic form, and it might be totally off topic, but it is those with an MTHFR genetic mutation that really need to be mindful of products that contain folic acid. That, you'd really want to understand first.

I think when PCOS is often found or diagnosed, is quite often in a fertility conversation because a woman's trying to conceive and suddenly realizes that it's not as easy as she predicted, and then further research or further investigation is conducted and PCOS is diagnosed. It is around a similar time of conception. We actually don't want to start taking folic acid if we don't understand our genes and our ability to tolerate that nutrient. You would still take a prenatal, but it'll be a methylfolate or a 5-MTHF. It's just mindful that you look at what you're taking and make sure you understand all the ingredients, because it's not that black and white.

Jen: Wow.

Steph: Bit of a side note for you.

Jen: That's an interesting side note. Especially around the gene. The gene. Because who knows? Unless you had specific testing for that, there's no way to know either way.

Steph: No, which is why I think it's really lovely to work with a natural health practitioner for ... as part of your fertility plan, because we can work all these out and then take the right prenatal, but also be taught how to manage insulin resistance and help support your PCOS without the need for pharmaceutical intervention. Then what you're doing is ticking all your fertility boxes if you do want to have children, and fertility is not just about [inaudible 00:31:10] making babies as well. There's other reasons why we want to have a normal menstrual cycle, and you probably let yourself, Jen, to avoid having to have surgery and things like that.

Jen: Absolutely, yep.

Steph: If you hadn't known, what you know now. That's something I think is really important to acknowledge because, yeah, we tend to jump to supplements. I'm not saying don't take Inositol, but I would probably do it under the guide or through a practitioner to make

sure that you're getting bang for your buck because they are expensive, but that you're not ... what is it? Missing the forest for the trees or-

Jen: Yeah. What was that-

Steph: [crosstalk 00:31:46]

Jen: Can say the wood for the trees, or something. Okay, whatever that one is. Which a great point too. You said before that nutrition was the number one, perhaps the most important way to manage and treat this disease. If that represents 90% of the solution, bu we're in a culture where we jump to supplements, which may only take care of a tiny bit of the problem, or may not be the most effective solution around.

Steph: Yeah, definitely. It needs to be taken in context. This is what I think we forget about in the supplement world. I mentioned there's two types of Inositol before, and then there's one that I said was Di-Chiro. There's plenty of research that that is not appropriate for women going through IVF, because it impacts with egg quality. We need to know all these factors because we need to look at the whole situation. I think podcasts are amazing, but what we don't know is the unique situation of the female listening. So we really have to be mindful for this black and white advice. That's why when we talk about supplements, we talk about high quality but we talk about looking at it in context and getting advice from someone that can look at your entire case history and health goals and plans for the future. That's the best way to do it, and you'll get better results that way.

Jen: Do the strategies differ whether you're trying to conceive or someone who just wants to feel healthy and well, when it comes to PCOS?

Steph: Do the strategies defer? No. I mean, there are probably going to be additional fertility based strategies, if that's a goal that you're including in your PCOS management. Most women have a bit of a timeline there. But the foundations would absolutely be the same. [inaudible 00:33:39] next in line is exercise. I mean, again, preaching to the choir.

Jen: [inaudible 00:33:43]

Steph: Yeah. In terms of where we go next as a natural treatment, it's movement. I mean movement is just one way to mobilize glucose into your cells, and that's part of treating insulin resistance or avoiding hot high circulating insulin and promoting fat burning.

Jen: Of course.

Steph: I know, hopefully our listeners are moving, but it is ... you can tick that box as part of your treatment strategy.

Jen: Yeah. So nutrition number one, exercise two, stress management three?

Steph: Yeah, absolutely.

Jen: Or thereabouts.

Steph: Yeah. I mean I'd say if you're on the pill, get off it. That could be number one. That could be number three. Obviously, the pill is masking your natural hormone or pattern, and you don't really have a look ... you can't really have a close look at the underlying imbalances of PCOS, and it is the bandaid solution. It also is interfering with your guard and impairing nutrient absorption. We often see things like magnesium and zinc deficiency in someone that's been taking the pill, especially long term. I'd be working with the practitioner to understand how to come off the pill and what to do to support your body on the other side of that.

Jen: Stress management, going back to what we were saying earlier. Rejuvenation practices, which Katie shared at Sparta Chicks Unleashed, and I know she's been [crosstalk 00:35:11] on your podcast talking about, and she's going to be on this podcast again this year talking about those as well. That's high on the agenda too.

Steph: Well, without a doubt, I think a simple meditation or yoga, all of your sessions that you built into your training program that are your, I think, rejuvenation or restoration are great words to describe that. It's not just about swim, bike, run, as I'm sure we understand. But it's very easy to know that, but to live and breathe that.

Jen: Very true. That's really true. I have to say the ... I mean those stress management rejuvenation practices tend to be the first one that get dropped from our day when life gets busy. But-

Steph: 100%.

Jen: ... clearly, they're the stuff that helps us manage the busy.

Steph: Well, we always forget that the actual benefits from training come in the recovery.

Jen: Yes.

Steph: I mean, to me that is the biggest thing to remember. Getting the benefits out of the training during the session, you're breaking down all the muscle fibers and causing all the damage. So how do you get better if you never put in recovery or restoration? You don't. You just get worse. That's why we say the say have a training conversation.

Jen: Yeah, yeah. Very true. Now, one final question that came in from my client who has PCOS, and she did admit that this question might be better suited to a psychologist, but I wanted to ask you. It was around self sabotage. Her challenge is that she says she knows what she needs to do, but when her mood is low, thanks to PCOS, and she's feeling terrible things to the side effects and symptoms, what recommendations or suggestions do you have to help manage the self sabotaging of it? How do you stop yourself from eating your feelings, when you're feeling shit?

Steph: I know it might sound a little bit basic, but respectfully, I think it is about the blood sugar control. Because I don't actually think it's a similar to the 3:30-itis conversation. Obviously it's deeper than that. Don't get me wrong. But you will make the wrong choices if you've got poor blood sugar control.

Jen: Oh yeah, that's so true.

Steph: Yeah, that's all part of the conversation. Why the default is chocolate in week four of your cycle? Or eating the refined carbohydrates on day one of your period or whatever it might look like for you. Some of them would get at mid month when they're ovulating, they want to eat shit, pardon me, or sleep all day or bawl their eyes out. It's not simple. I'm not saying that, because it's multifactorial. But if you've got great blood sugar control and you're not hangry, we all know that we'll make a better choice. You're much less likely to self sabotage when you've got those foundations. I would start there, definitely, and then I would always make sure that you've got "healthy options" available. If you have Cadbury's Top Deck in the fridge, and you'll eat it.

Jen: Yes, I will.

Steph: [crosstalk 00:38:25] I hate to be blunt, but we are not that evolved as humans. We're very similar to monkeys. You will eat it, so don't buy it, but go and buy a beautiful 75 or 80% dark chocolate, or make your own Bliss Bowls or Keto Bites, or bloody gluten free carrot cake with cashew cream ice cream. Whatever floats your boat, make it and have it there. We always say those options have inbuilt portion of control, because there's no refined sugar, which is just a drug that keeps you addicted and literally makes you eat the whole block of Cadbury's, versus using our natural sweeteners or our stevia or monk fruit, or even a bit of rice malt syrup. Yes, they tastes sweet, but those options are full of protein and healthy fats, which are our satiety macro nutrients. They actually balance our hormones, and you're far less likely to overeat.

Jen: So true. In my old life, I could have knocked over a block of Cadbury's [crosstalk 00:39:30]

Steph: The old [crosstalk 00:39:31] I recognize still can. I mean, I can't tell you the last time I had Cadbury's, but I can guarantee you that most of us are ... we're just one step away from having a sugar addiction if we open the floodgates. It is a drug. It's been shown to be more addictive than recreational drugs like cocaine. That's not even ... It sounds funny when I'm saying things like that, but it really is a drug that you are just dying for your next heat off. If you get rid of the refined sugar and replace it with those healthy alternatives, that's more than halfway there.

Jen: There are lots of great options for things that you can go and cook yourself on Steph's website at The Natural Nutritionist. Trust me, I have-

Steph: I know.

Jen: [crosstalk 00:40:14] I haven't made them all yet, but I'm on my way.

Steph: You just got to find something that floats your boat, that ticks that box for you. That's the best thing about this lifestyle, and that no one's asking you to do it 100% of the time. You're still allowed to trade. You've got to acknowledge what is a good trade for you, that's a good decision that doesn't unravel everything else you've done.

Jen: Yeah, that's a good point. Mine are the chocolate bites, or the Bliss Balls, and also the Pana Chocolate, [crosstalk 00:40:44] chocolate. Because I never would've ate dark chocolate normally, but I love milk chocolate. I can only eat a square. Any more than that and I don't feel very well because I've tried that. I get my little fix, and I feel ... and have good blood sugar control.

Steph: Do you find that you naturally have portion control?

Jen: Absolutely, yes.

Steph: Yeah, how life changing is that?

Jen: Massively. Massively. But I'm going to talk to Elly about that in a few weeks.

Steph: Oh, good.

Jen: Yes, yes. Steph, if anyone listening would like some more support and help around this, how can they get in touch with you, make an appointment to see you, or perhaps one of the other nutritionists at The Natural Nutritionist?

Steph: Yeah, thank you so much. Yes, our website, our online home is thenaturalnutritionist.com that I use. So you can contact us directly there, or give us a call. All the details are online. I am not that long away from maternity leave. I'll probably be on mat leave by the time this episode airs, so it won't be me. But, as you know firsthand Jen Elly is an amazing practitioner, and she is available to help anyone who's looking for that individual support, whether it be for PCOS or LCHF or just general health and longevity. So please do reach out, and stay in touch. It's so great to chat with you today, Jen.

Jen: You too, and all the very best for your impending arrival. The next time we talk to you, you'll be the mother of a little one.

Steph: I know, I keep saying I have my plus one. That's what's happening.

Jen: All the best. Thanks Steph.

Steph: Thanks, Jen. Speak again soon.