(introductory music)

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MARGO: All right. Hi, everybody. Welcome to *"Well, Actually…"*, a podcast with me, Margo Blackstone. I am excited to have another guest on today. And this is one I'm especially excited about talking about something we have not talked about on the podcast yet which is sort of surprising. So I'm going to introduce you to Lisa Henrickson-Jack. Thank you for being here today with me.

LISA: Thank you for having me. I'm excited to be here.

MARGO: Yeah. I'll tell them a little bit about you before we hope in. Lisa is the author of *The Fifth Vital Sign: Master Your Cycles and Optimize Your Fertility.* And I have a copy of the book sitting her next to me which I have very much enjoyed reading in the last week or so. And Lisa is a certified fertility awareness educator and holistic reproductive health practitioner who teaches women to chart their menstrual cycles for natural birth control, conception, and monitoring overall health. In her new book, *The Fifth Vital Sign*, Lisa debunks the myth that regular ovulation is only important when you want children by recognizing the menstrual cycle as a vital sign. Drawing heavily from the current scientific literature, Lisa presents an evidence-based approach to fertility awareness and menstrual cycle optimization. She hosts the Fertility Friday podcast, a weekly radio show devoted to helping women connect to their fifth vital sign by uncovering the connection between menstrual cycle health, fertility, and overall health. So pretty much you're a rock star, huh? You hit it all.

LISA: Oh, thank you. When you're listening to your own bio, it sounds like a huge mouthful.

MARGO: Yeah. I'm sure. Yeah. I'm super pumped. Maryn and I got the request from you to maybe hop on and talk about these amazingly important topics, and I jumped at the chance. I have been, at least loosely, following you for as long as you've been doing the podcast.

LISA: Wow. That's awesome.

MARGO: Yeah. And fertility awareness was kind of the way that I actually got into midwifery and all things holistic health. It was my entry point. So I'm really excited to

have you here. You're a wealth of knowledge, and I can't wait to see what we talk about.

LISA: I love that. I love that it was your entry way into midwifery. As you can imagine at some point, I considered if that would be the career path for me.

MARGO: Totally. I bet. It all connects. So yeah. I guess to start off I wanted to see if you could sum up for us this idea that's the central sort of tenet of the book which is that ovulation and health cycles should be regarded as a vital sign. And if you can just talk a little bit about what that means. Obviously, you talk about it for (inaudible) in your book. But yeah.

LISA: Yes. Absolutely. I think really and truly it's trying to get at a lot of the myths that we're taught about our bodies and to correct some misinformation and just, in general, to have us start thinking about our menstrual cycles as an important part of our physiology as a biological woman with a menstrual cycle. And so the—it's almost like a direct challenge to the current medical paradigm. And you'll notice I spend a lot of time in the book talking about birth control because it kind of gives us the sense of what happens when we suppress our cycles. But essentially, the current myth or paradigm around the menstrual cycle—it suggests that really it's only important for us to ovulate and have menstrual cycles when we're trying to have babies. And outside of that small window of time in our lives when we're trying to build our families, the idea is that it doesn't really matter if we're cycling or not.

And that idea really sets the stage for, essentially, a lifetime of—on hormonal birth control where it's really common and not to—it's not to say that no one should use birth control or anything. It's just to open up the conversation. It sets the stage for women to be on birth control for a lifetime and to really just not really think about our menstrual cycles or that they're important. So in the book, I'm arguing that the menstrual cycle is a vital sign because—so in my case, I've been teaching women to chart their menstrual cycles for almost 20 years. And I've been charting my own menstrual cycles for about as long. And when you do that and you start to see the menstrual cycle and literally track your—the total length, your periods, your cervical mucus production, all these different things, what happens is you start to see that a woman's health whether it's kind of day-to-day stress levels or day-to-day specific events or specific endocrine issues like thyroid disorders or other endocrine dysfunction or—you can kind of list a number of different health issues. What you start to notice is that the menstrual cycle is affected by these different factors, and it changes in response to whatever is happening in your life.

And essentially, your cycle is always reflecting back to you your overall health. And when you start to realize that and you start to realize that, for example, if a woman stops menstruating, so if a woman stops ovulating and stops menstruating, an example of that is in the case of hypothalamic amenorrhea where you—we typically think of the situation of an athlete who is over exercising, undernourished—so not getting enough energy in to offset the deficit or under a great deal amount of stress or a combination of those three factors who stops menstruating. In our culture, we kind of recognize that as an issue. But typically, the medical fields—the way that it is address is often just to put a woman on birth control. And what's interesting about the example of hypothalamic amenorrhea and the reason I often refer to that when describing the menstrual cycle as a vital sign is because if a woman loses her period it's a sign of really big period. Essentially, her body is—it does not—it's a combination of over exercise, under nutrition, stress, and, essentially, your body is stopping you from ovulating and stopping you from menstruating to conserve energy as a way to preserve your life because our fertility is important for health. But overall, it's not necessary for survival. So if your body is under a great deal of duress, it will kind of shut that off as a way to conserve energy.

MARGO: I see that could be super dangerous for your health.

LISA: Well, absolutely because, for instance, when a woman loses her period when she stops menstruating, her—she rapidly begins to lose bone mass and is—the longer that it lasts she's at a lifetime risk—greater risk of developing osteoporosis.

MARGO: Mm-hmm.

LISA: And so when you think about the menstrual cycle, typically, we just think about it in respect to our ability to have our children obviously. We don't think about it in terms of our bone health or our breast health or just overall even our heart health or—we don't think that it could be affecting all these different factors. But it does. And part of—one of the analogies that I use when I describe this is if I were to go to a car dealership and buy—wanting to buy a car, I could choose to put in the AC or not. And if I put in the AC or if I don't put in the AC, the engine works the same because a car is a machine that human beings have created. And these parts kind of are sold separately. But with regards to our menstrual cycle, we kind of have this idea it doesn't really matter, and it's not really integral for our health. But we're not machines. And therefore, if you can wrap your head around that, then we can recognize that the menstrual cycle is actually a central part of our physiology as women.

Our menstrual cycle is how we produce hormones. We produce estrogen as we approach ovulation. We produce progesterone between our ovulation and our next

period. And if you—if our period and our menstrual cycle and ovulation is how we're making hormones and if we have hormone receptors all throughout our body and if these hormones and the receptors—if they can contribute to all kinds of different health concerns outside of our ability to reproduce only then can we really recognize how important it is for women of reproductive age to have healthy menstrual cycles.

MARGO: Yeah. Amazing. And I was just going to add to it's like not only are these things so—not only is our cycle so important for our overall health as you so eloquently have just explained. I feel like one of the barriers in our culture is that it's not even just ignored. It's sort of considered a nuisance especially—I remember probably in my later teen years when they came out with the first pill where you were allowed to skip the sugar pills. You only would have to get your period—which is as you talk about in the book isn't actually a period. Four times a year. Wasn't it Seasonale, or something, was the name of it? And I remember thinking like, "Oh, man. That would be so fantastic as a gymnast who,"—and I totally was someone who was an over exerciser who lost my cycle for awhile in my teen years. Yeah. So it's just so amazing that we have a long way to go, I guess.

LISA: Well, and what's really interesting about just the concept of us being at a place now where the pill producers are making pills and suggesting that we don't need periods and all of that, when the pill was first developed the initial design didn't have a withdraw bleed. And when I was researching for the book, it was—the stories—it's kind of interesting. So it's hard, I think, for a modern woman in 2019 as we're recording this to think about what it would have been like in the fifties for women. And so as I was reading, these doctors—some of these doctors were really trying to help women sort out their fertility because imagine a woman—there was an example of a woman in one of the books that I was reading who was 30 years old. She already had 8 children. She didn't want to have any more. And her option was a hysterectomy really. The doctors, from a medical standpoint, they didn't really have a lot of options for women. And so that was part of the motivation just to give women some power in their ability to make decisions.

The first iteration of the pill there was no withdrawal bleed. And it was interesting because some of the women that they were testing this on had been trying to get pregnant. So it was almost as though they were trying to kind of restart their cycles. So you would have these women. They would take this pill. And then they would stop getting their periods and, literally, thought that they were pregnant. And because there was no precedent for this, because this is the late fifties, there had been no pill. And so before that, your period just came, and there was no way to stop it really unless you were actually ill or went through menopause or were breastfeeding, et cetera. Yeah.

No matter what the doctors tried to explain to them they couldn't—when the women realized that they weren't pregnant, many of these women actually were devastated because they were trying to get pregnant. They wanted to be pregnant.

So then that's what—when the pill was designed, that kind of—those series of events led to adding in the withdrawal bleed. And so now there is a lot of different articles. I'm sure you've kind of heard the buzz around it. So it's almost like now the drug companies are admitting that we don't really need to have the pill bleed because it's not a period. So now they're kind of embracing because it isn't a period. It's a withdrawal bleed. I mean I think most women realize just the thought of not actually bleeding for years on end feels kind of—like it just doesn't feel right. It doesn't sit right, I think, with most women. I mean from—like yeah. Periods are considered and talked about negatively and a hassle. But I think, on some level, for most of us when you hear, "So I'm just going to never bleed," it kind of feels a little weird. So I don't know how I feel about the idea of totally getting rid of the withdrawal bleed entirely. I honestly don't necessarily feel comfortable with that. But I can recognize that it's not a period. And technically, it's not actually—technically, it's not medically necessary from that standpoint.

MARGO: Right. Yeah. That was one of the most—I think that was the part I dog eared the most. (inaudible) the pill stop and the—that the fake menstrual bleed was added to make it a more palatable option for women. Yeah. That's so fascinating.

LISA: Well, and what's interesting about it as well is that the fake menstrual bleed was intended to make women think that they were still getting their period. So from the beginning, there was never a proper discussion about how—okay. It's not your period. This pill is suppressing ovulation, so it's preventing you from ovulating. And it's also thinning out your endometrial lining and filling your cervix with a thick mucus plug to prevent sperm—so there's these three main ways that it's preventing you from getting pregnant. But make no mistake. You're not actually having a cycle anymore. And so that was—that conversation never happened. So to this day, the majority of women on the pill believe that they get their period. And they believe that the pill regulates their period and all that kind of stuff. What they don't realize is because the pill is suppressing ovulation and the estrogen and progestins in the pill are not the same as the hormones we create because they can't patent those. We have to make money, right? And legitimately. In order to make money, they have to change the chemical structure of these hormones so that they can own them and sell them.

MARGO: Right.

LISA: And so you're—we just talked about how in order to make hormones—our main ovarian hormones—we have to ovulate, and that's why the menstrual cycle is important for health. When you suppress the menstrual cycle and you stop making those hormones, that's when you have a lot of different problems that can arise. And when you look at the roster of side effects of hormonal birth control from anxiety and depression to low libido to painful sex to nutrient depletion to how it affects your potential choice of a mate, all these different things, that's far outside of our ability to reproduce. It's only then can you really recognize, "Wait a minute. The menstrual cycle is about more than just reproduction, if by stopping it you can cause all of these unrelated side effects that just seem to be kind of random. How could it affect all of these different things?"

MARGO: Yeah. The other one that jumped out at me was that it—that hormonal contraceptives can shrink the clitoris and surrounding vulvar tissues. I didn't know that.

LISA: Yeah. Yeah. There's that. So I mean it's interesting when you look at the research. I think what struck me was that there is so much research about hormonal birth control and all of the different side effects. And so the one particular study that I cited, they did give women the pill. Well, it was—I'm trying to remember exactly. It might have been the ring. But it was a combined oral contraceptive preparation containing the synthetic estrogen, synthetic progestin combination. And all of the study participants that they looked at experience clitoral shrinkage. The actual clitoris shrunk by an average of 20%. That's an average. So that means some women had more and less. And they also looked at the vulvar tissue. So in particular, the opening of—the vaginal opening itself, in particular, was thinner. And that based on what the information in the study, I mean one of the side effects. And the word side effect almost implies that some women would experience it and some don't. So there's certain effects that happen on birth control, certain physiological changes, that happen to all women.

MARGO: Right.

LISA: And then how that plays out is different. So not every woman is going to have painful sex or identify that she's got really low libido. But all women across the board are going to experience a significant drop in testosterone. More than 50%. And so these changes to your physical vulvar tissues, clitoris, vaginal opening are related to the drop in testosterone because these tissues are very sensitive to the hormones that we produce. And so I mean—yeah. It's pretty terrifying. But then, again, I mean there's a running joke that one of the reasons why the pill is so effective is because you don't want sex anymore. Now everyone doesn't have that experience to the same degree, if you talk to a lot of different women. But you talk to quite a bit of women, and you realize

that this low libido thing is quite common. A lot of women talk about that. How either they—and the scary part is that a lot of women start on the pill when they were 15 or 14. And I know when I was 14 I wasn't really aware of what my libido was like yet. And so then it sets the stage for women having low libido and not knowing that it's low and thinking they just don't really like sex that much. And at some point, when they come off of it in the future, surprise. Like whoa. I actually do have a sex drive. And that's a really common response you hear from a lot of women.

MARGO: Yeah. That's amazing. The other thing I found really fascinating and I was reminded of as you were talking is this other piece of not just how it affects us physiologically but out in the world. Like you had said, it affects the way that we interact with potential mates. Or the example you gave of women who work in strip clubs and making more money when they're actually having a regular cycle as opposed to being on hormonal contraceptives, I thought, was just so interesting because I'm sure there' a million other even more subtle ways that it plays out beyond those examples that when I think about is really astounding. And I think terrifying is a good word too.

LISA: Yes. I would definitely agree. I mean so I've—I think a lot of us have heard that idea and potentially read an article or something like that about how the pill could potentially affect mate choice. And a lot of women when they're coming off the pill are scared. Am I going to hate the way my partner smells now? Things like that. So when I looked into it, I didn't really anticipate how much research there was. This is a theme. But there is an entire field in environmental biology essentially that is looking into this. And so the technical term is the major histcompatibility complex. And basically, our—the way that our genetics are is reflected—so our genes—it's reflected in the way that we smell to others. So there's two parts of it. One is how I perceive my partner's scent. And another one is how I actually smell to my partner.

And so part of it is within your ability but then part of it is out of your control because how people perceive is out of your control. And so what was interesting is that they've done studies—and so there is different ways they've looked at it. They've done T-shirt studies where they'll have people wear T-shirts. And then have women kind of pick the ones that they smell—that they prefer. And then they'll have other studies where they'll have women choose based on the actual physical features of the person. And so it's kind of controversial because these studies are very gendered. So it's often—it's not always man woman. But it's often man women.

MARGO: Right.

LISA: So I just put that out there because when I'm speaking about it I just want to know—want the listeners to know that I'm relaying the information, not necessarily

making judgments around gender. But what the studies show—that truth is stranger than fiction—is that when you're taking hormonal birth control you're more likely to be attracted to a partner based on their scent who is more similar to you from a genetic standpoint. And, again, controversial thing to talk about because there are studies that would suggest that if you are more similar genetically you are potentially more likely to have difficulties getting pregnant from a statistical standpoint.

MARGO: Right.

LISA: And then also women who were on birth control were more likely—so there were these—it's kind of strange. There were these studies where they would feminize the faces of men. And you could see the pictures of the men in the studies. They would actually do things to make their faces look more feminine. And so women were more likely to choose men that just had more feminine characteristics. So I'll just leave that there, and you can kind of interpret that how you will. But what it boils down to is that it's changing how we perceive scent, and that is one of the ways that we would naturally select a mate. And so for women who meet their partner while they're on birth control, then it's possible that when they come off at some point in the future they might actually—so I mean there's stories about—I give an example in the book of a woman who met her partner on birth control eventually went off of it and really wasn't attracted to him anymore and ended up breaking up with him. And then there's women who meet their partner first and then they go on the pill. Well, that's a little bit different because they actually did meet their partner when their olfactory senses were operating normally.

And then on the flip side—so the stripper study that you mentioned. Was an interesting study that we're looking at it because this is looking at the reverse effect. The question that the researchers were asking is—it's about what they call—what's the word for it? Competitive advantage. So they're trying to determine if women who are cycling naturally and ovulating have a competitive advantage compared to women who are not. So you had some of the women who were on birth control. Some of them who were ovulating naturally. And it, again, truth is stranger than fiction because in the study their measure was the tips. And so women who were cycling naturally—they would get—make more money around ovulation. And I mean there's a lot of research around how men respond. So on the flip side, the studies show that men are more likely to be attracted to women during that period of time. And they're even more likely to appreciate the sound of their voice more.

MARGO: Mm-hmm.

LISA: Which—around ovulation. Yeah. So these women, when they were ovulating, would make more money. They would make a little bit less money around

menstruation. But the overall—and then the women who were on the pill they just—there was no change. It was a constant amount. There was no big fluctuation. But for the women around ovulation, there was—and overall, I believe, if I remember correctly, the women who were cycling naturally made about $83 more per shift overall.

MARGO: Yeah. When I read that section, I thought, "Man, maybe that's why I was bad at getting boyfriends in college," because I was on the pill. That will be my new excuse.

LISA: We'll never know because it's such a strange area of research and so interesting to think about. But I think regardless of all the little specific details around it what we know is that it is changing how we smell to others and how we perceive the scent of others. And that is—

MARGO: That's a big deal.

LISA: That is outside of our ability to reproduce, and so it shows us this is really messing with something. The thought. Can you imagine? The thought of this drug could actually make me choose a different partner. That just makes—leaves me feeling unsettled.

MARGO: Yeah. And I think it's such a good—I mean it seems like the—one of the big barriers that—and one of the things that you're trying to bring light to is that—and what we talk about too with midwifery and birth here at Indie Birth is the body is not a machine, like you said. Like we can't separate out all these components. The way that our brain and nose works is connected to the hormones that our body is creating or not creating. And just the idea that everything is connected and interconnected is so—runs so contrary to the body as machine, kind of technocratic, medical paradigm. So yeah. It's amazing work that you're doing. I had a question for you that I think piggybacks nicely off of this which is that—let's see. How do I want to phrase it? Just that we're talking about a lack of transparency, obviously, around what can potentially come up with birth control. And I guess I could do a tiny version of my story in case people are interested.

Like I mentioned, fertility awareness is—was kind of the way I got into the world of alternative health, which I don't really like that term. But I can't think of a better one right this moment. And sort of holistic living and self healing and herbalism. And like it was just the way that I got into it because when I was 15 I went on birth control. My mom was very adamant, and we've had lots of conversations now. She feels about this in retrospect. I don't blame her at all. She really didn't want me to get pregnant. And so I went on birth control when I was 15 which was—we both were happy about. But I went in for my 3-month checkup that they like to do to make sure you're handling the

new drug as they would like. And they were doing my other vital signs, right? And my blood pressure had gone from being normal to stroke level.

LISA: Wow.

MARGO: At age 15 as a very athletic, healthy in other ways dancer, ex-gymnast. So I think my blood pressure at that checkup was 180/120. And they said, "Oh, we can't give you any more birth control because, obviously, you're responding badly to this. So you're going to have to go see your regular nurse practitioner." I had gone to—through the county program to get it for cheaper or something. I don't know why we did it that way. But so, "You need to make an appointment right now. You don't get any more birth control. Go see your nurse practitioner that you usually see." And so I think I saw her within a day or two. And instead of saying, "You shouldn't be on birth control," they said, "We'll switch it to a different kind that maybe you'll tolerate better, and we'll put you on blood pressure medication at age 15."

LISA: They did not put you on blood pressure medication at age 15. Holy cow.

MARGO: Yeah. So that was my—that was how it started, and then around the time I went to college a few years later—I started college at 17. Over the course of the years that I was there, I kept trying to get off the blood pressure medicine, off the birth control, tried every—I did the ring. I did—the Depo shot was the last thing I tried. I tried a couple other versions of the pill. And eventually, through all my searching, found fertility awareness, and said, "I'm going to try this." And we have a book coming out in the spring, and I talked about this just for a little bit in the book in my notes that I have now from seeing the—this group on campus. The campus health clinic. They had written down that I had very firm beliefs about what I would and would not do because I said I really don't want to take birth control anymore. I think it's killing me.

And so they were not supportive at all. And they were really worried about me going off birth control thinking I was going to get pregnant. And they referred me to a Catholic church in town to learn more. That was their best suggestion. And they really didn't recommend it. So long story short, I eventually did go off birth control completely, and my blood pressure never really went totally back to normal. So it's something that I've had to struggle with since I was 15. I'm 30 now. And I'm in my second pregnancy, and it's definitely made my life much more challenging. But on the other hand, I'm really grateful because it was the way that I started getting interested in how do I approach this in a different way and learning about herbs to help my blood pressure and all of those things. So that was my long short version of the story and bleeds into the question about this lack of transparency. So how do you—I'm sure you think about this more than I do. What are your thoughts around how do we get providers to be more

transparent? And I think you talked in our book a little bit about how they sort of approach this generally around terms of effectiveness as kind of their main concern. And then on the flip side, if we can't control that, how do we help get this information into the hands of women so that we don't have to rely on providers to be more transparent if they're not going to be ever?

LISA: Yeah. It's a big question. I don't know if I have an answer. I know that I—so for instance, one of my colleagues, Dr. Marguerite Dwayne—I quote her a couple times in the book. She runs an organization FACTS, Fertility—and I'm going to brutalize the title. Fertility Awareness Collaborative to Teach the Science, I think it is. I think. I think I did okay. So I remember speaking with her because every time I get my hands on a medical doctor I want to know. I want to know what is it that you learn in med school because I—part of my motivation whenever I get an opportunity to talk to a doctor—I just want some insight because you see—the proof is in the pudding. I've spoken to hundreds if not thousands of women over the years. And they share their experiences, and it's not every woman that has a negative experience. And it doesn't even necessarily mean that it's negative, but most of the women that I've spoken to over the years, if they're bringing up fertility awareness to their practitioners, it's often not encouraged. So there's that.

The hormonal birth control is typically pushed for everything, every issue that can possibly arise. And I've experienced that both personally and professionally. And so in terms of, I think, the first step is understanding. So my understanding from my interviews with doctors is that in medical school doctors are taught about the menstrual cycle and they're taught about it in a way that reflects our understanding of it. They are taught about basically—even though it's incorrect, they're taught that all menstrual cycles are 28 days. Ovulation always happens on day 14. And basically any change or deviation from that then all—they learn about all the different pathologies. But essentially, the solution to the pathology is the hormonal birth control for basically all of them. And when I asked about how doctors—in some of my interviews when I asked some of my doctor interviewees what they were taught about the side effects for birth control, I mean they're taught about the life threatening side effects such as stroke. But it's often in such a way that yes, these happen. But really we want to identify women that have specific risk factors for this. So it's not necessarily taught like we have to worry about every 15-year-old girl. It's more like if she's over 35 and if she smokes or if she has a blood clot disorder, whatever, then she's at an increased risk, so we want to identify her. And then the solution is to put her on a different type of birth control. So to know how to prescribe so that you know maybe she should be on this type or maybe she shouldn't be on—maybe she needs to be on a type that doesn't contain estrogen.

But it's, again, not from the perspective that I'm coming from which is that the menstrual cycle is a normal and natural, healthy part of being a woman. It's a sign of health. It's a vital sign that we can monitor. Suppressing the cycle is bad. This is not the same perspective. So in my conversations, for example, with my colleague, Dr. Marguerite Dwayne—I mean she started her organization because she is a medical doctor. She saw a need for it. She's done surveys of doctors. The majority of doctors are not taught anything really about fertility awareness. It's lumped in with the rhythm method. So they're not aware that it is an effective natural option for women. Because if you lump it in with the rhythm method and believe that it's at best 70% effective, then you really—it's not really—you can't really consider it legitimate. So they're not taught the—and shown the science about specific types of fertility awareness based methods that are up to 99.4% effective. And that it's not the rhythm method. That it's different.

And so in terms of your original question about how could we improve transparency, I think ultimately what she is doing is targeting students—medical students. So before you're a full blown doctor and have started your practice and have really become firm and solid in your belief system, at that point it's a good opportunity to teach. To teach about fertility awareness, to teach about the effectiveness, and to try to change the narrative around the menstrual cycle as being irrelevant unless you're trying to have kids and do that. Your other question around what, as women, can we do so that we don't necessarily have to rely on our providers we have to talk about this. We have to demand better. We have to—if you are—if you have concerns about birth control and you're—your doctor is either dismissing them or not taking them seriously—like for instance, if you're on birth control and you have side effects, your blood pressure goes way up. You start feeling depressed and anxious. You start having panic attacks. You have painful sex. You have low libido. If you actually, legitimately, have side effects and you go to your practitioner or recurrent yeast infections or whatever the case, and your practitioner is basically, "Oh, it couldn't be that." Those are such common—the medical gas lighting example is such a common reaction so many women experience.

Find a new provider. We have to, as women, start advocating for the care that we need. We have to demand better. We have to understand where our practitioners are coming from. You can't go to a medical doctor who is classically trained and expect them to give you nutrition advice because they didn't go to nutrition school. So we have to really start to understand what services do medical doctors provide? What services do midwives provide? What services do naturopathic doctors provide? Acupuncturists? And start to recognize that for women's issues when we want to get to the root of our problems, we have to go to someone who is trained in a root cause type of philosophy where we're actually looking to see what could be the underlying problem. If you're going to a practitioner who is trained to provide hormonal birth control for irregular

periods, painful periods, anything periods, then that's what you're going to get when you go there.

MARGO: Yeah. Being more knowledgeable about the different kinds of practitioners, and I really like the list you had at one point in there of the many different members that could be part of your team because I feel like so many people don't realize that that could be—part of their answer. Just finding people who have different perspectives. Like you said, finding the root cause instead of being like, "Oh no. You have high blood pressure. We'll put you on blood pressure medicine too then."

LISA: Yeah. Well, and that is a—that's a situation where—that specific situation obviously doesn't happen to every woman. The kind of—the trend of you take birth control and then it causes a side effect whether that be high blood pressure, recurrent yeast infections, depression, then—so for example, young women, teenagers, who take birth control, are more likely to be on antidepressants.

MARGO: Yep.

LISA: Well, duh. We talked about some of the different ways that—so there is a few specific ways that the pill alters mood and makes you more susceptible to depression. We talked about how it dramatically reduces testosterone, and low testosterone is associated with an increased risk of depressive symptoms. But in addition to that, some of the nutrient depletion. So vitamin B6, in particular. The pill depletes vitamin B6 at a ridiculously high rate. So in order to offset the deficiency of vitamin B6 caused by birth control, you would have to take about 4,000 times the RDA. Yeah. So it's pretty pronounced with vitamin B6. I feel like vitamin B6 is the most obvious significant—you can't let the participants take a multivitamin to make it look better because there is just too much.

And vitamin B6 is crucial for tryptophan metabolism, which is associated with our serotonin production which is associated with mood. And so it affects each woman differently but some women go on to develop panic attacks. Some women just experience depressive symptoms. Some women report just a general feeling of flatness. Others report a significant loss of energy. They just don't feel like themselves. And so it's important to know that. Not because no one should ever use it but because if you—for example, in your case, if you are put on it and then you develop high blood pressure, at some point, in my opinion, if we know that this medication can be associated with these effects it would be ethically responsible to say, "Well, we just put you on this. Let's take you off of it for a couple of months to see if it could be related," instead of opting to put you on something different. I don't understand the logic of—it's

so important that we prevent pregnancy that we're going to just give it to you regardless of the side effects. I mean come on.

MARGO: Totally. And I think part of it—and I had written this down as something maybe we could talk about. But in my case, and I think in a lot of people's cases especially with youth—like young teenagers, it's so much a part—it's so intertwined with the sex phobic antisex cultural stuff we have going on because I think it was just too horrifying perhaps to this nurse practitioner or my parents or whatever to be like, "If she goes off of birth control, now we have to talk about sex more. Are you having sex? And what can we do to make sure that you do that safely and don't get pregnant for a couple months?" Which to me, I have a daughter who is 4 ½--I feel like I'm raising her in a way—in such a way that that won't be a weird conversation. That'll be like, "Oh,"—if she were to choose to go on birth control, which I would personally be appalled but would try to be supportive. (inaudible) to navigate that part. But if we got to the point where she was on it and stuff was going on, that would just be a conversation that we would have. Like, "Hey, this is really harming your body. Let's think of some other ways," which, hopefully, we won't get to that point because she already knows so much about the cycle and is already learning and probably knows more than a lot of people about birth and that. So yeah. I guess that was a question I had for you is what have you seen be the barriers in terms of basic body literacy and helping people get more educated about fertility awareness specifically?

LISA: That's a good question. I mean I would say that the number—and I don't know if—but in the moment, I feel like it resonates with me to say that the number one barrier is education. The lack of education. And it's what you mentioned. The discomfort around talking about it fully—actually talking about it. A friend of mine—I was having an interesting conversation with one of my best friends last night. We talked for a really long time and talked about a bunch of different stuff. But one of the things that came up—because I had never thought about it this way. So we were talking about, back in junior high, the sex ed that we got. And she's like—she said to me—she's like, "I had a lot of guy friends. Basically, they learn how to ejaculate. And we learn that we need to be really scared about getting pregnant." I had to ask her a couple times. I was like, "What do you mean they learn how to ejaculate?" So I remember I was kind of like—because I had never thought about it that way.

But in their sex ed class, they're taught about wet dreams. And they're taught about this whole situation of having erections in class because anyone who went through junior high knows that that phase of puberty when the boys start to have to actively figure out how they're going to hide their erections in class. So in the—they're not necessarily talk about—I mean we're not in a super sex positive—well, at least when I was growing up.

It was super sex positive where we were talking about pleasure and how that's good and all that. But it was more—at least for them, it was focused on how to manage this random penis ejaculation situation that was happening. So for me, it was actually—from her—it was such an interesting way that she framed it which is why I'm talking about it today. But it was like even though we're not sex positive, the education for men was still around their ejaculation and, essentially, orgasm and how to not—how to not—I don't know. How not—how to sort this out and how they can kind of figure out how to navigate that.

The conversation about orgasm and pleasure is 100% absent in the—so even though it could be better for the boys, it's completely absent for the girls. And the focus is literally on this random terror. For most of the women that I've spoken to and for myself as well, I was taught that pregnancy can happen on any day of the cycle. There is no safe days. And I left that conversation, as a young woman, terrified that if I ever had sex with another human being 100%, guaranteed, I would be pregnant that day. Probably within the hour. So pregnant, right? And so that really change—when you—when we're—and we weren't really taught why. We were given that general understanding of sperm and egg, but, honestly, compared to—you read the book. So compared to what actually happens, you're given a 1% barely window into what's going on. And so the fact that we're not told why—we're just told that you can pregnant every day but you're not really told why—it leaves it as a mystery and, therefore, it predisposes us to just be afraid. We're not connected to it. We don't understand it. We're terrified of it. So I mean in terms of why we are not taught and why we don't know and why so many women email me and they say things like, "I am 35 years old. I am 42 years old, and I just learned about this. And I'm furious. I've had 2 kids, and I didn't know." It's education really.

And it baffles the mind. So when you actually start to think about it and you think about this information isn't discussed and isn't part of the education system and then you—if you reflect back to what you did learn in high school and junior high, I learned a lot of detail about my eyes and my ears. Biology class was—I mean it was real. We learned about a lot of really significant, complicated processes. And so the reason isn't—there's a deeper reason why we're not taught this. And the only way to—for me, personally, as you can tell, I'm not waiting around for the government or the school system to decide this is important because, obviously, they haven't decided that it's important yet. The only way that women are going to learn about this and have the opportunity of it is by talking about it which is—and by, as women, us kind of standing together and demanding this to be taught and demanding for our daughters and our sons to deserve better because it's not just women that need to be taught.

MARGO: Right.

LISA: Because that doesn't make any sense because a lot of men go onto—I don't know. Date and marry women and have children with them. So I think it's important for all of us to know.

MARGO: I agree. I've been invited to do some guest speaking pretty regularly here in my area with junior high and high schoolers and college students too. And I always like to at least spend a few minutes on this topic and, usually, it's enough to perk people's ears up and, hopefully, send them down a rabbit hole. But I've been wanting for a long time to figure out to offer some free community education and get people excited about it. I feel like that's one of the barriers that I've seen is just like getting people to think it's applicable to them. Once they do realize it's applicable to them, people get really super nerdy about it. And I have two people right now who are like, "I'm next in line for the book. Bring it on." So I feel like people get really gung ho once they get going and, like you said, they're usually furious that they weren't taught this. And so I think there is a shift happening, but it's definitely on my list of things to brainstorm how to make that shift happen faster where I live because—yeah. Girls and women and all of us and men deserve so much better.

LISA: Yes.

MARGO: Okay. I have one last piece I want to get—make sure we get to before we have to wrap up, and that was just kind of the topic of using fertility awareness. So I guess I can frame the question a little bit. In my work as a midwife, I'm doing home births. These are people who already on the crunchy spectrum, I guess, you could call it. But even then, I'd say—I don't know if I had to put a percentage on it. But not a huge amount of them are really familiar with fertility awareness. Most of them have maybe heard about it. But most of them were not practicing it before getting pregnant. And so I'm someone who did practice it—let's see—four years or so before getting pregnant. And so I feel really confident, and I have felt confident avoiding pregnancy when I wanted to during my postpartum, breastfeeding, two-year journey. I think I got my cycle back at 13 months postpartum. But a lot of the women that I work with they don't have that frame of reference from before pregnancy. And so I'm just curious what kind of—and, obviously, we don't have enough time to really cover it all. So I guess my first one would be maybe making an appointment with you to talk about this, I think, is high on the list of advice to give. But just a basic conversation about is that something that's doable. Have you seen that work well for people? I have a few clients who are having babies really close together right now because they were just kind of winging it. They weren't practicing fertility awareness. But they kind of went into it without a plan, and

they're happy about it. But I would really love to feel like I could resource people better in terms of—yeah. Using fertility awareness (inaudible).

LISA: I mean you highlighted a really important point, which is that it is different. First of all, postpartum is a different type of—it's the same logistical charging. But it is different than charting when you're cycling naturally, normally. So when a woman is cycling—I mean if we take you through the menstrual cycle, the first day of your cycle is the first day of your period. The first day where you have flow. And then as your period stops, as your period comes to an end, you typically have a couple of days before you start to see your cervical mucus. From a fertility awareness standpoint, cervical mucus is the most crucial sign of fertility because it's your mucous that keeps sperm alive for up to five days. So as you approach ovulation, any day that you observe cervical mucus—sometimes it looks like creamy hand lotion. Sometimes it looks like clear, stretchy, raw egg whites that you can kind of stretch between your fingers, and some women will just find that it—as a (inaudible) as they wipe—they go to the bathroom and wipe, it's really slippery. Or they feel like they have to wipe a couple times to get it. Yeah.

So however it presents, then women who practice fertility awareness and they become more experienced monitoring their cervical mucus, then they'll see that—so you have your period. You have a couple days before you start seeing mucous. And then you start seeing mucous. Assuming that your cycles are healthy and normal, you ovulate, and then your mucous dries up. It goes away. And then you get your period about 12 to 14 days later, and it repeats. And it's not the same. Ovulation shifts from cycle to cycle if you have a stressful event or if something is going on. It's not uncommon for there to be a shift. We're not robots, as you mentioned. So there is some fluctuation that is normal in there. But you still have this general pattern of period, ovulation, period. Period, ovulation, period.

When you're in the postpartum, you mentioned that you got your period back about 13 months postpartum, and it was similar for me. In both pregnancies where I got a random period around the 9, 10-month mark, but I didn't actually get—I mean it went away again. And then I didn't actually get my regular periods around—so around the same time roughly. So in the postpartum period, it's almost like you're having one really, really long cycle.

MARGO: Right.

LISA: So for women who have charting experience, they've—they have that experience of daily checking for cervical mucus. Your basal body temperature is fairly useless until you actually ovulate. So you can't—it doesn't help you. So you're kind of reduced to

this one sign plus your cervical position, if you're comfortable checking that. And so for the record, fertility is an effective method of birth control. When you learn it correctly and you understand how to interrupt your fertile signs, then it is possible to use fertility awareness successfully postpartum very well. The challenge is for a woman who has never charted before. If this is her first foray into charting, then my suggestion is for her to actually seek support from a charting instructor because it's a different type of—it's a different period of time. It's a different circumstance, and there can be certain challenges.

So for some women when they're breastfeeding, they have more—for lack of a better word, discharge. Some women will produce some degree of mucous every day. And so when you're working with an instructor, you can start to differentiate between what's happening. Is that arousal fluid triggered by ovulation—or triggered by breastfeeding? That was a misspeak because breastfeeding triggers oxytocin production, which can cause you to have more arousal fluid, et cetera. Even me just saying that sounds fairly complicated. So I think that it's important to know that it can work, but it is different. If a woman has charted before—like in your case, you had 4 years of experience. In my case, I had over 10. So when I was in my postpartum, it was fairly straightforward. I just kept checking for mucous every day. And it's important to know that you ovulate before you have your first period. And so what you're—you're basically on mucous watch. You're looking for mucous. And when your mucous returns, for me, it was very clear. Like, "Oh, here's the mucous. I'm going to ovulate soon." And so I knew that that was my—even though—but who—again, you have to get into the mindset of it could take 4 months. It could take 3 months. It could take 6 months. It could take 12 months. So you're checking for mucous every day and charting it and okay with the fact that it could take months before you see it. So I hope that answers the question.

MARGO: Yeah. No. That's really helpful to hear. Yeah. I think that has been the challenge that I've seen with people is just it's such a long project. And people are often sleep deprived and tired and (inaudible). If they miss the first day of their fertile mucous and they have sex that day because they finally maybe feel like it because they're getting all the signals from their body like, "Hey, it's time to make another baby,"—

LISA: Well, we talked about how the pheromones change and how—so I mean when you think about it from that perspective, in general—so outside of the specific signs of fertility, your cervical mucus, and your cervical position. When you have just a general understanding of your cycle—and for women who have been charting, I'm sure that you can appreciate this. I recognize that every woman isn't the same, and there is some research to say, "Oh, it's overrated. This idea that we're more horny around ovulation." But from my experience, my lived experience and my experience working with women,

there is something there. So for a lot of women , they do notice that they're more aroused around that time. As the approach ovulation, estrogen levels are high. Mucous is flowing. And also, outside of your control, is the fact that your partner is—if there is ever a time that your partner is going to be all over your situation, it's typically around that time. And it's literally pheromones. It's been proven by research, et cetera, and then you will also have the lived experience of women. So it's kind of the joke of, "Well, we only had sex that one time."

MARGO: One time you both really wanted to.

LISA: Yeah. And if you're aware of that—so that's another level of awareness that can happen as you chart your cycles. So for me, I'm aware of it when I am in that stage. Not only do I have the physical—the mucous observation, I am aware that my—I am aware of the fluctuations in my levels of arousal, for example. So for me, having that, "Oh, man. I really want it," like, "Oh, okay. Let me check for mucous,"—you know what I mean? You kind of have this additional understanding of your body.

MARGO: Yep. That's what I was going to share was that I feel like that's—that was really helpful to me in my postpartum time was—because I can't say that probably checked my mucous every day, but I also was in one of those, "Well, if I got, then okay," kind of places. It was more like I was relying on some of that inner wisdom that I had developed over the 4 years of observing how my mood felt and how my—yeah—level of arousal felt and that sort of thing beyond just the three (inaudible), which are great and people need to know about those too. But it's cool to notice those other pieces. So cool. Yeah. I think that was really helpful. And do you have a suggestion for if people are wanting to work with a—what did you—what was your special word you used?

LISA: Oh, fertility awareness educators.

MARGO: Educator.

LISA: I would say that—I mean especially we're in an interesting time now where periods are getting a lot of press. And a lot of women are really pissed off that we weren't taught this. So a lot of women are jumping into the menstrual cycle space, and not all of them are trained and certified. So I would say it's important if you're seriously considering using fertility awareness especially as birth control. The research that has been done that—I mentioned a study that—the results of the study were 99.4% effectiveness. They were looking at the symptothermal method meaning they were looking at the combination of cervical mucus, cervical position observations, plus basal body temperature. But these women in the study were trained by educators in a specific method.

And so when you're working with someone who has been certified and trained, in my—so for instance, in my experience, in my training—and I went through training on two separate occasions. But in my training, what I learned—and just like any other profession, so you don't see a doctor who has basically had an illness once, and then they're a doctor. They learn about all these different things. So they're able to treat and support individuals who have issues that they didn't. When you have a woman who has charted her own cycle and is really enthusiastic and starts teaching, she has only seen her cycle. And often, we're so tempted to think everyone's cycle is going to be like theirs. So it's important to, when you're looking for an educator, to find someone who is certified, and so there is an Association for Fertility Awareness Professionals that certify individuals that have gone through the training. And at least, that gives you some peace of mind. Like this person—because it is a profession. And it's not—although it seems like it's really simple, there is a lot of nuances to it. And because the menstrual cycle is a vital sign, a lot of women coming to you do have different challenges and issues. And one of my roles when I'm working with clients is to help them to identify it.

So for them, if they're seeing certain things in their cycle, to help them identify what that could be and support them in terms of getting married with the correct support that they need to address those issues. So yeah. That would be my main suggestion to really look for someone who is certified, someone who is experience, someone who is trained. I mean, of course, I have a lot of different programs, and I've been running them for a long time. But I recognize—I mean some—a lot of women really like the opportunity to work with someone in their local area. So also kind of looking to see what's available, what organizations teach and maybe you'll be able to see somebody locally in your area.

MARGO: Awesome. Well, anything else you want to add before we wrap up? Anything I missed. I had a million more questions.

LISA: Well, this is a lot of fun. I really liked your questions. This is really a nice conversation. And I would invite the listeners—I mean if you are—if you enjoyed this conversation, if you are interested more to learn about the vital sign aspect, you can actually get the first chapter of *The Fifth Vital Sign* for free over at thefifthvitalsignbook.com. And otherwise, if you really want to nerd out with me over a thousand research citations—like I said, I was really fascinated by the research. And one of my goals with the book—because I'm—I feel generally just—I feel the collective pissed offness about not being educated about these things. And so for me, I didn't want to create a fluff piece of, "Lisa's opinion is this." I wanted to try to make some of that research more accessible because who has time to go through 2,000 research studies. I wanted to create that resource so that we can kind of elevate our own

understanding and our knowledge of these issues as women so that we can feel more empowered when we're going into our doctor's office, feel like when we choose fertility awareness and the doctor is saying it's not effective, at least you can have a solid resource and feel more confident in the fact that no, no, no. There is research that shows that this method is effective. It kind of goes back to the idea that as women—what you were mentioning. We want to—we're uncomfortable talking about it.

It's almost as though they think if they tell us about it that either it's too complicated for us or we won't be able to do it right. So in all of the years that I've taught women to chart their cycles, I recognize that not every woman is going to want to use fertility awareness for birth control. It's not the right method for everybody. But for the women who want it, like you and me, the women who chose it, who it resonated with us, we're motivated, and we're really smart. And at the end of the day, even though it's—there's nuances, and there's lots of complexities, every woman that I've worked with, she really starts to get it by the second cycle. If I'm working with a client, by the time we're in cycle two together, cycle three together, they still have questions, and they still have little concerns around some of the health aspects. But ultimately, the charting—we get it. We're smart. We can do it. We got this. So if you're motivated and if you want to do it, you can do it. And it is effective.

MARGO: Yeah. That's amazing. That's an amazing to end on because that was certainly one of the things I wanted to get to too was just the idea that—I think that that's one of the barriers is that the system, I guess, if we're—

LISA: Women are too stupid to do it. We can't tell them. We need to pat them on the head and be like, "No. You need to take this pill because this would involve you writing things down and observing things and—

MARGO: Using your brain. Being a scientist.

LISA: Yeah. And it's not rocket science. Literally. And the great thing too, as you've experienced with all of your charting experience, is that it is a cycle. And so it does continue happening. And what I always say is you can't predict ovulation because we're not robots and it doesn't always happen on the same of the cycle. But you start to get a sense of I have my period. And then I start seeing cervical mucus. And I tend to have cervical mucus for a certain number of days before I ovulate. And then my period usually comes a certain number of days after that. So it's a cycle. So you get to practice cycle after cycle after cycle after cycle and develop those skills and gain that confidence. And here I am almost 20 years in and I have never had an unplanned pregnancy. My two boys were highly planned. Outrageously planned.

MARGO: That's awesome. And then your website is fertilityfriday.com, right? For people to go look at.

LISA: Yes. And then if anyone wants to (inaudible) the podcast, whatever your favorite podcast player is, if you type in *Fertility Friday* and search for it, I will pop up.

MARGO: You have over 200 episodes.

LISA: Yeah. I'm almost—I'm about to—this week I release 249. But next week, I release 250. So it's—we're 250, which is a lot of episodes.

MARGO: That's a lot of good content, and then the book, again, is called *The Fifth Vital Sign.* You can get it on Amazon and also through your site. Is that right?

LISA: Well, Amazon is the main venue, and then the eBook is available in different retailers.

MARGO: Cool. Perfect. Well, thank you so very much for joining me. This is really fun. And for people listening, if you want to learn more about Indie Birth and haven't been to our website somehow, it's indiebirth.org. And Maryn and I both have our own podcasts. There is a huge podcast archive for you to check out. And we both are available by email. You can email us at margo@indiebirth.org and maryn@indiebirth.org, if you want to get in touch and if you have any questions or anything. So thanks so much for listening and until next time.

(closing music)