BBRF MEET THE SCIENTIST WEBINAR
SEPTEMBER 2026 · #BBRFWEBINAR

Hormones, the Brain, and Female Suicide Risk

Tory Eisenlohr-Moul, PhD

Professor of Psychiatry and Behavioral Neuroscience, The University of Chicago
Director, CLEAR Lab · Licensed clinical psychologist · 2018 BBRF Young Investigator

Contact Information

temo@uchicagomedicine.org

www.clearlabresearch.com

BEFORE WE START

Disclosures and a thank-you

- **No financial conflicts. No pharmaceutical funding.**
- Support: NIMH, and a 2018 BBRF Young Investigator Grant (#27304) that paid for the blood assays in CLEAR-1.
- Volunteer: IAPMD clinical advisory board.
- Some treatments I'll mention are **off-label**. This is education, not individual medical advice. I'm a licensed clinical psychologist, **not a physician**, so I can't speak to anyone's specific symptoms.
- **Nothing here means hormones should be given to treat cyclical suicidality.** Safety concerns with long-term premenopausal use, and some people have adverse mood effects we can't yet predict.

We'll be talking about suicide. If you need support at any point: call or text 988 (US).

HOW IT STARTED

Before I studied cycles, I treated instability.

I loved working with patients who were blamed for their own symptoms because they experienced unpredictable emotions and impulsivity (e.g., borderline personality disorder).

> **What struck me was how seemingly unpredictable their symptoms could be.**
>
> Relationships · work · substances · self-harm · suicidality · trust in therapy

DBT, circa 2012. The DBT workbook on the table.

Why does this get worse when it does?

BEFORE WE START

Four questions

1

Does suicide risk really follow the menstrual cycle?

Hospital records, PMDD, and what we found when we followed people day by day.

2

Why would normal hormones cause symptoms?

Hormone levels are normal. The brain's response to normal change is the problem.

3

Is hormone sensitivity one thing?

Two timings, two symptom profiles, and a working model: sensitivity to the surge vs. sensitivity to the fall.

4

Can we find the trigger, and for whom?

Three double-blind trials: what they prevented, what they made worse, and the first clues toward matching treatment to the person.

1

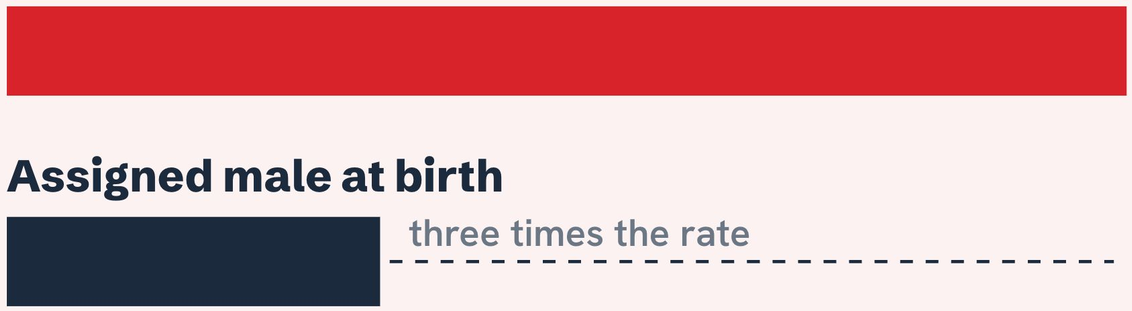
PART 1

Does suicide risk follow the menstrual cycle?

SUICIDE RISK AND THE MENSTRUAL CYCLE

Females carry most of the burden of suicidal thoughts and attempts

3× more likely than males to have suicidal thoughts and to attempt suicide



#1

cause of hospitalization during the reproductive years: suicidality

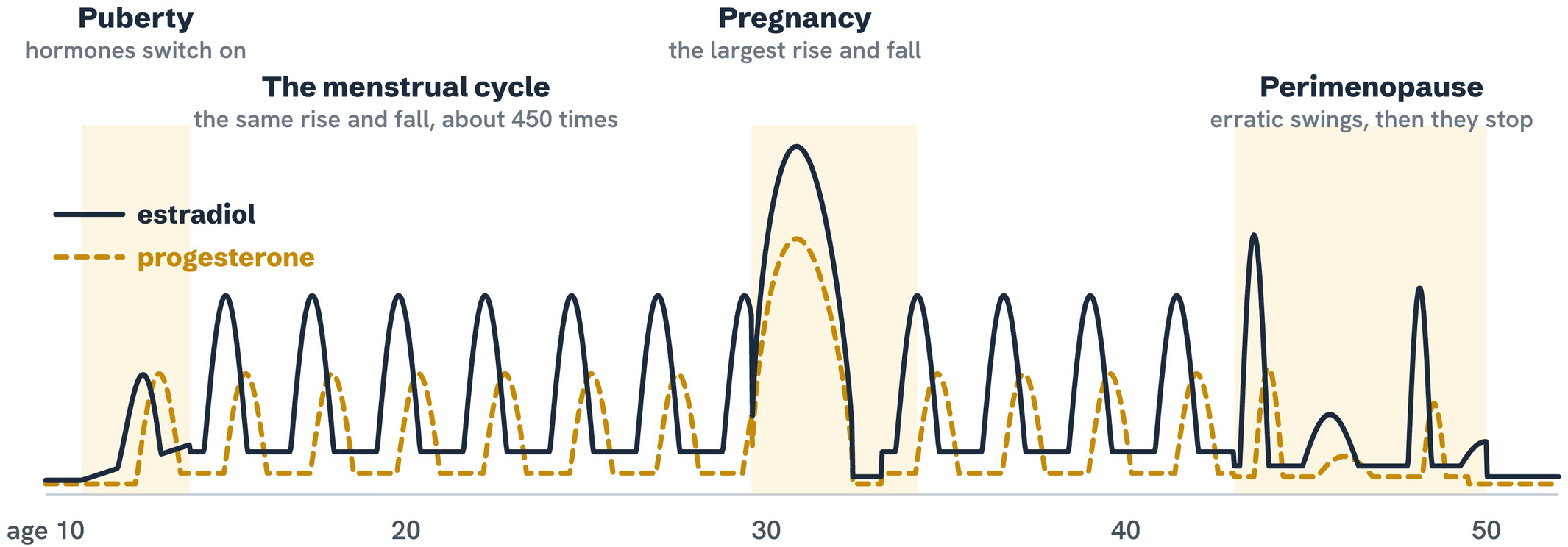
4th

leading cause of death, ages 15 to 45, in the US

CDC WISQARS; WHO; SAMHSA. Ages 15–45.

SUICIDE RISK AND THE MENSTRUAL CYCLE

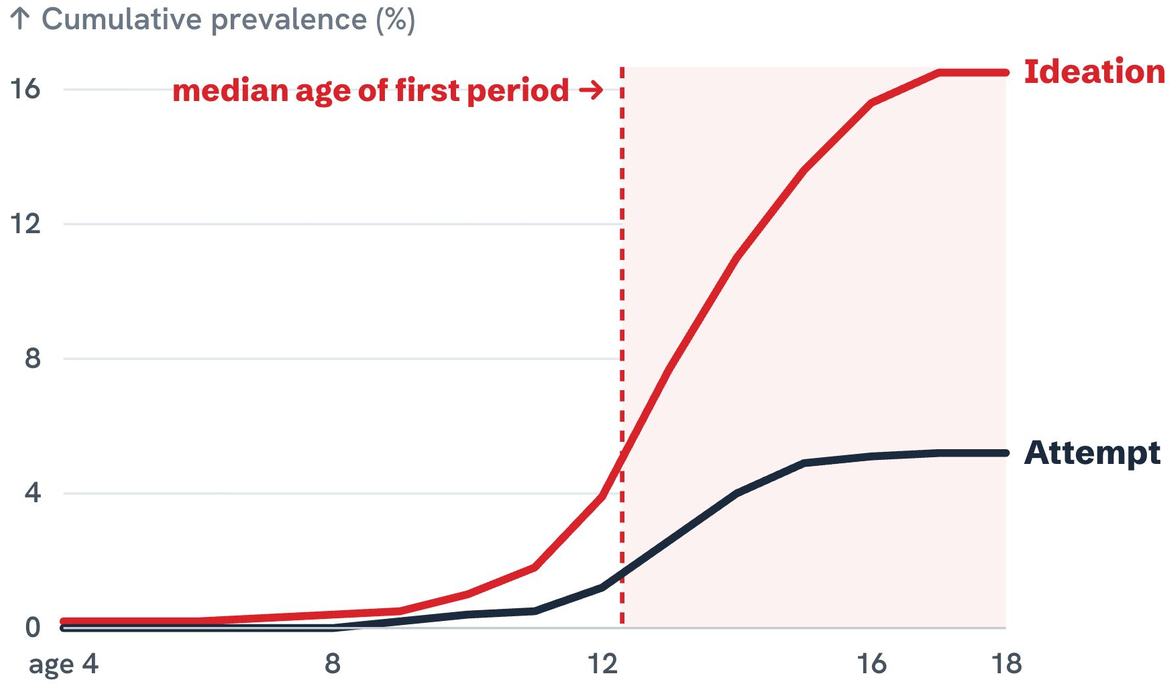
Mental health problems cluster at hormone changes



Nock et al., 2008; Kessler et al., 1993; reviewed in Ross, Patterson & Eisenlohr-Moul, 2026, Biological Psychiatry

SUICIDE RISK AND THE MENSTRUAL CYCLE

Suicidal thoughts and behaviors climb steeply after puberty, beginning around the first period



Mood disorders. Minimal sex difference in childhood; about 2:1 female by mid-adolescence.

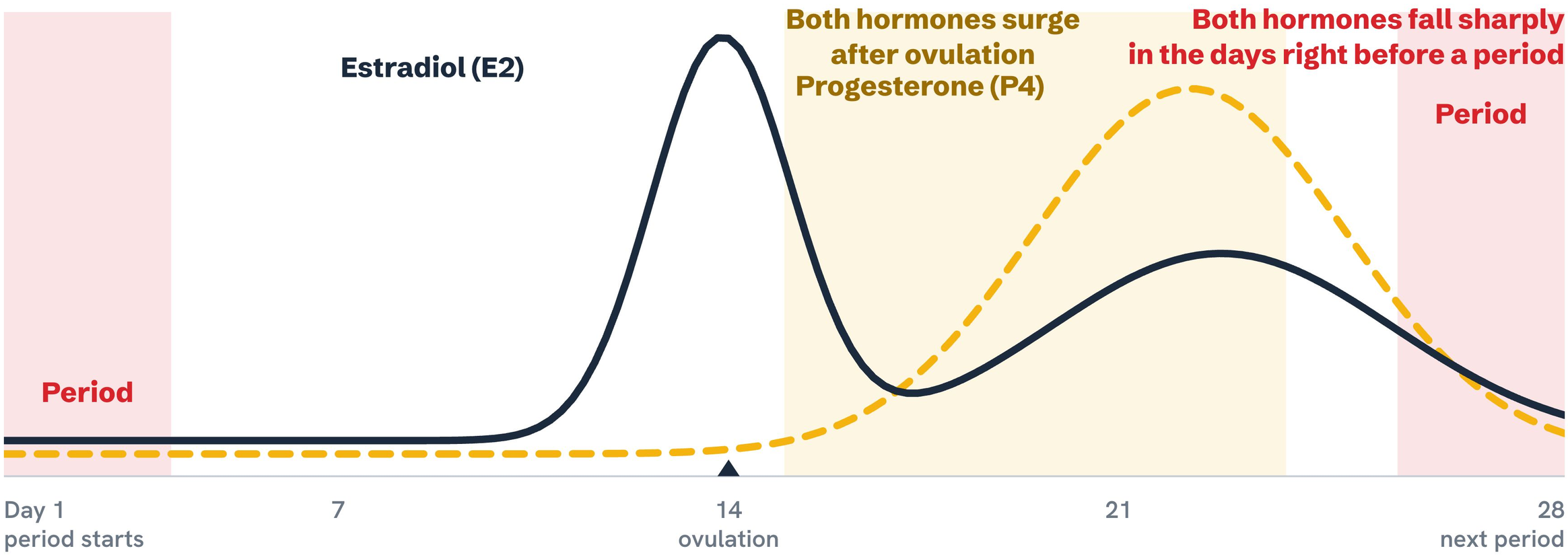
ADHD and autism. Distress and impairment rise at puberty in girls.

Suicidality. A sharp post-pubertal increase that coincides in time with the onset of the cycle.

Redrawn from Nock et al., 2013, JAMA Psychiatry (National Comorbidity Survey, adolescent supplement). Values approximate from the published figure.

SUICIDE RISK AND THE MENSTRUAL CYCLE

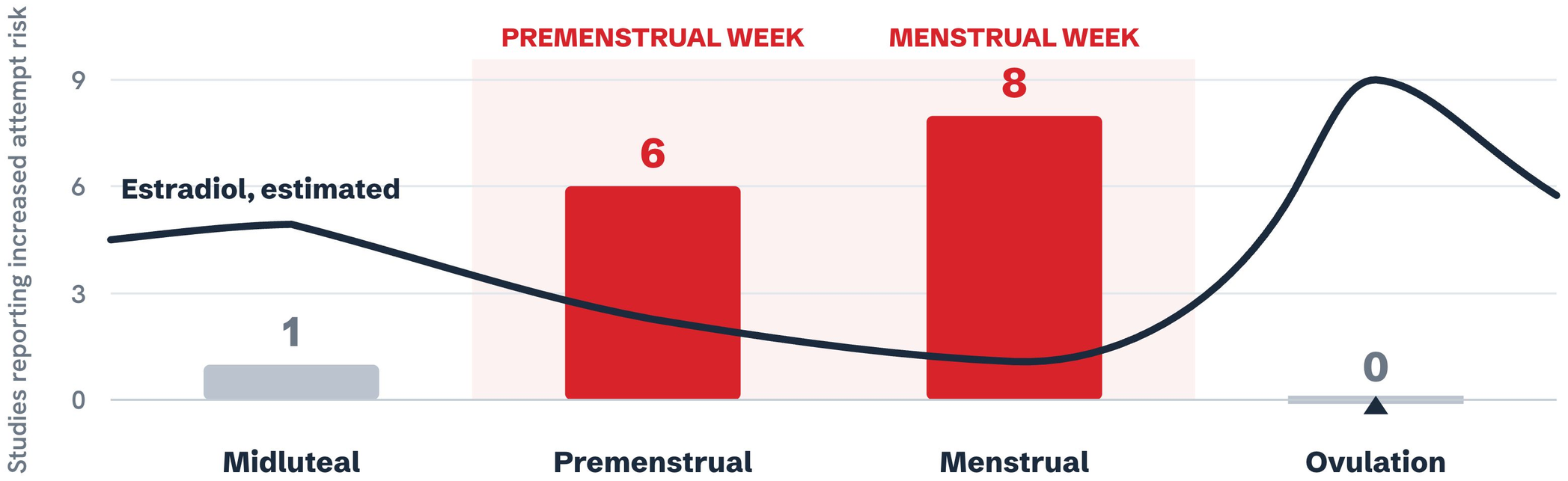
The Menstrual Cycle – Two Critical Hormone Triggers



E2 = estradiol (the main estrogen). P4 = progesterone. Idealized 28-day cycle.

SUICIDE RISK AND THE MENSTRUAL CYCLE

Hospitalizations and emergency visits for suicide attempts cluster in the two weeks around menstruation



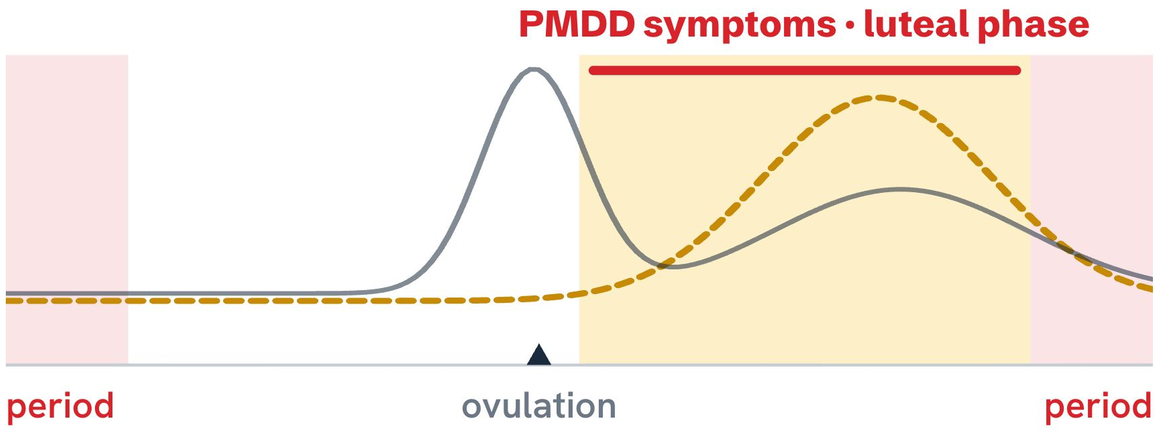
15+ studies over 50 years, across countries. Risk is highest in the days around the onset of bleeding.

Counts of studies reporting increased attempt risk in each phase. Saunders & Hawton, 2006, Psychological Medicine; Owens & Eisenlohr-Moul, 2018, Current Psychiatry Reports

SUICIDE RISK AND THE MENSTRUAL CYCLE

PMDD is the only formal menstrual-cycle mood diagnosis

About 5.5% of cycling people. Symptoms start after ovulation and clear once the period begins.



DIAGNOSIS (DSM-5)

5+ symptoms (at least one emotional), present the week before menses, gone the week after:

- mood swings
- irritability, anger, or conflict
- depressed mood
- anxiety
- decreased interest
- difficulty concentrating
- lethargy or fatigue
- change in appetite
- sleeping too much or too little
- feeling overwhelmed or out of control
- physical swelling, pain, or bloating

Exclusion: not “merely an exacerbation” of another disorder. Since comorbidity is common, this rules out most patients with cyclical worsening.

DSM-5 PMDD criteria (APA, 2013); Gehlert et al., 2009 (prevalence). Suicidality is not in the criteria.

SUICIDE RISK AND THE MENSTRUAL CYCLE

PMDD is the best-established hormone-sensitive disorder, and suicide risk in PMDD is high

599 patients with PMDD diagnosed by a medical provider using daily ratings

72%

lifetime suicidal thoughts

34%

lifetime suicide attempt

51%

lifetime self-injury

Rates were similar with or without another psychiatric diagnosis. Severe PMDD by itself carries suicide risk.

Suicidality is not in the diagnostic criteria, and for years it was assumed to be rare because symptoms remit every month. It is not rare. PMDD is not a mild PMS story.

Eisenlohr-Moul et al., 2022, BMC Psychiatry (Global Survey of Premenstrual Disorders); Gehlert et al., 2009 (prevalence)

SUICIDE RISK AND THE MENSTRUAL CYCLE

In a national registry, premenstrual disorders carried nearly twice the rate of death by suicide

1.92×

the rate of death by suicide among people with a diagnosed premenstrual disorder, compared with matched people without one

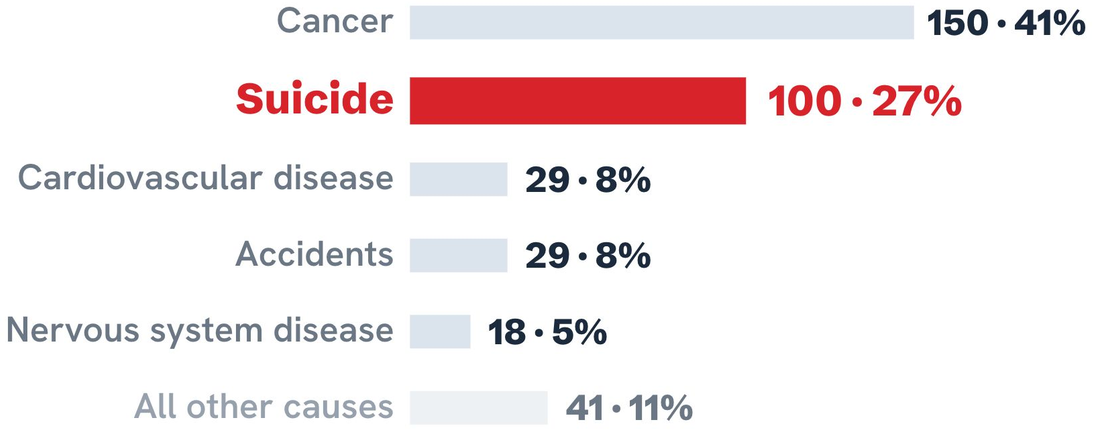
2.30 suicide deaths per year per 10,000 people with a premenstrual disorder

1.06 matched people without one

406,488 people followed in Swedish national registers, up to 18 years

Suicide accounted for 27% of all deaths in this group.

367 deaths among people with premenstrual disorders



Overall mortality was not elevated. The excess was specific to suicide.

Among those diagnosed before age 25, roughly **one death in three** was a suicide.

Hazard ratio 1.92 (95% CI, 1.42–2.60). Opatowski M, Valdimarsdóttir UA, et al. JAMA Netw Open. 2024;7(5):e2413394. Table 4 and eTables 3–5.

Cyclical worsening shows up across many conditions, in some people with each

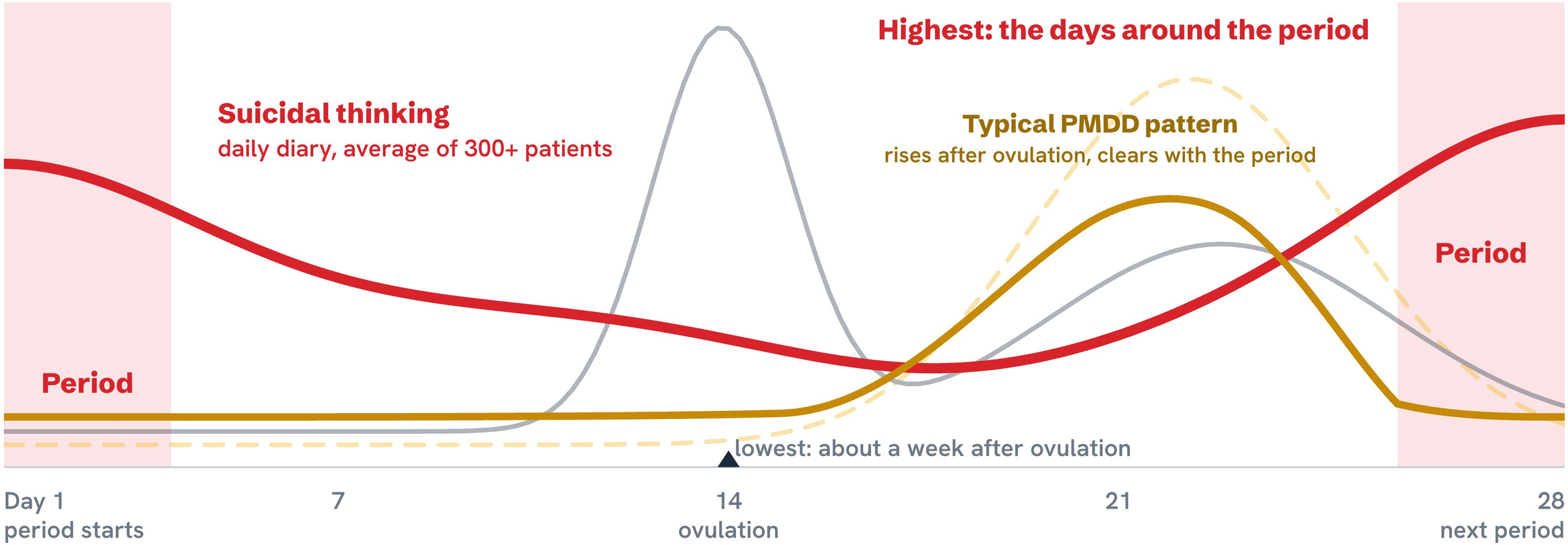
Major depression	about **60%** show premenstrual worsening
Bulimia nervosa	restriction, binging, purging
Borderline personality	anger, shame, rejection sensitivity, aggression
Risky substance use	alcohol and cannabis use
Bipolar disorder	both depression and mania
Anxiety and fear disorders	re-experiencing, avoidance, fear learning
ADHD	inattention, hyperactivity, impulsivity
Suicidal thoughts and behaviors	the focus of this talk

Not present in everyone with a given condition, but people with chronic mental health conditions are at higher risk of cyclical symptom change. None of them can currently receive a cycle-related diagnosis.

Systematic review: Nolan & Hughes, 2022. Depression estimate is population-based (Hartlage et al., 2004).

SUICIDE RISK AND THE MENSTRUAL CYCLE

Following people day by day: a second pattern, peaking around menstruation



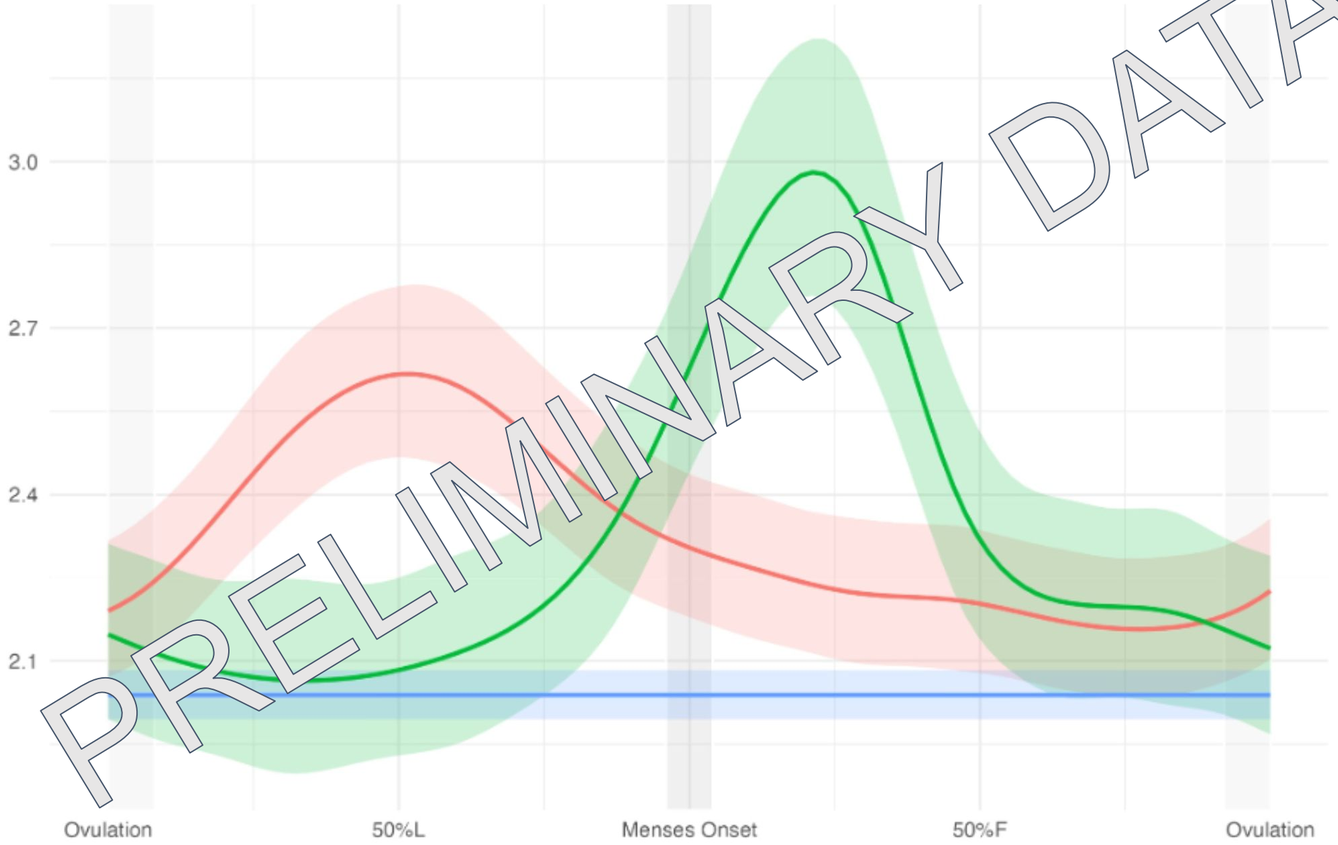
LED BY
Jackie Ross, PhD

Owens et al., 2023, J Psychopathology & Clinical Science (N = 38); Ross et al., 2024, American Journal of Psychiatry (N = 119); CLEAR trial baselines.
Average pattern, schematic.

SUICIDE RISK AND THE MENSTRUAL CYCLE

Common patterns of suicide risk across the menstrual cycle

The same three-group structure replicates across 139 patients with suicidal thoughts, 124 with BPD, and adolescent samples.



Luteal pattern
Builds over about 1.5 weeks before menses; irritability, anxiety, suicidal thoughts and behaviors. The PMDD timing.

Perimenstrual pattern
Peaks in mid-to-late menses and settles only by ovulation; depression, hopelessness, suicidal thoughts and behaviors.

No cycle effect, about half
Symptoms are real and often moderate, but the cycle isn't driving them.

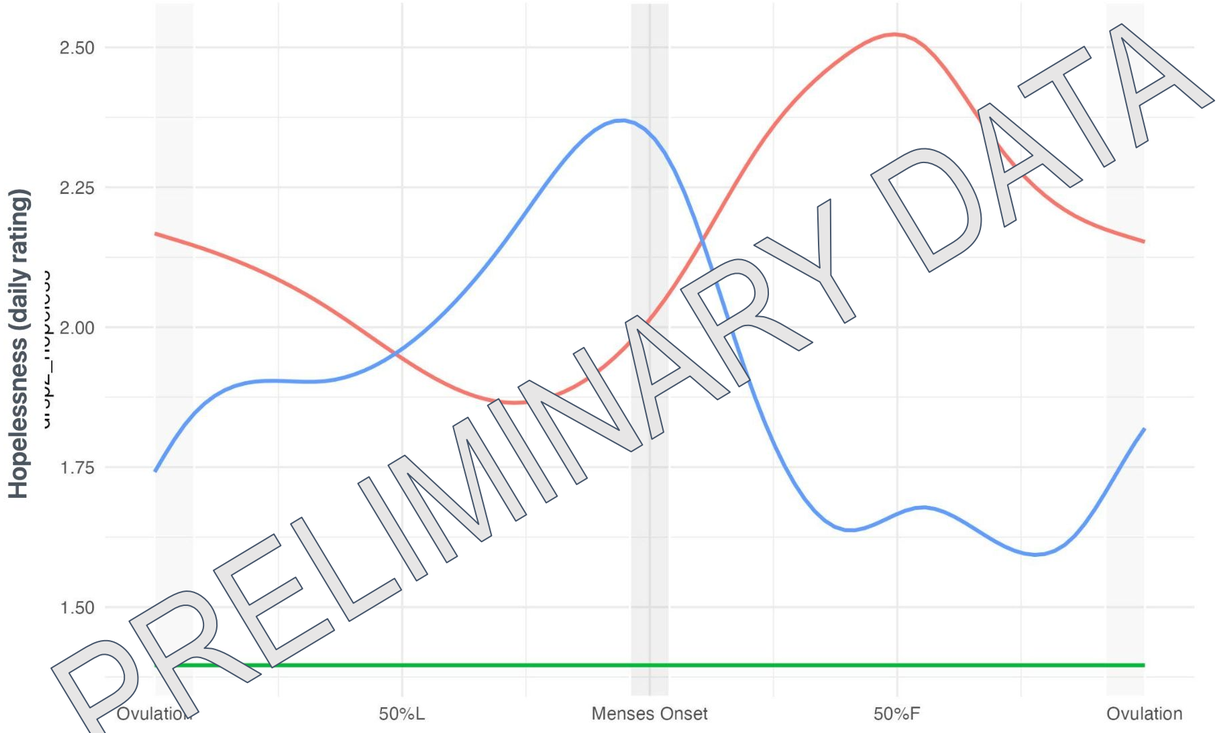
When symptoms occur, not which sensitivity a person has.

COLLABORATOR
Jessica Peters

Daily suicidal thinking, model-implied subgroup curves with confidence bands; smoothing mixture models, N = 139 outpatients (Eisenlohr-Moul lab).

SUICIDE RISK AND THE MENSTRUAL CYCLE

Teenagers show the same three patterns, and the cyclical ones have more severe suicidality



94 teens with suicidal thoughts, about half with a prior attempt, followed daily soon after their first period.

Same subgroups as in adults: luteal, perimenstrual, and no cycle effect.

Girls with a cyclical pattern had more severe suicidality.


COLLABORATOR
Mitch Prinstein, PhD


COLLABORATOR
Matt Nock, PhD


LEAD AUTHOR
Ashley Ross


COLLABORATOR
Elizabeth Andersen, PhD

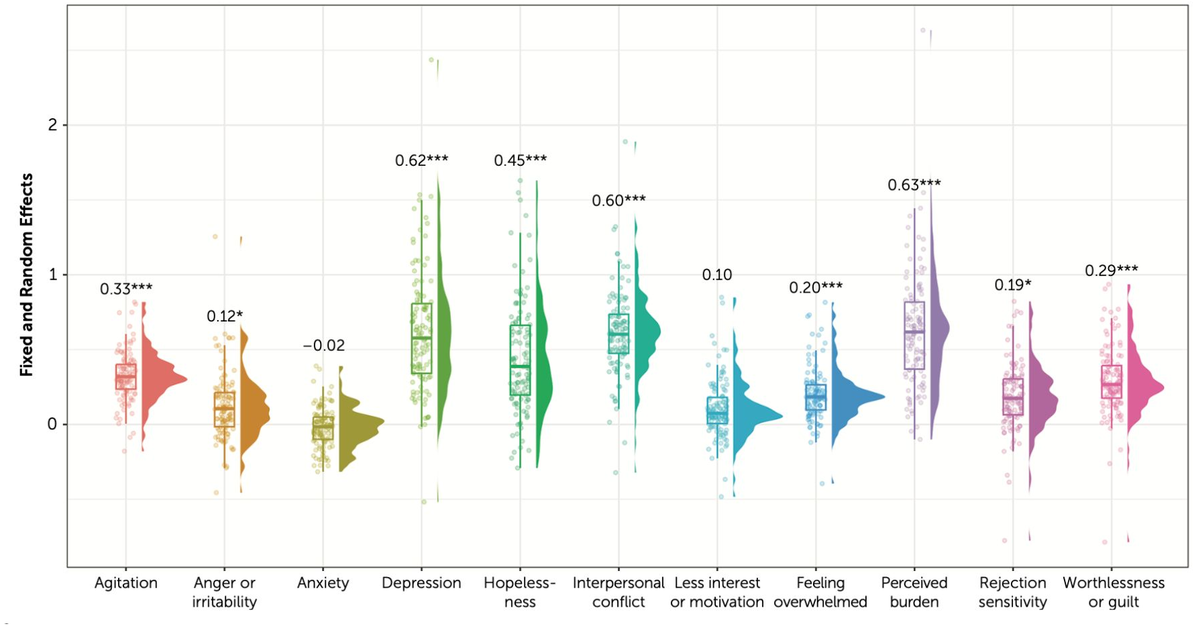

COLLABORATOR
Susan Girdler, PhD

CLEAR Lab adolescent cohort (N = 94, recruited for past-year suicidal thoughts, 1 year post-menarche); daily ratings 1–4 cycles.

SUICIDE RISK AND THE MENSTRUAL CYCLE

The psychological route to suicidal thinking differed from person to person

FIGURE 1. Graphical depiction of fixed and random effect estimates from multilevel models predicting suicidal ideation from each psychiatric symptom[a]



In every analysis, the link between a symptom and suicidal thinking varied from person to person. For one patient hopelessness tracks the risk; for another, feeling like a burden; for a third, the daily link is weak.

Differences were largest after ovulation through menses, the window where the hormone changes are.

Suicidal planning was the exception. Where it worsened perimenstrually, it did so consistently across people.

The psychological mechanism is not one mechanism, which is the same argument for matching treatment to the person.

LED BY

Jackie Ross, PhD

Ross et al., 2024, Am J Psychiatry, Figure 1. Each dot is one participant; random effects significant in every model.

2

PART 2

Why would normal hormone changes cause psychiatric symptoms?

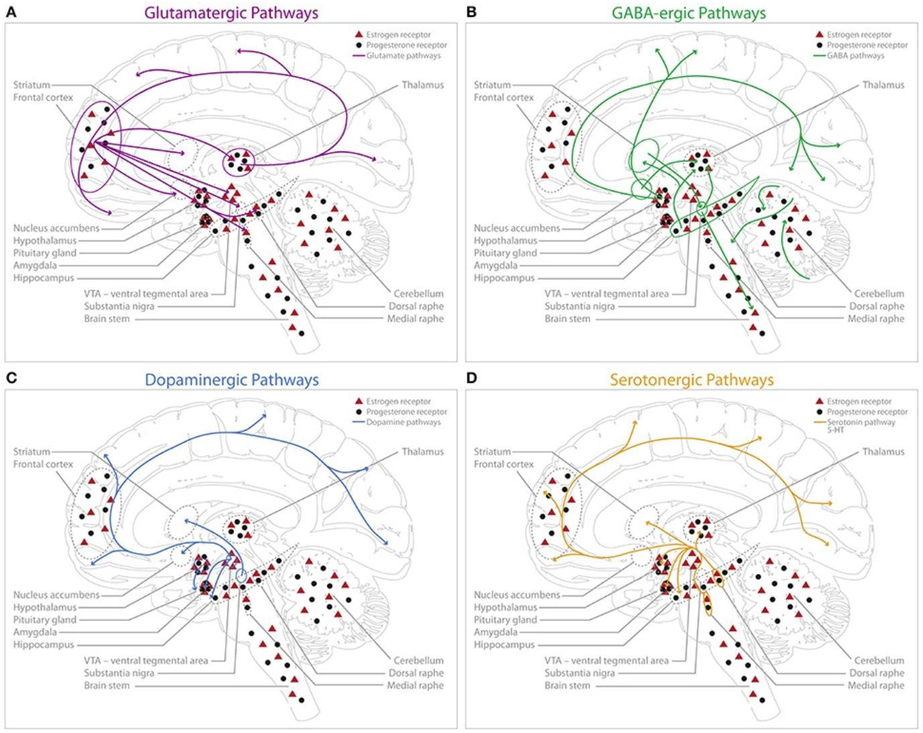
HORMONE SENSITIVITY

Estradiol and progesterone are powerful brain chemicals… but the brain’s ability to adapt is also powerful

Both E2 and P4 have strong effects on brain structure, connectivity, and function.

Receptors for these hormones are dense in the circuits that run threat, reward, stress, memory, and thinking (glutamate, GABA, dopamine, serotonin).

So a normal monthly change in hormones is also a normal monthly change in brain chemistry.

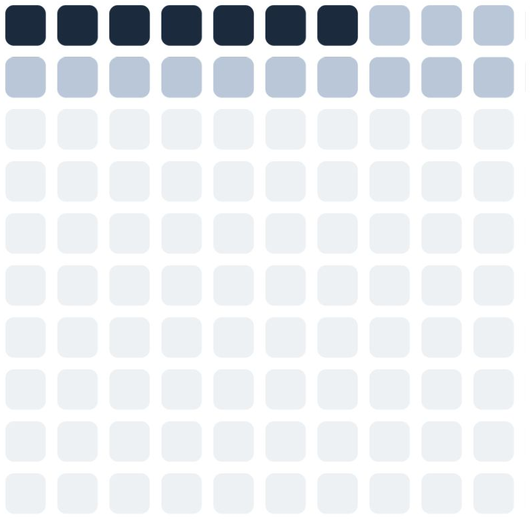


Barth et al., 2015, Frontiers in Neuroscience.

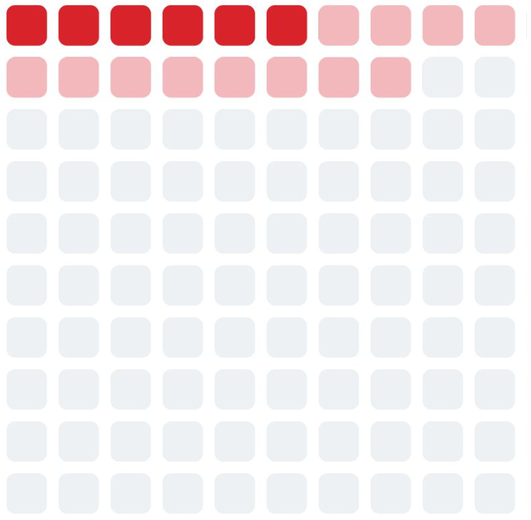
HORMONE SENSITIVITY

Everyone gets the same hormone changes, but only a minority get sick from them

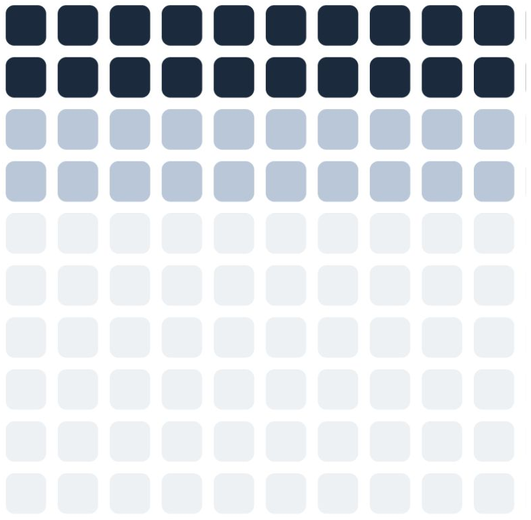
Perinatal
7–20%



Premenstrual
6–18%



Perimenopausal
20–40%



Universal hormone changes, symptoms in a minority: the hormones alone cannot be the explanation.

Each square = 1% of people; solid = low estimate, tinted = high. Reviewed in Schiller et al., 2016.

HORMONE SENSITIVITY

It is not a hormone imbalance: hormone levels are normal

In PMDD, the menstrual cycle and the hormones are normal: **normal amounts, normal balance, normal patterns, normal metabolism.**

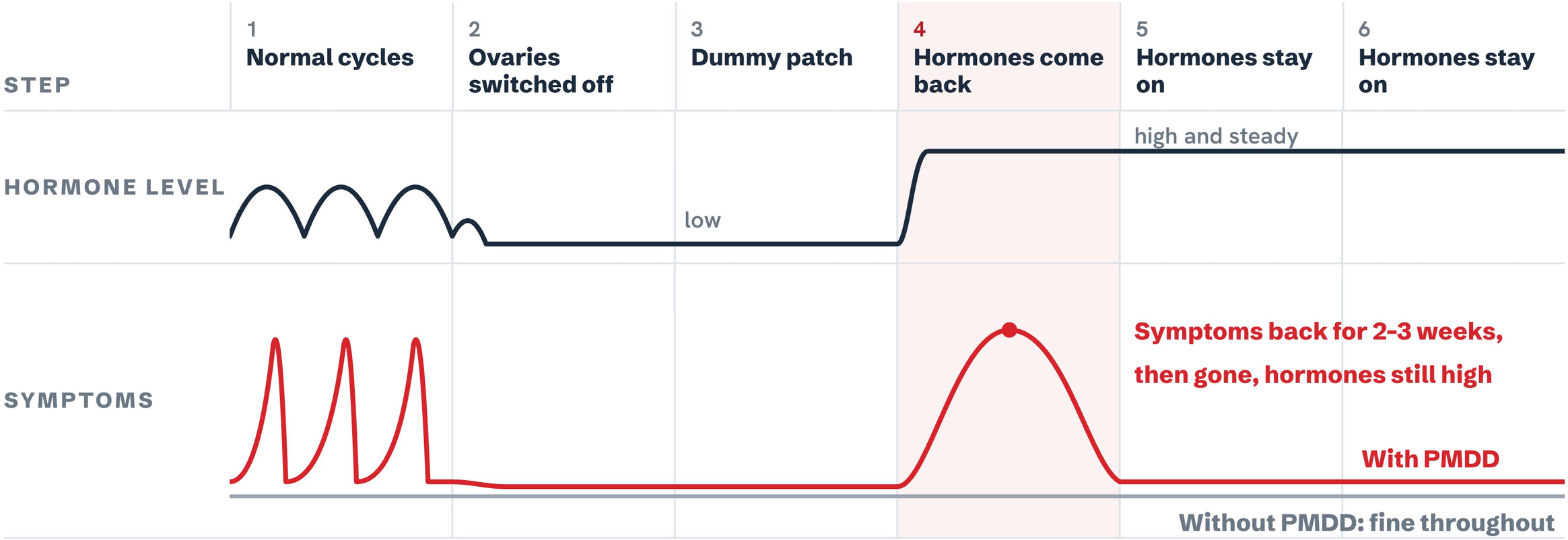
Experiments comparing patients with healthy controls show the difference is in the **brain's sensitivity** to a normal hormonal event.

Patients often find this disappointing. An "imbalance" feels more fixable and less stigmatized than "it's my brain." But it is the more useful truth: it tells us what to target.

Reviewed in Schiller et al., 2016; Schmidt et al., 1998, 2017.

HORMONE SENSITIVITY

The classic experiment: normal hormones, abnormal response



The hormone levels are normal. The brain's response to the change is different.

INVESTIGATOR

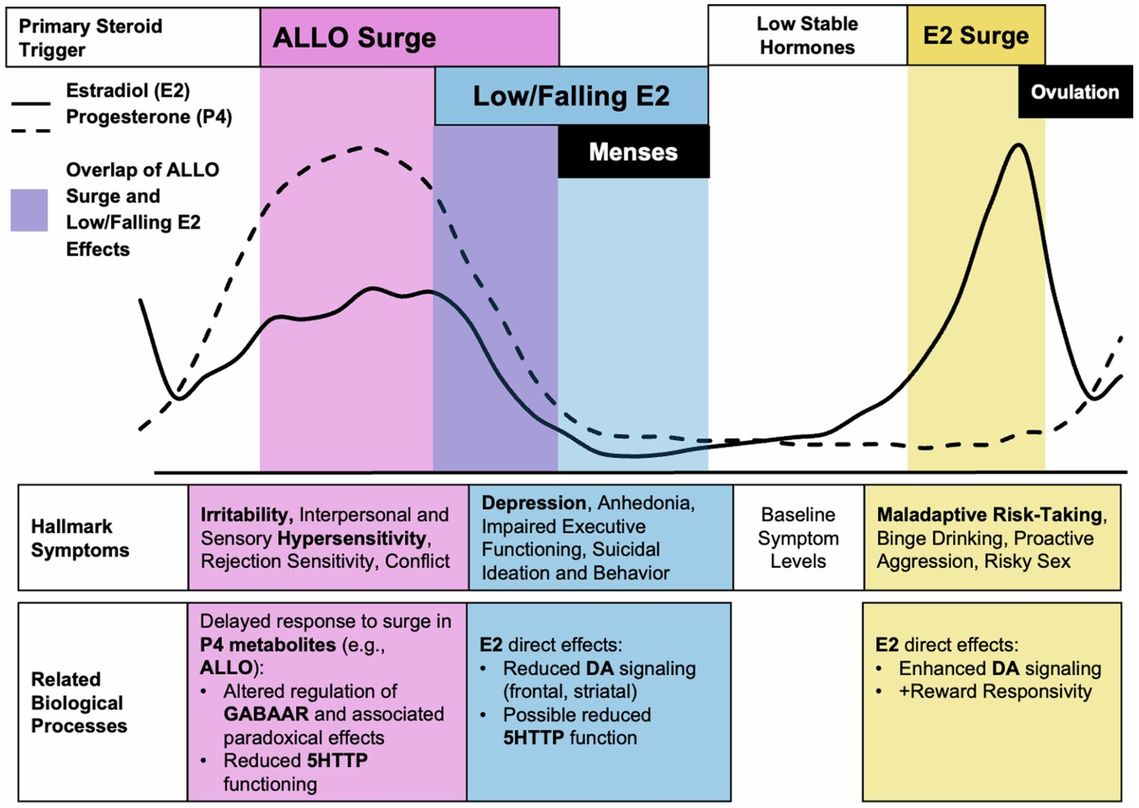
Peter Schmidt, NIMH

Schmidt et al., NIMH: NEJM 1998 (10 with PMDD, 15 without); Am J Psychiatry 2017 (12 with PMDD). Schematic.

3

PART 3

Are there different kinds of hormone sensitivity?



DIFFERENT SENSITIVITIES

A working framework: three sensitivities, three windows, three symptom profiles

Sensitivity to the progesterone (ALLO) surge after ovulation

agitated negative feelings: irritability, anxiety, feeling overwhelmed

Sensitivity to the estradiol fall around the period

low, flat negative feelings and foggy thinking: depression, hopelessness, brain fog

Sensitivity to the estradiol surge at ovulation

heightened reward-seeking: impulsivity, substance use

Not mutually exclusive; one person can have more than one.

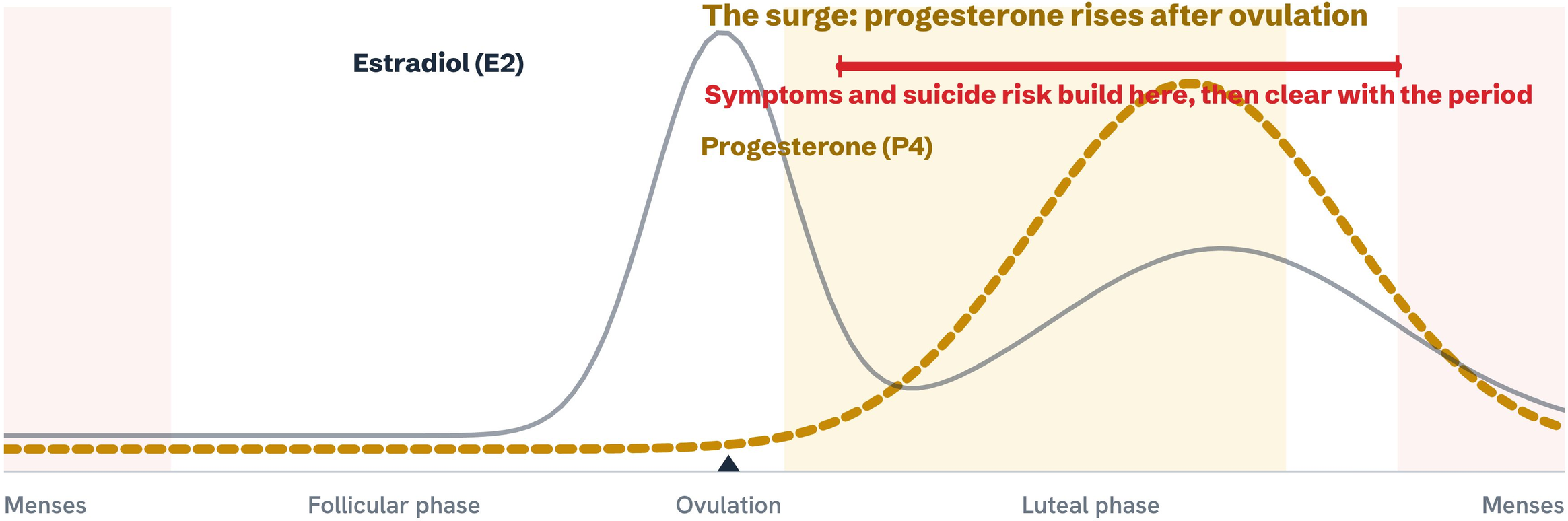
COLLABORATOR

Jess Peters, PhD

Peters, Eisenlohr-Moul et al., 2025, Molecular Psychiatry (DASH). Figure from the framework paper.

DIFFERENT SENSITIVITIES

Sensitivity #1: the progesterone surge after ovulation (the PMDD timing)



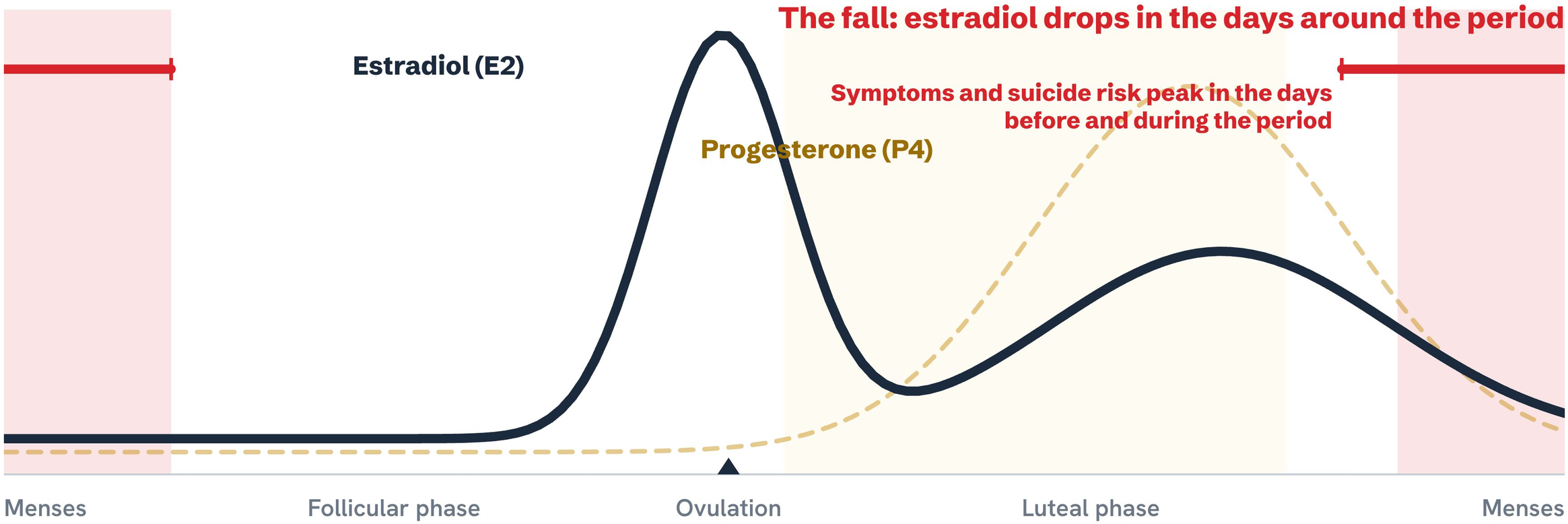
Mechanism. Progesterone → ALLO, which acts on GABA, the brain's "brake pedal."

Often: irritability, anxiety, feeling overwhelmed.

Reviewed in Peters et al., 2025, Mol Psychiatry (DASH framework); Ross, Patterson & Eisenlohr-Moul, 2026, Biol Psychiatry.

DIFFERENT SENSITIVITIES

Sensitivity #2: the estradiol fall around the period (the perimenstrual timing)



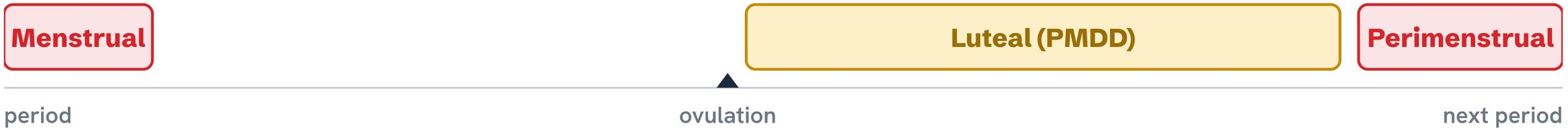
Mechanism. Estradiol fall → less dopamine, serotonin, and growth-factor support.

Often: depression, hopelessness, brain fog.

Reviewed in Peters et al., 2025, Mol Psychiatry (DASH framework); Ross, Patterson & Eisenlohr-Moul, 2026, Biol Psychiatry.

DIFFERENT SENSITIVITIES

Both patterns can carry suicide risk, but only one currently has a diagnostic home



SURGE SENSITIVITY

Luteal pattern: PMDD

- Recognized diagnosis (DSM since 2013); symptoms begin after ovulation and clear with the period
- **Substantial suicide burden:** 72% lifetime suicidal thoughts, 34% attempts
- Sensitivity to the progesterone surge is the best-understood mechanism
- FDA-approved treatments exist

WITHDRAWAL SENSITIVITY

Perimenstrual pattern

- No distinct diagnosis; excluded from PMDD because symptoms never fully clear
- Often occurs as an exacerbation of another disorder (depression, PTSD, BPD)
- Emerging evidence for sensitivity to the estradiol fall
- **No approved treatment. The primary focus of the CLEAR trials**

DSM-5 PMDD criteria; Nolan & Hughes, 2022; Eisenlohr-Moul, 2021 (premenstrual exacerbation)

4

PART 4

Can experiments identify the trigger, and eventually help us match treatment to the person?

THE CLEAR TRIALS

CLEAR-1: if the hormone fall causes the spike, preventing the fall should prevent the spike

SAMPLE

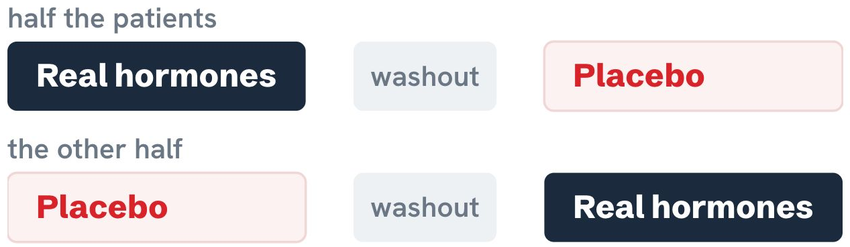
30

outpatients with suicidal thoughts in the past month, **73% of whom had made an attempt**. Recruited with no mention of the cycle; none met criteria for PMDD.

DESIGN

Double-blind, placebo-controlled crossover

Two weeks of real hormones (patch + pills) vs. identical placebo, in random order, with a washout cycle between.



patient and rater blind · estradiol patch 0.1 mg/day + oral proges

DAILY SURVEY

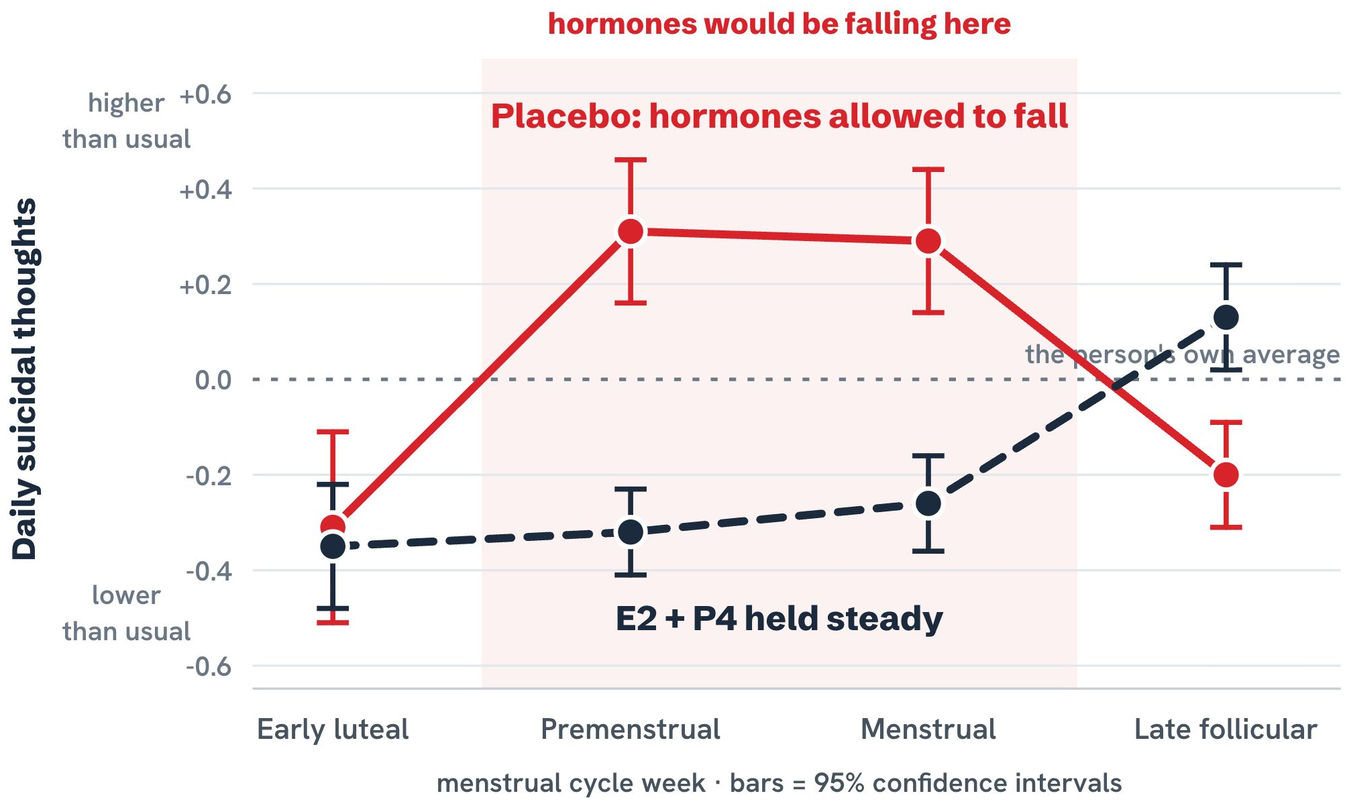
Every day, for months

Mood and suicidal thoughts rated daily, so the timing of any change is measured rather than recalled.

Eisenlohr-Moul et al., 2022, Translational Psychiatry; NIMH K99/R00 MH109667; NCT03720847.

THE CLEAR TRIALS

CLEAR-1: hold hormones steady, and the perimenstrual spike does not happen



Values from Eisenlohr-Moul et al., 2022, Translational Psychiatry, Fig. 4 (N = 28 analyzed; double-blind placebo-controlled crossover), redrawn.

THE CLEAR TRIALS

CLEAR-2: which hormone matters?

CONDITION A

Estradiol only

real E2 patch + placebo pills

CONDITION B

Progesterone only

placebo patch + real P4 pills

CONDITION C

Placebo

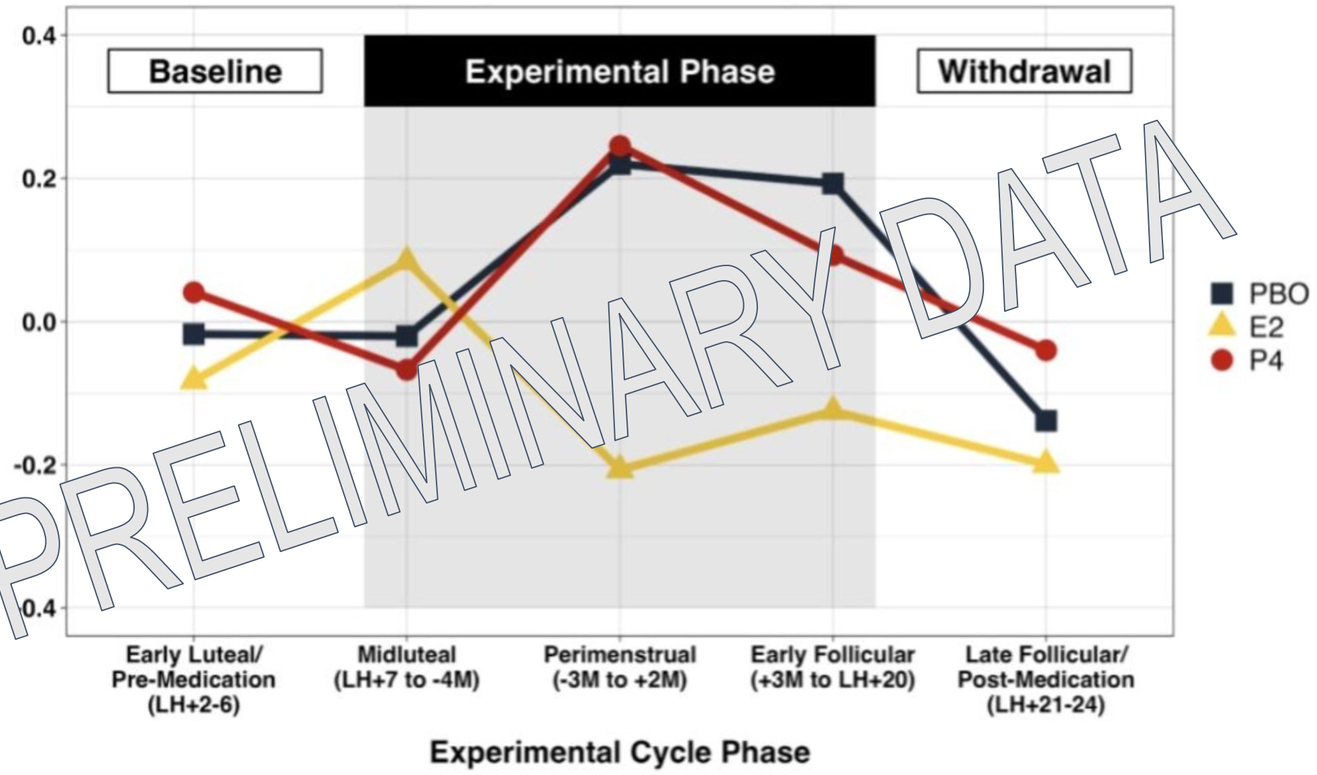
placebo patch + placebo pills

- 44 patients randomized, same population as CLEAR-1. Each completed all three conditions in random order, double-blind, with washout cycles between.
- Blood drawn three times per condition to measure estradiol, progesterone, and ALLO, the calming steroid the body makes from progesterone.
- **Our expectation going in: progesterone withdrawal, via ALLO, might explain this perimenstrual spike. It didn't.**

Eisenlohr-Moul et al., manuscript under review. NCT03498313. Funded by NIMH R00 MH109667.

THE CLEAR TRIALS

In this timing pattern, estradiol prevented the spike, and progesterone did not



Placebo: suicidal thinking rises in the perimenstrual window, as hormones fall.

Estradiol alone: the rise is gone; thinking stays below each person's own average through the window.

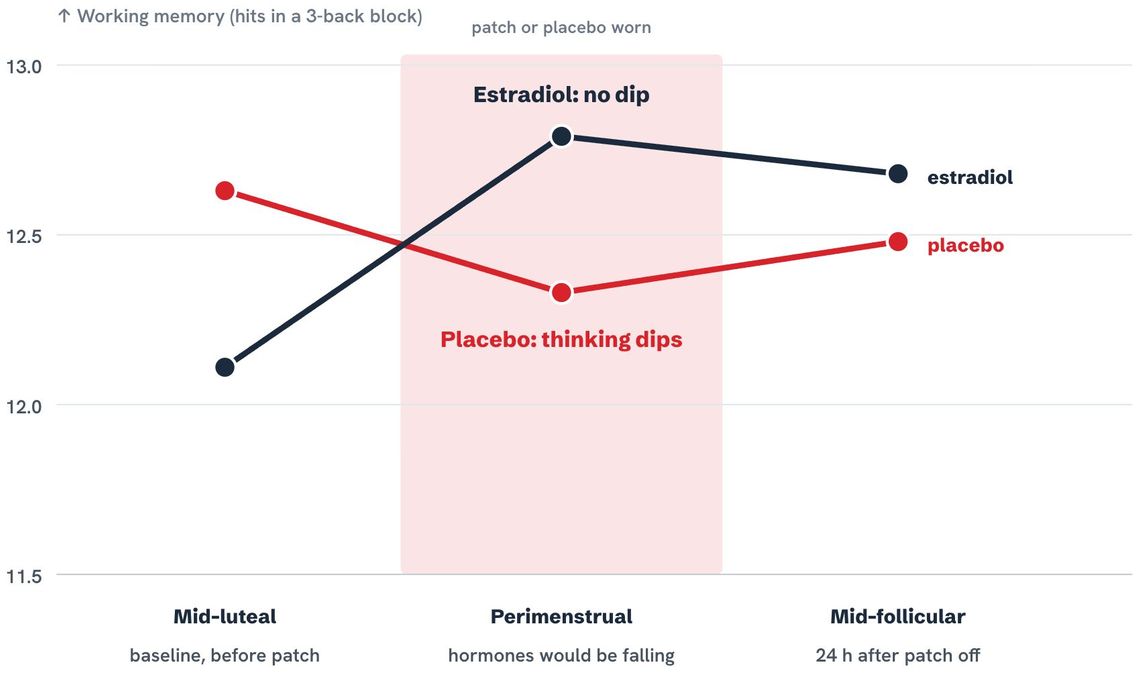
Progesterone alone: looks like placebo. No protection, and a small number got worse.

Values are relative to each person's own average. The shaded block is the two weeks on study medication; the last phase is after the patch came off.

CLEAR-2, N = 44, double-blind three-way crossover (NCT03498313). Eisenlohr-Moul et al., under review. Phase means of daily suicidal thinking, person-centered.

THE CLEAR TRIALS

Estradiol changed cognition along with suicidal thinking



When suicidal thinking worsened, working memory worsened too. Estradiol prevented both changes.

Working memory depends partly on dopamine-regulated prefrontal systems.

LED BY

Katja Schmalenberger, PhD

Schmalenberger et al., 2024, Psychiatry Research (working memory, N-back; values redrawn from the published figure).

THE CLEAR TRIALS

Three trials, one conclusion, one caution

TRIAL	N	COMPARED	SUICIDAL THINKING	STATUS
CLEAR-1	30	E2 + P4 vs placebo	Prevented the perimenstrual spike	Published 2022
CLEAR-2	44	E2 vs P4 vs placebo	E2 prevented it; **P4 worsened it for some**	Under review
CLEAR-3	90	E2 + P4 vs placebo	Prevented the perimenstrual spike	In preparation

CONCLUSION

In patients with the perimenstrual pattern, **estradiol withdrawal can act as a causal trigger for the monthly spike, and preventing it prevents the spike.** In this timing pattern, progesterone and its metabolites did not explain it.

CAUTION

- Two-week mechanism experiments. **Not a sustainable treatment**, and nothing here is approved.
- **Not appropriate for luteal PMDD.** For some people with surge sensitivity, adding hormones can worsen symptoms.
- **The trigger is real; the treatment has to be matched to the person.**

PART 4 · CONTINUED

Can we eventually tell which sensitivity a person has?

Two early clues. These are research leads, not clinical tests.

WHO RESPONDS

Treatments today buffer the brain's sensitivity or remove the cycling hormones

FIRST LINE

SSRIs

Luteal-phase only or full cycle. Work within days in PMDD, unlike in depression. FDA-approved; about **60% benefit**.

SUPPRESS OVULATION

A specific birth-control pill (drospirenone + ethinyl estradiol)

Taken 24 days on, 4 off. FDA-approved for PMDD; smaller benefit, and mood reactions are common.

SEVERE CASES

Switch the ovaries off, add steady hormones back

A medication pauses the ovaries; steady estradiol and progesterone are added back. Symptoms return in the first add-back month, then settle. Effective in pooled trials; never taken to the FDA.

ALONGSIDE

Symptom-focused therapies

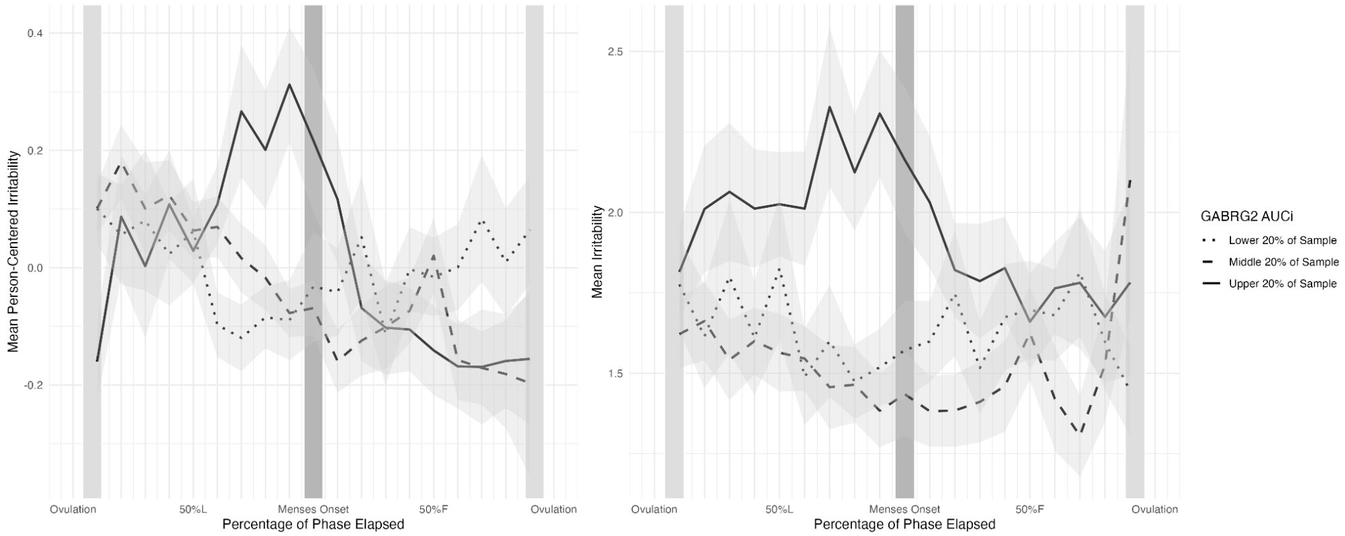
CBT, DBT, and targeted medication for specific symptoms.

All developed for PMDD. Nothing is approved for the menstrual pattern, and in secondary analyses many of these do not work for it.

ACOG Clinical Practice Guideline, 2023, Management of Premenstrual Disorders; IAPMD treatment guidelines; Marjoribanks et al., 2013 (SSRIs); Lopez et al., 2012 (drospirenone); Wyatt et al., 2004 (GnRH agonist).

WHO RESPONDS

Clue 1: a blood test that tracks the surge pattern (GABA receptor genes)



Daily irritability across the cycle, grouped by how much one GABA receptor gene (GABRG2) swings over the month in each patient's blood. Solid line = largest swings.

LUTEAL PATTERN

Bigger monthly swings in three GABA receptor genes (**GABRG2, GABRD, GABRA5**) → more **luteal** irritability, anxiety, and suicidal thoughts.

Not depression.

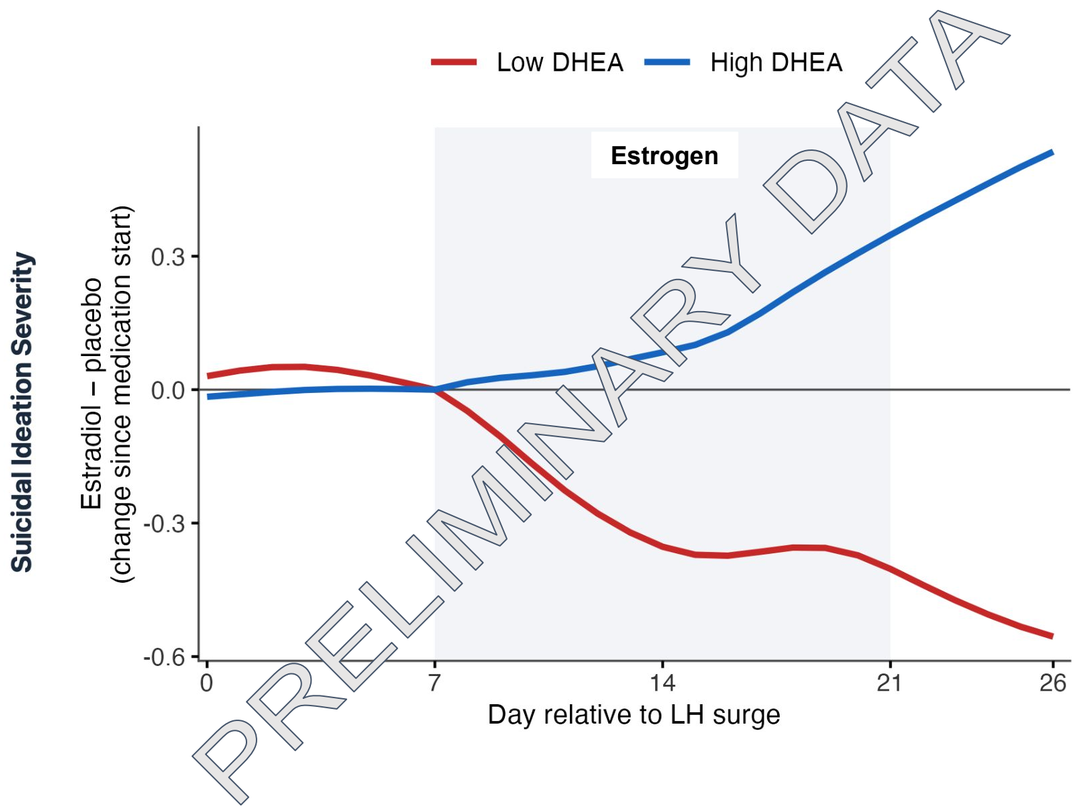
GABA receptors are the brake pedal ALLO acts on, so this points at the receptor remodeling we think underlies surge sensitivity.

LED BY
Jordan Barone, MD/PhD

Barone JC, Romano R, Nagpal A, Salerno A, Patterson A, Wenzel ES, Guzman G, Alluri V, Maki P, Pinna G, Eisenlohr-Moul TA. Peripheral cyclical expression of GABA-A receptor subunit genes and menstrual cycle affective change: a dimensional, transdiagnostic study. Transl Psychiatry. 2025 Dec 20;15(1):533. doi: 10.1038/s41398-025-03767-9. PMID: 41422264; PMCID: PMC12722714.

WHO RESPONDS

Clue 2: lower baseline DHEA predicted more benefit from estradiol (preliminary)



WHAT WE SAW

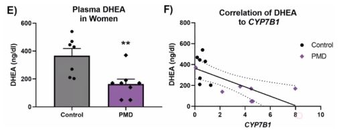
In CLEAR-2, patients with lower DHEA before treatment got more benefit from the perimenstrual estradiol patch.

WHY IT MIGHT MATTER

DHEA is a steroid the body can convert toward estrogens. Less DHEA may mean less buffer against the fall.

WHY IT MATTERS FOR "WHO"

Measured before treatment, from a blood draw. That is what a usable predictor would look like.

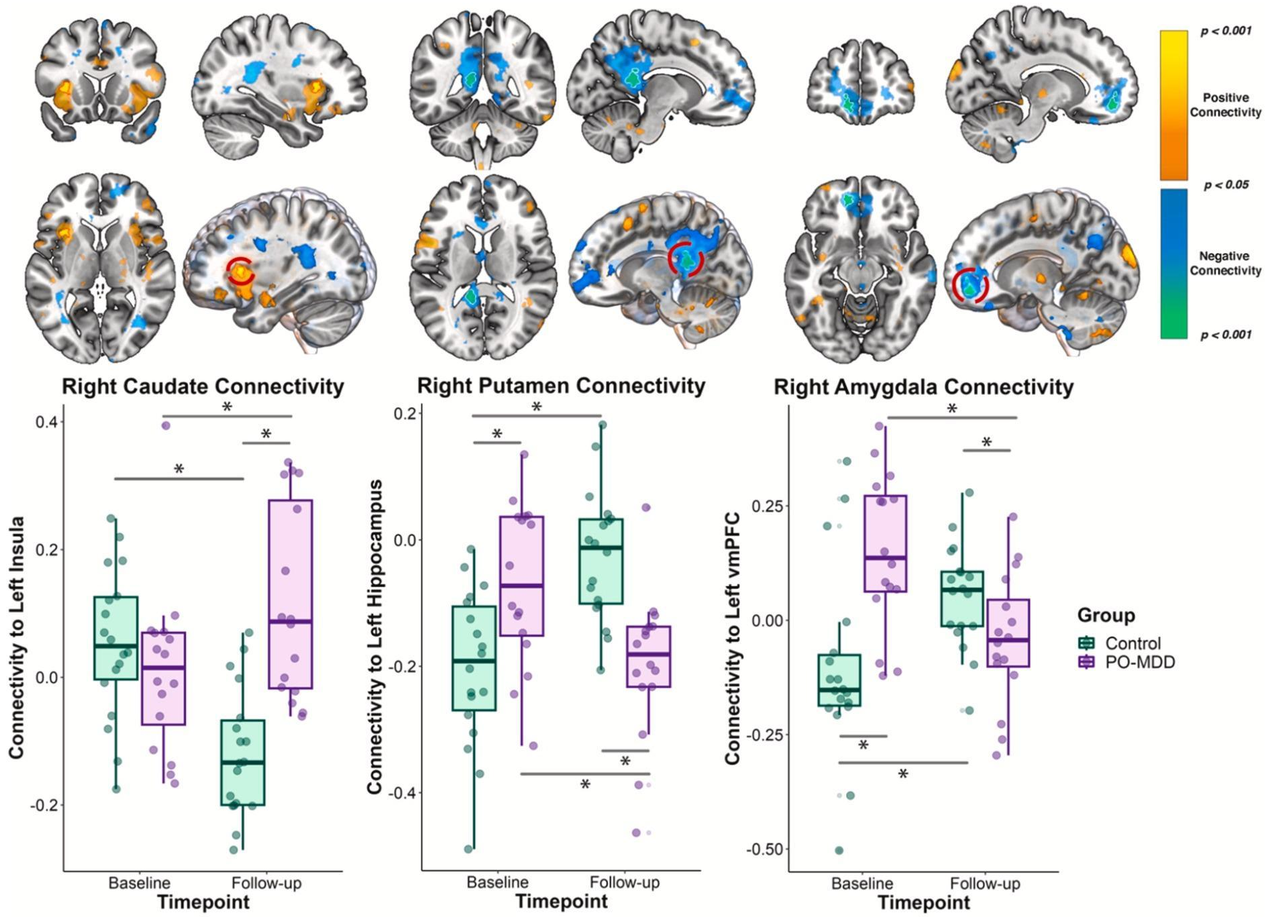


Context: DHEA is also lower in perimenopausal depression, another estradiol-withdrawal condition, and tracks a steroid-metabolism gene (CYP7B1). Rudzinskas et al., 2020, Mol Psychiatry.

CLEAR-2 secondary analyses (unpublished). Trait DHEA = mean of 5 baseline draws. Assays: BBRF NARSAD YIG #27304.

WHAT'S NEXT

Understanding how estradiol changes how the brain's different regions talk to each other



Brain scans before and after an estradiol patch: 16 people with depression that began in perimenopause (purple) and 18 without (green).

Estradiol changed how strongly emotion and reward regions talked to each other, **in the depressed group only**: some connections strengthened, others weakened.

COLLABORATOR

Crystal Schiller

Hynd M, Gibson K, Walsh M, Phillips R, Prim J, Eisenlohr-Moul T, Walsh E, Dichter G, Schiller C. Estradiol modulates resting-state connectivity in perimenopausal depression. J Affect Disord. 2025 Feb 15;371:253-260. doi: 10.1016/j.jad.2024.11.068. Epub 2024 Nov 22. PMID: 39581384; PMCID: PMC12035911.

What changes in the brain when the suicidal state changes?

Estradiol patch alone vs. placebo, across the perimenstrual window, with brain imaging (resting-state fMRI).

The same person, scanned in three states:

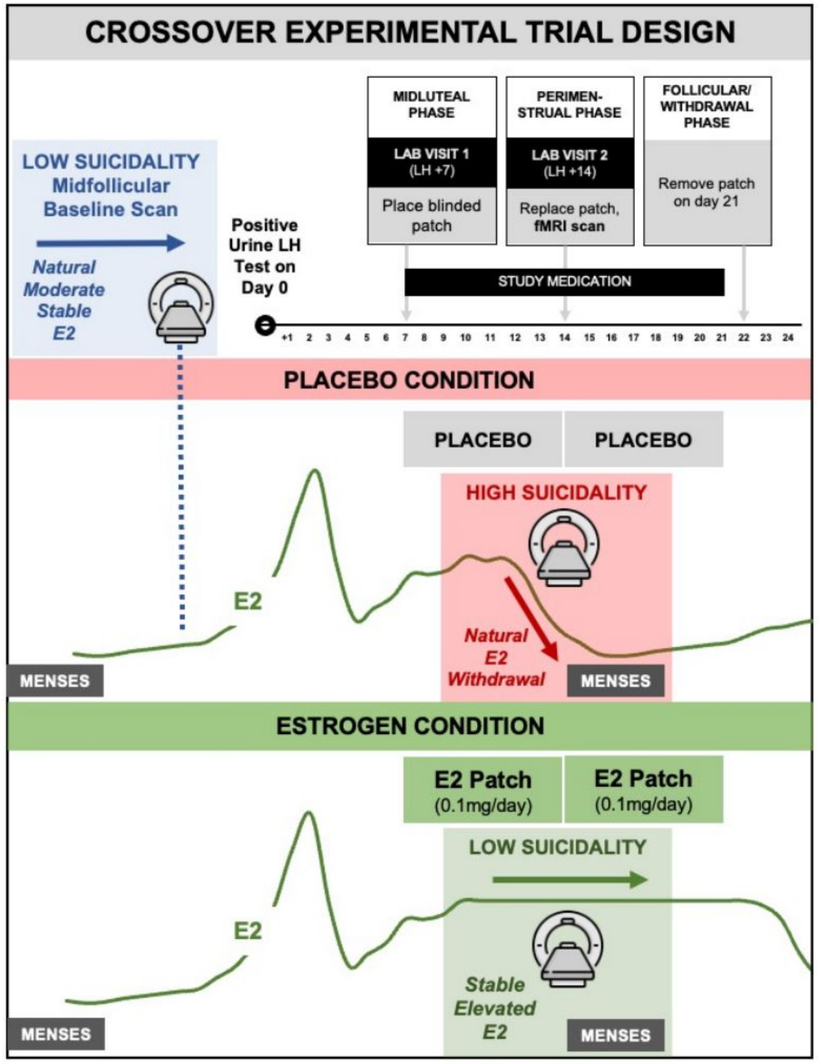
1 **Natural, lower risk:** early cycle, estradiol moderate and stable

2 **Natural, higher risk:** perimenstrual estradiol fall, under placebo

3 **Rescue:** same window, the fall prevented by the patch

Goal: Use a computational approach called group iterative multiple model estimation (GIMME) to compare brain changes in response to treatment, aiming to understand why some people benefit from estrogen while others do not.

Enrolling at the University of Chicago later this year. Ages 20–40, regular cycles, recent suicidal thoughts, in outpatient care.



PINES: Parsing the Idiographic NeuroEndocrinology of Suicidality. NIMH R01 MH140472; UChicago IRB26-1180.

WHAT YOU CAN DO

What you can do now

1

Track it

Two months of daily ratings, not memory. Free apps exist (e.g., MAC-PMSS). Recall alone gets the pattern wrong about 60% of the time.

2

Name the window

If suicidal thoughts reliably worsen in the luteal weeks or around the period, that is clinical information. Tell your prescriber and therapist, and bring the ratings.

3

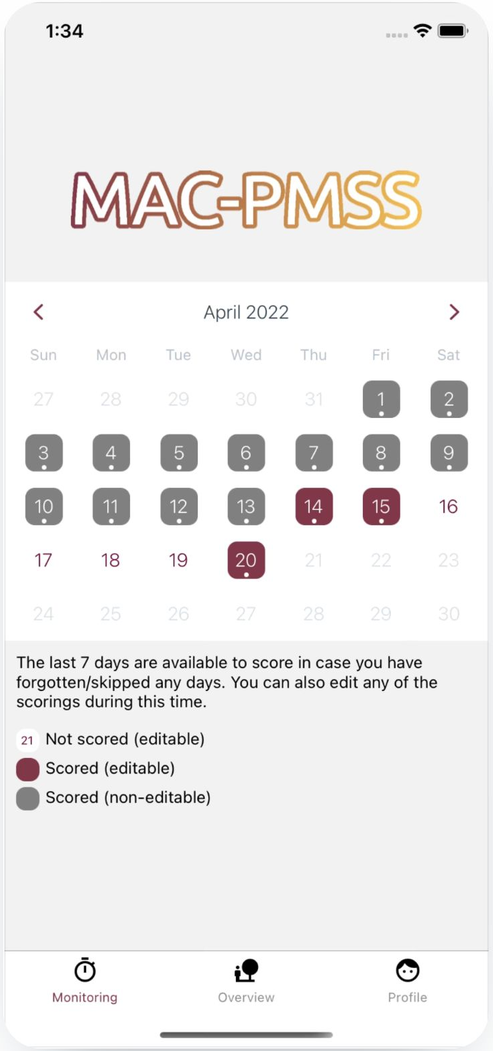
Time the safety plan

Extra check-ins, means safety, and support concentrated in your high-risk days. Predictable risk is preventable risk.

4

Know your pattern before changing hormones

SSRIs and continuous drospirenone have evidence for the luteal pattern. Hormonal changes can help or harm depending on the sensitivity involved. Track before and after.



Owens & Eisenlohr-Moul, 2018; Eisenlohr-Moul et al., 2016 (measurement); IAPMD patient treatment guide: iapmd.org

QUESTIONS · #BBRFWEBINAR

Questions, and ways to get involved

CLEAR
CLARIFYING THE ENDOCRINOLOGY OF ACUTE RISK

IF YOU HAVE SYMPTOMS	Track two cycles and bring the ratings to your clinician. Free daily tracking: **MAC-PMSS** app (iPhone). **iapmd.org** for the patient treatment guidebook, provider directory and support. Crisis support (US): **call or text 988**.
IF YOU'RE A CLINICIAN	**ncrptraining.org** (National Curriculum in Reproductive Psychiatry) · **nabrp.org** (efforts to create a standard reproductive psychiatry subspecialty) · **iapmd.org** (clinician guidelines)
IF YOU'RE A RESEARCHER	**menstrualcycleR** (cycle timing) and **cpass** (PMDD scoring) R packages · CLEAR Lab: **clearlabresearch.com**
IF YOU WANT TO GIVE	BBRF funds critical science. **bbrfoundation.org** · IAPMD serves patients directly. **iapmd.org** · To support the CLEAR Lab specifically: **temo@uchicago.edu**