

Perinatal ADHD

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Disclosures

Neither I nor my spouse has a relevant financial relationship to
a commercial interest to disclose.

Learning Objectives



Discuss

- Discuss general risks of stimulant use during pregnancy with their patients with ADHD;



Create

- Create a tailored risk/risk analysis of stimulant use vs. risk of stopping treatment for their patient with ADHD;



Consider

- Multi-faceted demands of early motherhood and risk for roughening comorbidity of depression & anxiety in women with ADHD.

ADHD in Women: A New Lens on Cognitive Differences

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder affecting:

Attention

Executive functioning

Impulse control

Hyperactivity



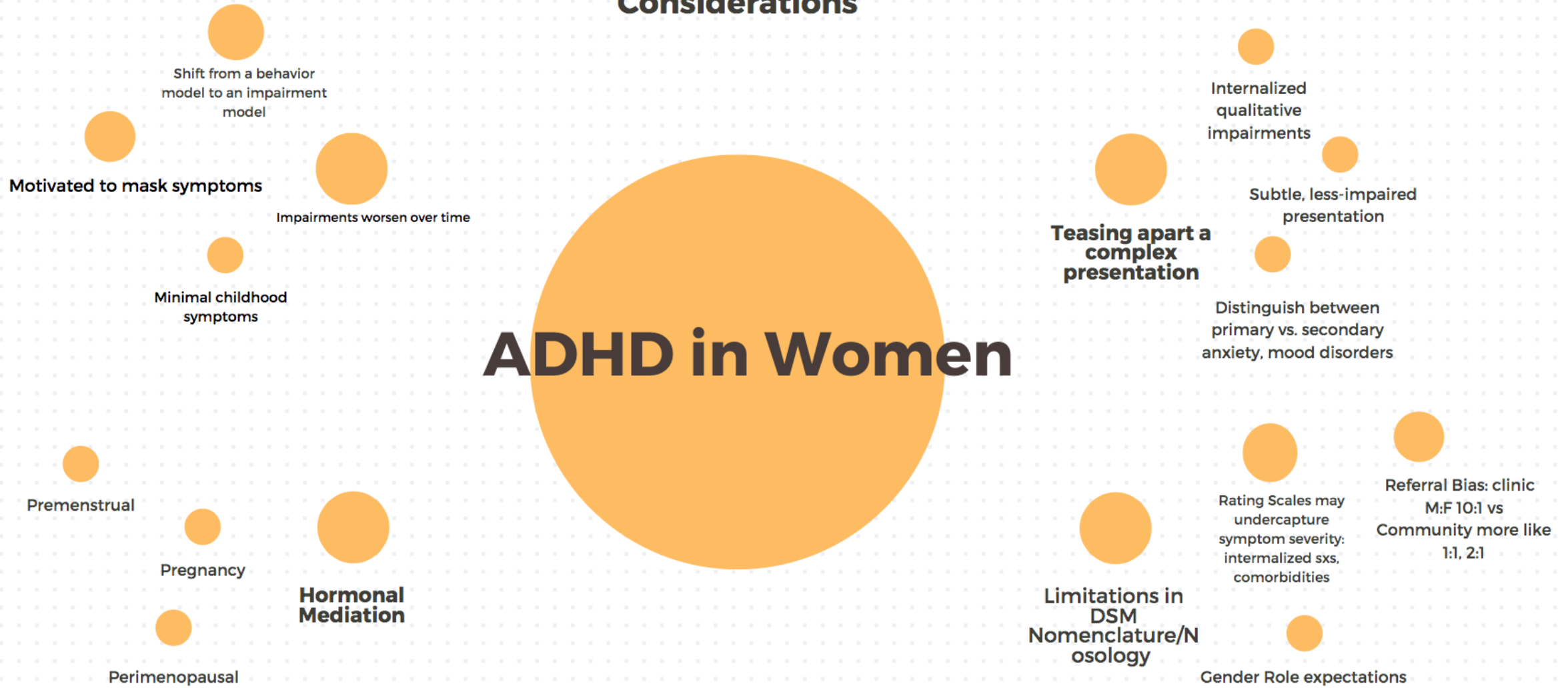


Background

- Roughly 1 in 30 women has ADHD (Faraone 2018).
- ADHD is linked to elevated risk of poorer general & mental health, substance use disorders, impaired work performance, and financial distress (Biederman 2010 & 2012).
- Women with pre-existing diagnosis of ADHD may be more vulnerable to worsening cognition during pregnancy (Freeman 2014).

Diagnostic Considerations

ADHD in Women





ADHD in Reproductive Age Women

ADHD in adulthood for women associated with depression, anxiety, substance use, occupational, social, and overall impairment domains.

Adult women with ADHD can experience difficulties at work and home related to their ADHD symptoms.

Treatment of adult ADHD improves functioning and quality of life, women on treatment for ADHD may wish to continue their medications during pregnancy.

ADHD Often Presents Differently in Women

Core pattern

- Predominantly inattentive presentation
- Symptoms often internalized, subtle, and under-recognized

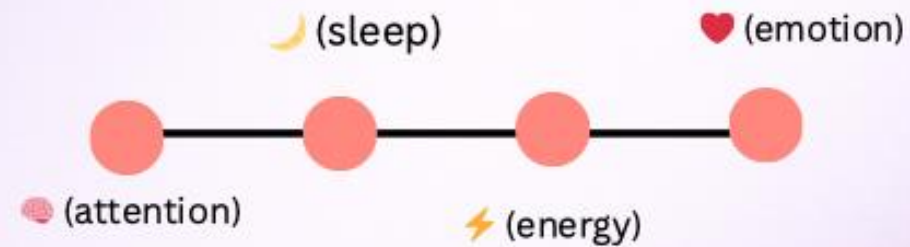
Common clinical features

- Chronic disorganization, time blindness, difficulty initiating / completing tasks
- Mental restlessness, hyperv verbal or ruminative thinking rather than physical hyperactivity
- Emotional dysregulation, rejection sensitivity, and low frustration tolerance
- High rates of masking and compensatory overfunctioning, especially in high-achieving women



ADHD Across Hormonal Transitions

Puberty → Pregnancy → Postpartum → Perimenopause



Hormonal, physical, and emotional shifts across these transitions can alter dopamine signaling and cognitive reserve—changing how ADHD symptoms emerge, intensify, or are recognized.

One diagnosis, four clinical moments

ADHD doesn't go on hold for reproduction. But prescribing does, often reflexively.

01 · REPRODUCTIVE YEARS

A rising tide

Stimulant prescribing among reproductive-age women has climbed for two decades — and accelerated sharply since 2020.



02 · PREGNANCY

Reflexive discontinuation

Most women stop on their own before anyone counsels them — against a safety literature that is largely reassuring.



03 · POSTPARTUM

The rebound window

Diagnosis dips in pregnancy and rises above baseline 2–5 years after — often in women already known to us.



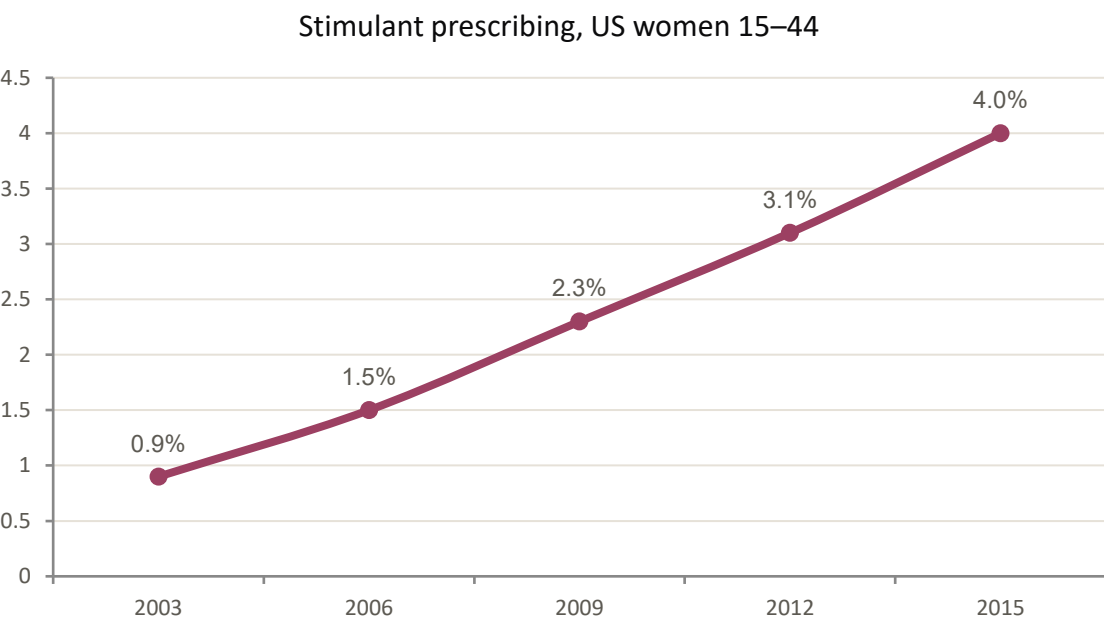
04 · PREMENSTRUAL WINDOW

Cycling brings a new variable.

The late luteal phase is a frequent breakthrough window on a previously stable regimen — prompting many women to self-titrate upward premenstrually.

A quiet, four-fold rise

Stimulant prescribing to privately insured US women aged 15–44 rose from 0.9% to 4.0% between 2003 and 2015 — a 344% increase — before the pandemic accelerated things further.



US commercially insured women, 15–44, 2003–2015; Danielson et al., MMWR 2023

+25%

additional rise in incident stimulant prescriptions among women, pre-pandemic to pandemic era (2018–2022) — on top of the existing trend.

2020 →

Ontario, Canada shows the same inflection: incident stimulant prescribing to women 18–44 surges sharply starting in 2020 (Myran et al., JAMA Netw Open 2025).

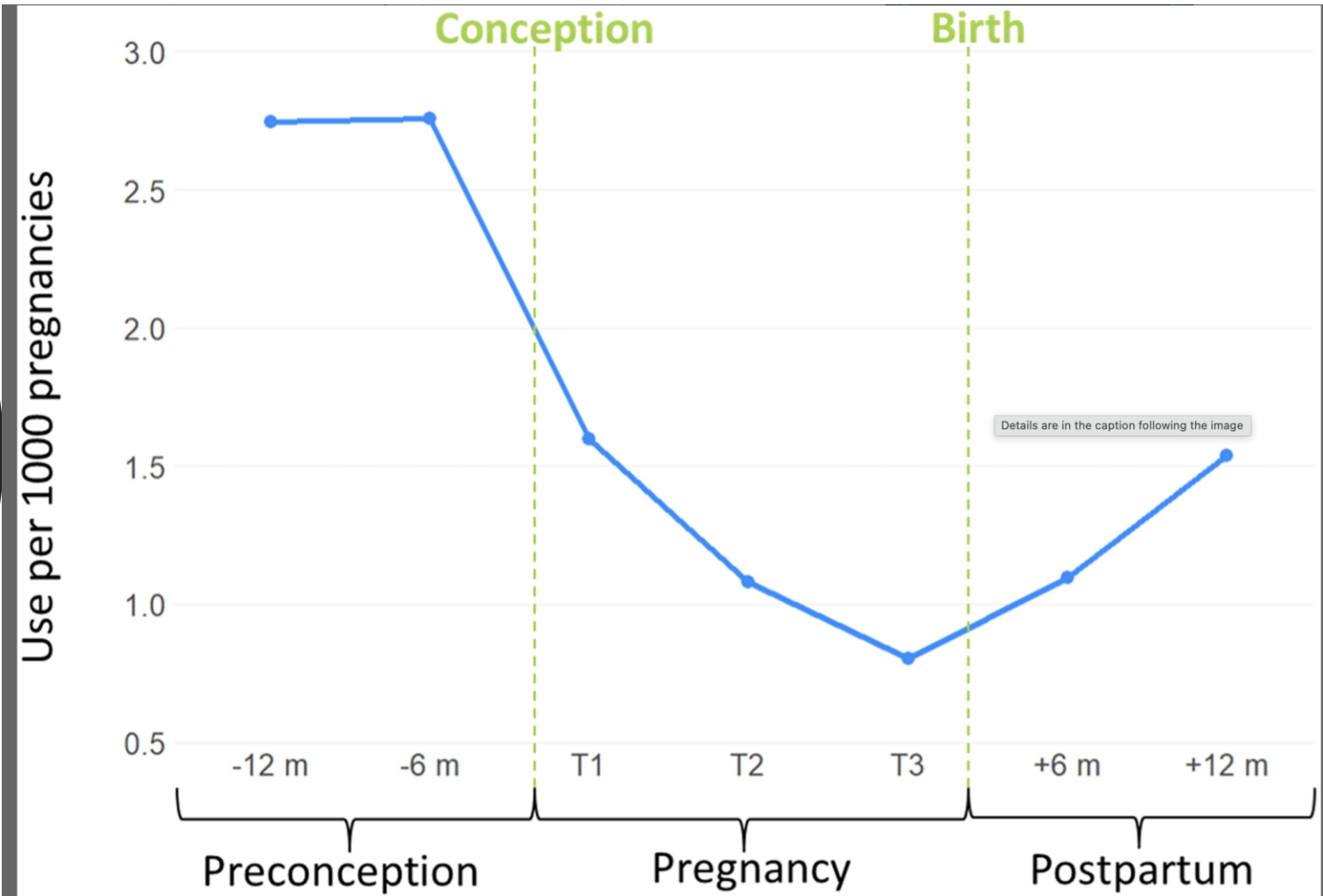
NPs

Nurse practitioners show the largest unadjusted percentage increase in prescribing across all behavioral health drug classes during this period.

Drivers include expanded telehealth, rising awareness of adult ADHD (partly via social media), and new direct-to-consumer assessment clinics — against a backdrop of no formal US adult ADHD prescribing guidelines.

Stimulant use in pregnancy is rising rapidly, but most patients still discontinue treatment.

Use increased 11-fold from 2000–2021, yet 77% stopped before or during pregnancy; emerging safety data are generally reassuring, underscoring the need for individualized risk–risk counseling that considers both medication exposure and the consequences of untreated ADHD.



Prevalence Trends and Patterns of Perinatal ADHD Stimulant Medication Use in British Columbia, Canada.
Pharmacoepidemiol Drug Saf. March 31, 2025.

Treatments commonly used to treat ADHD in the perinatal period

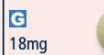
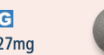
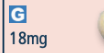
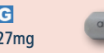
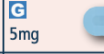
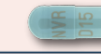
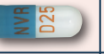
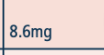
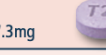
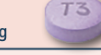
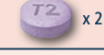
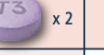
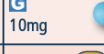
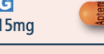
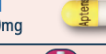
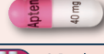
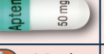
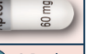
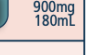
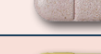
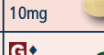
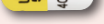
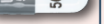
Severity of Symptoms	Treatment and Self-Management
Mild to moderate	A. Psychoeducation B. Self-management or coaching C. Psychotherapies i. Cognitive behavioral therapy (CBT) ii. Mindfulness-based interventions iii. Dialectical behavior therapy
Moderate to severe	Treatment for mild to moderate symptoms plus: D. Pharmacotherapy (medications) i. Stimulants a. Amphetamine-based stimulants b. Methylphenidate-based stimulants ii. Nonstimulants

ADHD, attention-deficit/hyperactivity disorder.

Scoten. Attention-deficit/hyperactivity disorder in the perinatal period. *Am J Obstet Gynecol* 2024.

Methylphenidate Formulations – Long Acting, Oral**

(Capsules and tablets in this section are shown at actual size)

Relexxii®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg											
Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg											
Focalin® XR‡ (dexamethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 10–40mg; SD: 10mg (biphasic – 50/50)											
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg (biphasic – 25/75)							 x 2		 x 2		
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg (biphasic – 40/60)										Methylphenidate Formulations - Long Acting, Transdermal (Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.) Daytrana® Methylphenidate (transdermal system) 30mg / 9 hrs 1.5" x 3.9" 3 mg/hr	
Quilivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 20/80)	 1 Bottle: 300mg 60mL		 1 Bottle: 600mg 120mL		 1 Bottle: 900mg 180mL		 2 Bottles: 600mg 120mL	 2 Bottles: 750mg 150mL	 2 Bottles: 900mg 180mL		
QuilliChew ER®§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 30/70)											
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg (biphasic – 50/50)											
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg (biphasic – 30/70)											

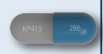
Methylphenidate Formulations - Long Acting, Transdermal

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)



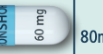
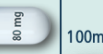
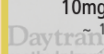
Methylphenidate Pro-Drug Formulations - Long Acting, Oral**

(Medications in this section are shown at actual size)

Azstarys®? (dexamethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg					
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Methylphenidate Formulations – Long Acting/Delayed Onset, Oral**

(Medications in this section are shown at actual size)

Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg					
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Methylphenidate Formulations – Short Acting, Oral**

(Medications in this section are shown at actual size)

Focalin® (dexamethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID					
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID					
Methylin Chewable®§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID					
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID					

Daytrana®
6-17 Yrs: 10–30mg; SD: 10mg



Administration Key:

- Orally disintegrating tablet
- Must be swallowed whole
- Chewable
- Can be mixed with yogurt, orange juice, or water
- Can open capsule and sprinkle medication on apple sauce
- Can open capsule and mix with apple sauce or yogurt
- Can open capsule and sprinkle medication into water or onto apple sauce

Generic Key:

- Indicates a generic formulation is also available; generic products are not shown
- Indicates a generic (but NOT a branded) formulation is available

View the latest version of the ADHD Medication Guide at:
www.ADHDMedicationGuide.com

* **Important Information:** The ADHD Medication Guide only includes medications indicated by the FDA for the treatment of ADHD. The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. “SD” refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the FDA-approved product information to learn more about each medication.

♦ **Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Adzenys ER (liquid); Cylert (pemoline); Dexedrine Spansules (5mg, 15mg); Dexedrine tablets; DextroStat tablets; Evekeo ODT tablets; LiguADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylin Chewable tablets; Ritalin LA capsule (50mg); Ritalin SR tablets (20mg), Strattera.

** **Disclaimer:** The ADHD Medication Guide was created by Dr. Andrew Adesman of Northwell Health, Inc. Northwell Health is not affiliated with the owner nor is it an owner of any of the medications or brands referenced in this Guide. No endorsement or affiliation exists between Northwell Health and the owner of the medications or brands. The ADHD Medication Guide is a visual aid for professionals caring for individuals with ADHD. In clinical practice, this guide may be used to assist patients in identifying medications previously tried, and may allow clinicians to identify ADHD medication options for the future. Although every effort has been made to

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Dyanavel® XR§ (d- & l-amphetamine sulfate) (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg (biphasic – 20/80)		5mg			10mg			15mg			20mg						
Dyanavel® XR (d- & l-amphetamine sulfate) (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg (biphasic – 20/80)	2.5mg 1mL		5mg 2mL		7.5mg 3mL		10mg 4mL		12.5mg 5mL		15mg 6mL		17.5mg 7mL		20mg 8mL		
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5–50mg; SD: 12.5mg (triphasic – 33.3/33.3/33.3)		12.5mg			25mg				37.5mg				50mg				
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg (biphasic – 50/50)			3.1mg		6.3mg		9.4mg		12.5mg		15.7mg		18.8mg				
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5–30mg; SD: 20mg (biphasic – 50/50)			5mg		10mg		15mg		20mg		25mg		30mg				
Dexedrine Spansule® (d-amphetamine sulfate)	6–17 Yrs: 10–60mg; SD: 5mg 1-2x/day				5mg	10mg		15mg										

Amphetamine

Xelstry™
(d-amphetamine)
6–17 Yrs: 4.5–18mg;
SD: 4.5mg

Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Vyvanse [®] Y (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg		10mg		20mg		30mg		40mg		50mg		60mg		70mg
Vyvanse [®] S (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg		10mg		20mg		30mg		40mg		50mg		60mg		

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1-2x/day			5mg				10mg										
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–16 Yrs: 5–40mg divided BID; SD: 5mg 1-2x/day	2.5mg		5mg		7.5mg		10mg				15mg		20mg		30mg		
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1-2x/day			5mg		7.5mg		10mg		12.5mg		15mg		20mg		30mg		
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1-2x/day			5mg/5mL														

Non-Stimulants** (Medications in this section are shown at actual size)

Onyda™ XR (clonidine, extended release) (orange flavor)	6–17 Yrs: 0.1–0.4mg; SD: 0.1mg (dosed at bedtime)	0.1mg 1mL		0.2mg 2mL		0.3mg 3mL		0.4mg 4mL										
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1–0.2mg BID; SD: 0.1mg qHS		0.1mg															
Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1–4mg; SD: 1mg 13–17 Yrs: 1–7mg; SD: 1mg Weight-based dosing: SD: 0.05–0.08 mg/kg/day; may increase to 0.12 mg/kg/day		1mg		2mg		3mg		4mg									
Qelbree®‡ (viloxazine)	6–11 Yrs: 100–400mg; SD: 100mg 12–17 Yrs: 200–400mg; SD: 200mg Adults: 200–600mg; SD: 200mg		100mg		200mg		300mg		400mg		500mg		600mg		700mg			

Amphetamine Formulations- Long Acting, Transdermal

Xelstrym™
(d-amphetamine)
6-17 Yrs: 4.5–18mg;
SD: 4.5mg
Adults: 9-18mg;
SD: 9mg

4.5mg / 9hrs
~0.9" x 0.9"

9mg / 9hrs
~1.2" x 1.2"

13.5mg / 9hrs
~1.5" x 1.5"

18mg / 9hrs
~1.7" x 1.7"

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse



Pregnancy Considerations

ADHD medication use among pregnant women is increasing but consensus about the safety of ADHD medication use during pregnancy has been lacking.



Given that nearly half of U.S. pregnancies are unintended and early pregnancy is a critical period for fetal development, these are matters of great clinical importance.

Course of ADHD During Pregnancy

Investigating ADHD Symptoms and Functioning Among Women Who Chose to Discontinue, Alter, or Maintain Pharmacologic Treatment for ADHD in the Perinatal Period

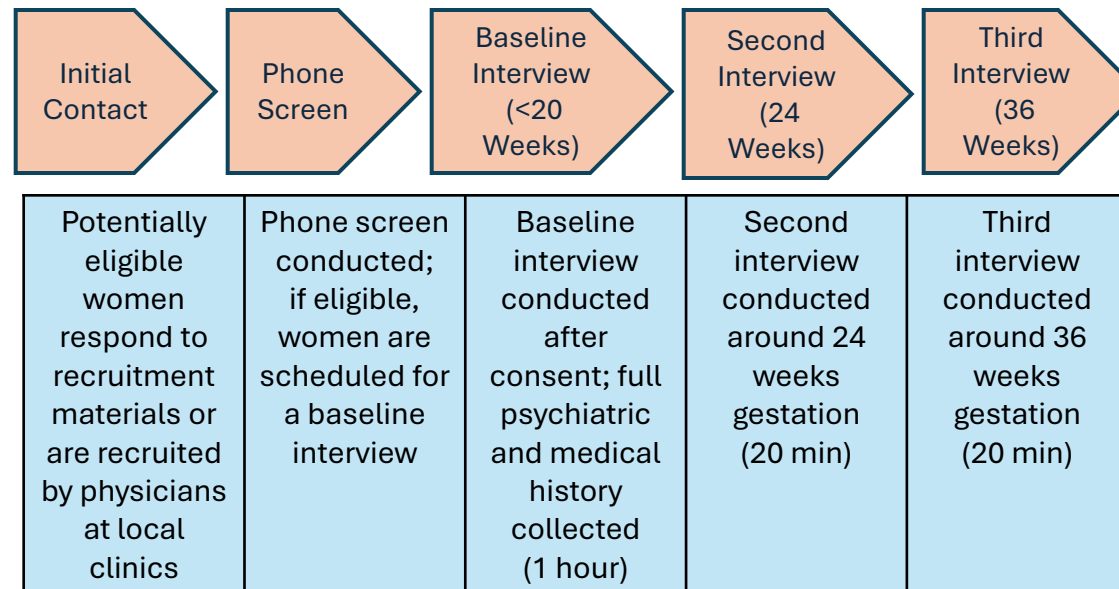
Allison S. Baker, MD, Rebecca Wales, BA, Olivia Noe, BS, Peter Gaccione, PhD, Marlene P. Freeman, MD, and Lee S. Cohen, MD

Journal of Attention Disorders
December 2020

Funded by Gerstner Family
Foundation

Study Outline and Procedure

- Pregnant women ages 18-45 were prospectively followed during pregnancy using 3 structured clinical interviews
- ADHD symptoms were recorded at each timepoint using the AISRS
- Additionally, symptoms of anxiety, depression, stress, and functional impairment were monitored



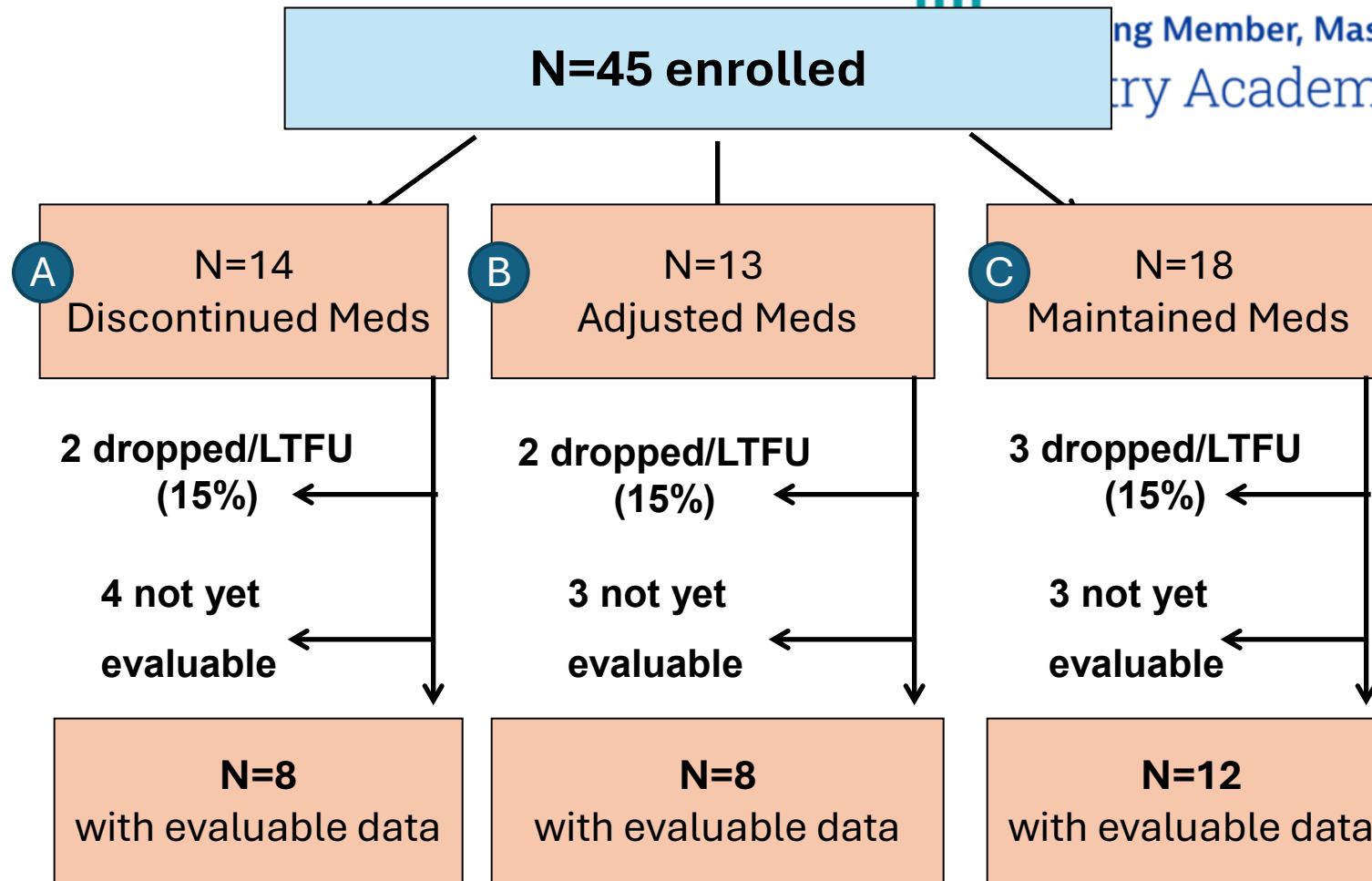
Use of ADHD Medications Across Pregnancy



Massachusetts General Hospital

Long Member, Mass General Brigham

Primary Academy



Group A → Discontinued ADHD medications during pregnancy

Group B → Adjusted ADHD medication use throughout pregnancy

Group C → Maintained dose of ADHD medication throughout pregnancy

Psychiatric Comorbidity in Pregnant Women with ADHD

Diagnosis	Group A (n=8)	Group B (n=8)	Group C (n=12)	Overall (n=28)
	N (%)			
Generalized Anxiety Disorder (GAD)	5 (62.5%)	4 (50%)	5 (41.67%)	14 (50%)
Major Depressive Disorder (MDD)	2 (16.67%)	3 (37.5%)	4 (33.33%)	9 (32.14%)
Panic Disorder	1 (12.5%)	1 (12.5%)	1 (8.33%)	3 (10.71%)
Bipolar Disorder II	3 (37.5%)	0	0	3 (10.71%)
Obsessive Compulsive Disorder (OCD)	1 (12.5%)	1 (12.5%)	0	2 (7.14%)
Post-Traumatic Stress Disorder (PTSD)	0	1 (12.5%)	0	1 (3.57%)

Outcome Variables

- Adult ADHD Investigator Symptom Rating Scale (AISRS)
- Weiss Functional Impairment Rating Scale – Self Report (WFIRS-S)
- Edinburgh Postnatal Depression Scale (EPDS)

Results: WFIRS-S (Family Functioning)

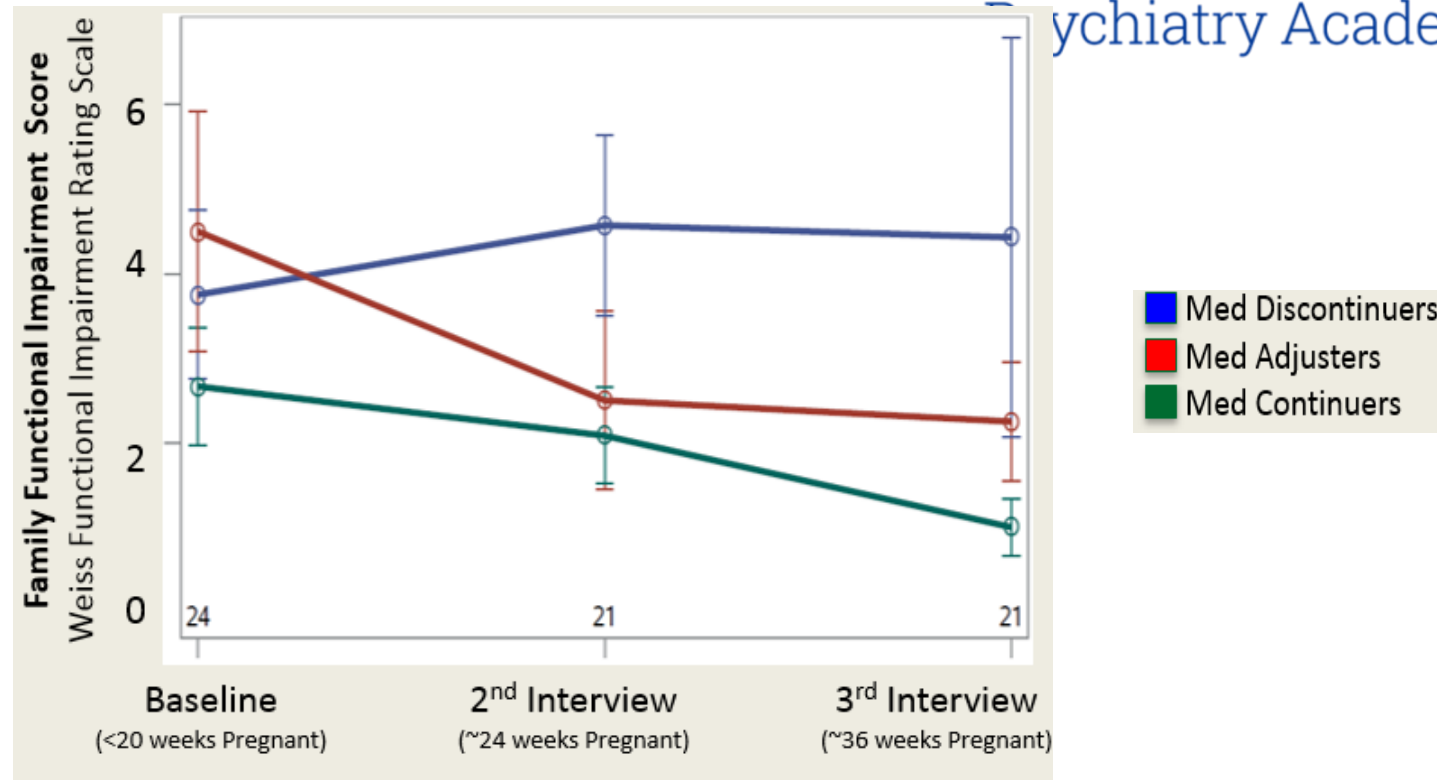


Figure 1. Self-reported impairment in family functioning measured across three pregnancy by medication group. The adjusted mean changes of: discontinuers, 1.55, meds as needed, -1.70, maintainers, -1.54, showing significant differences between those who discontinued meds and those changing meds as needed (3,3, $p=0.0309$) and discontinuers vs maintainers (3.09, $p=0.0197$).

Results: EPDS Score



Massachusetts General Hospital
Founding Member, Mass General Brigham

Psychiatry Academy

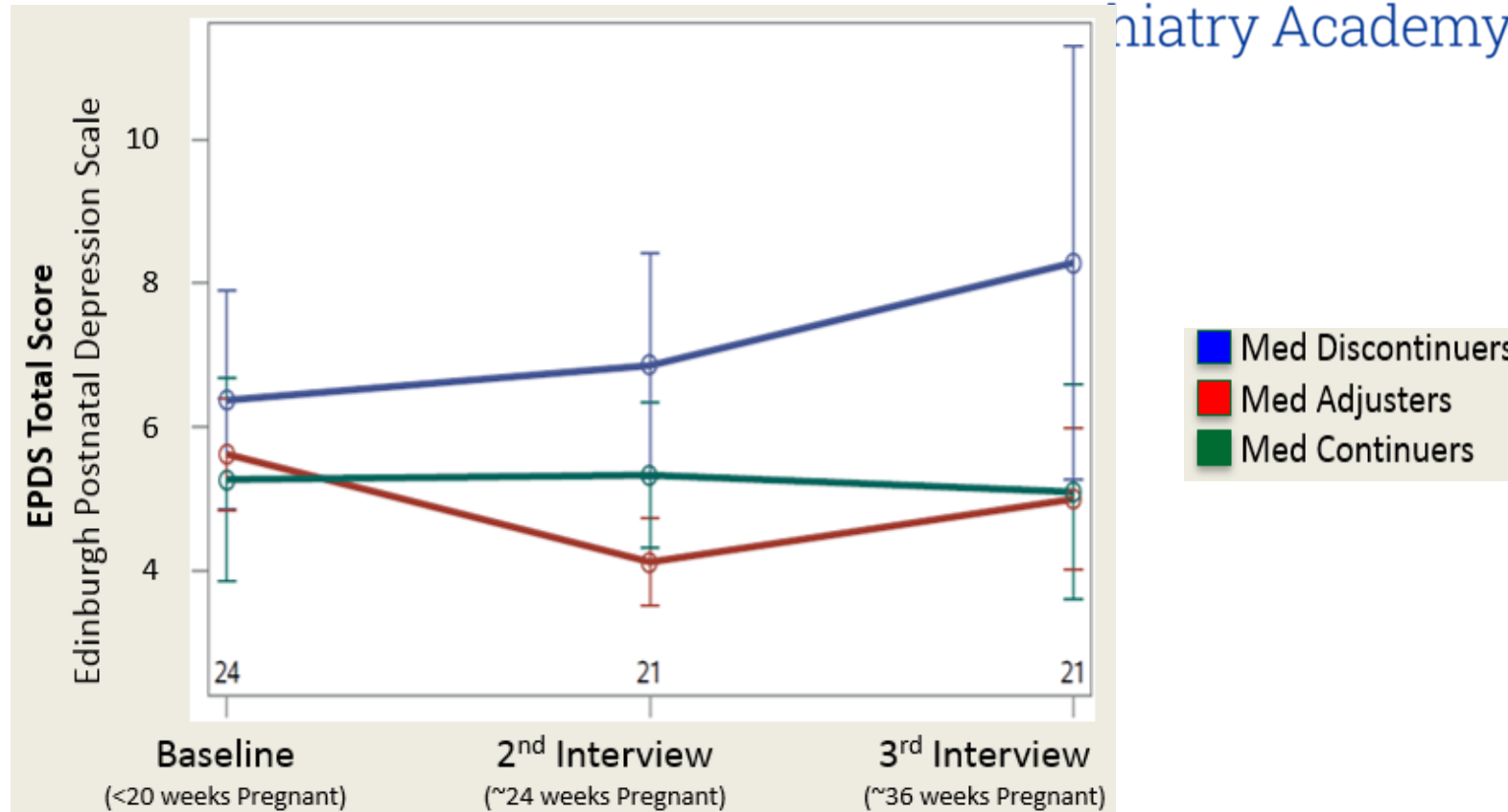


Figure 2. Edinburgh Postnatal Depression Scale (EPDS), self-reported depression and anxiety symptoms across timepoints and treatment groups. Adjusted mean changes of: discontinuers, 4.32, meds as needed, -1.01, and maintainers, -0.65, showing significant differences between those who discontinued meds and those changing meds as needed (5.3, $p < 0.0001$) and discontinuers vs maintainers (4.98, $p = 0.0009$).

Clinical Implications

Despite generally reassuring reproductive safety data, stimulant discontinuation is often recommended for women with ADHD symptoms who appear able to function without medication.

Our data suggest this approach carries risk, as stimulant discontinuation during pregnancy may worsen ADHD symptoms and functioning for some women.



Stopping Pharmacotherapy for Pregnancy

- Worsening mental health
- Seriously impaired functioning
- Spontaneous abortion
- Preterm birth
 - Scoten et al. AJOG 2024



Summary: Safety in Pregnancy

- While some studies have shown increased adverse effects among infants exposed to maternal ADHD medications, most have not.
- There are indications that higher rates of miscarriage are associated with maternal ADHD rather than fetal exposure to psychostimulant medications.
- One study found a small increased risk of CNS disorders and admission to a NICU (? exposure to psychostimulant med vs. assoc. w/ maternal ADHD)

PREGNANCY

Congenital malformations

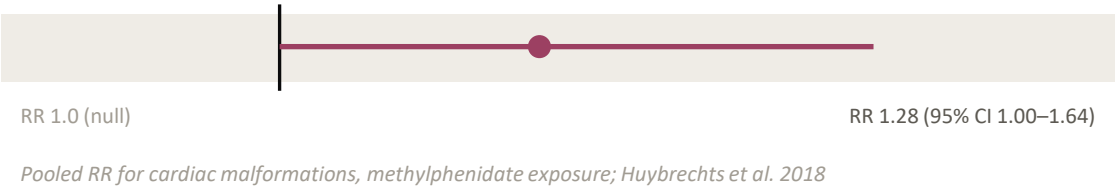
Huybrechts et al., JAMA Psychiatry 2018

1.8M US Medicaid pregnancies, replicated in 2.5M Nordic pregnancies: no increased risk of overall malformations with methylphenidate or amphetamines.

di Giacomo et al., JAMA Netw Open 2024

Meta-analysis, 10 studies, 16.6M pregnancies: no significant increase in congenital anomalies or miscarriage with methylphenidate or atomoxetine.

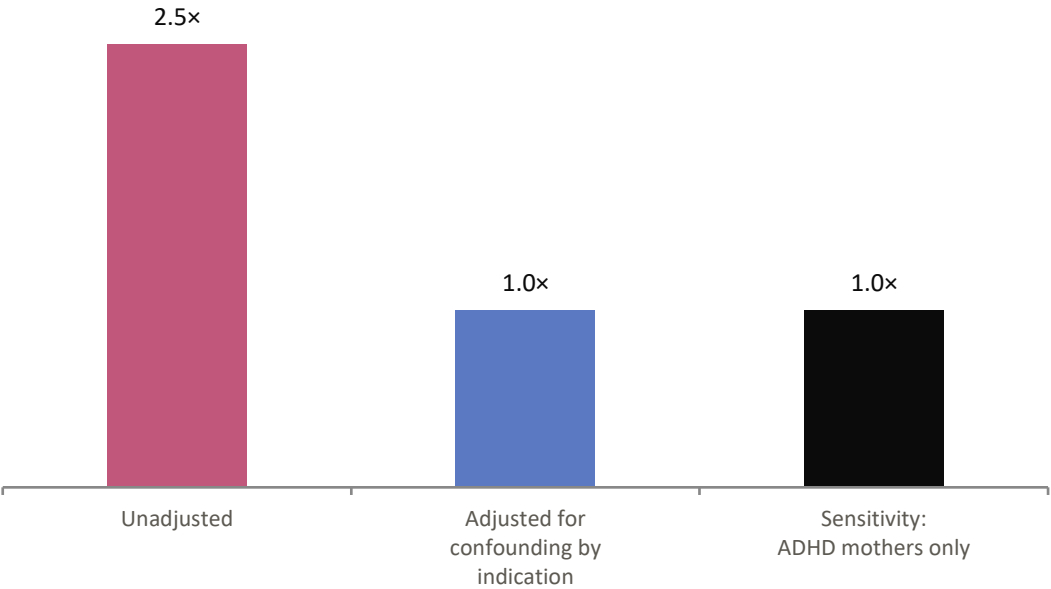
Signal to know: a small possible cardiac malformation signal with methylphenidate — not seen with amphetamines.



NEURODEVELOPMENT

Confounding by indication, unmasked

Suarez et al. (JAMA Psychiatry, 2024) — >4M US pregnancies, up to 18 years follow-up. Unadjusted analyses showed a 2–3× risk of ASD, ADHD, and neurodevelopmental disorders in exposed children. After adjustment for confounding by indication, that signal collapsed.



Obstetric risk of the medication

Andrade, J Clin Psychiatry 2018

Adjusted absolute risk increases are small. Worst-case NNH ~63 for amphetamines and preeclampsia; >500 for other outcomes.

Winther et al., Soc Psychiatry Psychiatr Epidemiol 2026

Danish register, 741,905 births: continued medication associated with gestational hypertension (aRR ~1.4–1.6), but not other major obstetric complications after adjustment.

Obstetric risk of untreated ADHD

Andersson et al., Acta Psychiatr Scand 2026

Swedish study, ~1.6M pregnancies: maternal ADHD–preterm birth association attenuates to nonsignificance after adjusting for comorbid mental disorders and smoking (adjOR 1.06, 95% CI 0.99–1.13). ADHD independently associated with LGA infants and planned cesarean.

Amikam et al., BMC Pregnancy Childbirth 2024

US database, 9M deliveries: maternal ADHD associated with higher adjusted rates of hypertensive disorders, cesarean, SGA, and congenital anomalies — though smoking, substance use, and obesity are common confounders.

Untreated ADHD is not a neutral comparator — it carries its own obstetric signature.

The diagnostic dip and rebound

Madsen et al. (J Atten Disord, 2025) — Danish cohort, 363,904 mothers.

- **Incident ADHD diagnoses drop sharply during pregnancy** (IRR 0.28) — not because ADHD resolves, but because it isn't being looked for.
- **Diagnoses rise above pre-pregnancy levels** in the 2–5 years postpartum (IRR 1.24).
- **Over half of women diagnosed postpartum had prior psychiatric contact** — suggesting underrecognition during pregnancy itself, not new-onset illness.

Clinical guidance summary

- ✓ No formal society guidelines exist for ADHD treatment in pregnancy. This is judgment-based, evidence-informed care.
- ✓ Overall evidence is generally reassuring for stimulant safety, with small absolute risk differences for obstetric complications.
- ✓ Amphetamines appear slightly safer than methylphenidate regarding cardiac malformation risk.
- ✓ Methylphenidate may be preferred if breastfeeding is planned.
- ✓ Individualize by severity, comorbidities, driving safety, and functional impairment.
- ✓ Untreated ADHD carries its own risks including worse mental health, and potentially obstetric complications.

The principles to prescribe by

ACOG PRINCIPLE

Don't change what's working

Individuals stable on a medication throughout pregnancy should generally not have pharmacotherapy changed postpartum for lactation reasons alone — fetal exposure risk supersedes lactation exposure in this calculus.

THE 10% RULE

Relative infant dose < 10%

Generally considered compatible with breastfeeding. Methylphenidate (0.16–0.7%) sits comfortably within.

THE BIGGER PICTURE

Treat the mother

Effectively treating maternal ADHD is prioritized to support parenting and bonding, an undertreated mother is not a protective default for the infant.

