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Child Abuse and Perinatal Outcomes: Examining Prenatal Health, Intergenerational Abuse, Motherhood, and Childbirth for Survivors

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Abstract This chapter provides an overview of outcomes related to child abuse that may be challenging for child abuse survivors during the perinatal period. In Part 1, general and psychological prenatal health is examined. This includes a discussion on prenatal substance use and eating disorders which have implications for the mother and child. Part 2 of this chapter examines motherhood, particularly the mother-child relationship and the intergenerational implications of child abuse. We discuss attachment, from its early prenatal development to postpartum bonding, and its importance for the infant in forming internal models of caregiving that, if impaired, can contribute to later mental health problems. The important role of breastfeeding in maternal bonding and the difficulties

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some survivors may encounter are also considered. Next, we examine the influence of previous child abuse on parenting practices and consider intergenerational abuse, that is, the potential of a mother with their own history of abuse to harm their child. Drawing on social learning theory and the parenting literature, it is clear that a parent's childhood experiences, which may include abuse and harsh parenting, are influential in their parenting practices. This part of the chapter concludes by considering child abuse survivors' risk of revictimization and the implications this risk poses for pregnant women and their unborn children. Indeed, pregnancy may increase the risk of IPV, and this violence can impact the mother and developing fetus through direct harm and epigenetic effects. The final part of this chapter examines the challenges of childbirth for survivors of childhood abuse and the importance of sensitive care. While childbirth can be particularly traumatizing for some survivors, empirical data suggest that positive birth experiences provide opportunities for caregivers to attenuate negative effects.

Keywords Prenatal eating disorder • Prenatal substance use • Attachment • Mother-child bonding • Revictimization • Intergenerational abuse • Childbirth

Child abuse is a global issue and, for some children, has long-term deleterious consequences (see Chap. 2 for definitions and prevalence) (Irish et al., 2010). Given the high incidence of child abuse in many countries, it is likely that a large proportion of women who become pregnant and have children will have a history of childhood abuse. This chapter provides an overview of certain outcomes related to child abuse that can present challenges for survivors during the perinatal period. In the first part of this chapter, we consider prenatal health, examining general and psychological health. This includes a discussion on prenatal substance use and eating disorders (ED) and the associated implications for mother and child. The second part examines the mother-child relationship from its early prenatal development to postpartum bonding and attachment. We also consider the influence of previous child abuse on parenting practices and intergenerational impacts. This part concludes by considering child abuse survivors' risk of being revictimized and the implications for

pregnant women and their unborn children. The final part examines the childbirth experience for survivors of childhood abuse, including tokophobia (i.e., fear of childbirth), and the importance of sensitive care. While we have not covered psychopathology in detail in this chapter, other chapters in this book specifically address anxiety, depression, suicide ideation, and PTSD (i.e., Chaps. 4 and 5).

Part 1. Prenatal Health

It is well established that the in-utero environment can have long-term implications for the unborn baby. Consistent with the fetal programming hypothesis or developmental origins of health and disease (Ellison, 2010), nutrition and environmental factors can alter development pathways during critical periods of prenatal development. In this first part on prenatal health, we consider the potential impact of child abuse on the mother and developing fetus.

General Health

During pregnancy, survivors of child abuse may experience poorer general health than other women. For example, in a case-control study of mother-infant pairs (matched for age and psychosocial status), women with a history of physical or sexual abuse had more pregnancy complications (e.g., severe vomiting), and their infants had more medical complications (e.g., feeding disorders) than other mothers (Möhler et al., 2008). Studies examining childhood sexual abuse, in particular, have identified that survivors may have more chronic pain, long-term health conditions (e.g., cardiopulmonary or gastrointestinal symptoms), and a greater likelihood of gynecological problems (e.g., genital tract infections) than other women (Brunton & Dryer, 2021; Irish et al., 2010). In addition, many survivors perceive their previous childhood abuse to negatively influence their prenatal care experience (Brunton & Dryer, 2021).

Concerningly, these health-related outcomes have consequences for the fetus. Specific conditions such as hypertension and diabetes increase

the risk of preterm birth, low birth weight, placental abruption, congenital malformation, stillbirth, and miscarriage. Moreover, these health-related issues can contribute to perinatal complications and other procedures, such as a cesarean birth (Ali & Dornhorst, 2011, provide a review). These additional health issues likely increase prenatal care utilization and place additional demands on health systems.

Prenatal Substance Use

For some pregnant women, substance use contributes to these health-related issues. Substances such as alcohol, tobacco, and illicit drugs introduce harmful teratogens into the fetal environment and, even at low levels, can impact the growth and development of the fetus and contribute to adverse outcomes such as spontaneous abortion, preterm birth, and low birth weight (AIHW, 2020; Andersen et al., 2012). Moreover, being under the influence of alcohol or drugs while pregnant increases the risk of physical injury or harm due to impaired functioning (AIHW, 2020). The implications of longer-term substance use for the child include congenital disabilities, malformation (e.g., craniofacial abnormalities), developmental disorders, lower IQ, and, in some cases, a longer-term adverse sequela from fetal alcohol spectrum disorder (Keegan et al., 2010; Lewis et al., 2012). While most women decrease or eliminate alcohol when pregnant, a small percentage continue to consume alcohol despite the known risks (Brunton & Dryer, 2023; Meschke et al., 2003).

It is worth noting that research conducted in this area has been limited, with few studies examining child abuse specifically, and we therefore draw on the findings reported from research on adverse childhood experiences (ACEs). Despite this limitation, the findings predominantly confirm a relationship between childhood abuse and prenatal substance use. Racine et al. (2020) found that a history of family violence (i.e., physical abuse, emotional abuse, and domestic violence) nearly doubled the risk of prenatal binge drinking or smoking and increased the risk of drug taking by 1.5 times. A history of child sexual abuse increased the risk of drug use by 2.25 times. Frankenberger et al. (2015) noted a dose-response relationship between ACEs and pregnancy drinking. After adjusting for

pre-pregnancy drinking and other demographics, experiencing one ACE increased the odds of drinking nearly threefold (aOR = 2.92), whereas four or more ACEs exponentially increased the risk to 4.8 times. Meschke et al. (2008) found that women who reported previous sexual abuse had 38% increased odds of prenatal drinking. However, while Osofsky et al. (2021) identified an increased risk for prenatal smoking, cannabis, and opioid use for those with ACEs (compared to no ACEs), the results for alcohol consumption were not statistically significant. Similarly, Brunton and Dryer's (2023) examination of 548 pregnant women found no relationship between childhood abuse and antenatal alcohol consumption. These inconsistencies may reflect methodological limitations such as samples with a low child abuse prevalence lacking the power to detect an effect (i.e., Brunton & Dryer, 2021), recruitment during antenatal care confounding accurate reporting of alcohol intake or by subsuming abuse and neglect under ACEs (i.e., Osofsky et al., 2021), which can mask individual findings. Notwithstanding this, evidence points to childhood abuse as a risk factor for prenatal substance use, with the severity of abuse potentially having a significant and negative influence on this relationship.

Psychological Health

In addition to physical health, a history of child abuse and, more broadly, early life maltreatment (ELM) is associated with a greater risk of psychopathology in the general population (Norman et al., 2012). Therefore, it is conceivable that pregnant women with a history of ELM will also be more susceptible to these psychological outcomes. Some of these particular outcomes are covered in more detail in Chap. 4 (PTSD) and Chap. 5 (depression, anxiety, and suicidality). In this chapter, we consider other psychological aspects with potentially high relevance for the perinatal period, that is, prenatal eating disorders.

Prenatal Eating Disorders (ED)

For victims of child abuse, there is reportedly an increased prevalence of ED (Rayworth et al., 2004). A global review estimated that the prevalence of ED for women in the general population is 3.3–18.6% (Galmiche et al., 2019). During pregnancy, maternal concern for the developing fetus can reduce ED symptoms (Crow et al., 2008); however, pregnant women with a child abuse history may be at greater risk of continued symptomatology. One case-control study identified that women who met the criteria for an ED (i.e., bulimia, anorexia, or binge-eating) or reported ED symptoms were twice as likely to have a child physical abuse history. They were also over three times more likely to have a history of physical and sexual abuse in childhood (Rayworth et al., 2004). Among these women, severe abuse was associated with a threefold increase in ED diagnosis. These findings are consistent with previous research using larger samples (Senior et al., 2005). ED in pregnancy has also been associated with postnatal depression (Riesco-Gonzalez et al., 2022), thus potentially exacerbating the psychological issues of perinatal women with a history of child abuse.

ED can lead to malnutrition, electrolyte imbalances, anemia, and vitamin deficiencies for the mother (Sidiropoulos, 2007). These associated outcomes are of particular concern as an inadequate or restricted diet can harm the fetus. EDs in pregnancy are linked to poor fetal outcomes, including miscarriage, preterm birth, disabilities, and malformations (Sebastiani et al., 2020). In addition, fetal programming studies have identified that altered nutritional patterns, common among women with ED, can alter or influence epigenetic patterns (i.e., the expression of genes). These changes can trigger biological and psychological alterations in the offspring (e.g., a predisposition to chronic disease) that have long-term implications. Evidence on fetal programming and its implications for pregnant women is limited and requires further investigation. However, studies on pregnant women exposed to extreme hunger through war have shown an elevated risk of psychiatric disorders in their offspring (Ellison, 2010). Therefore, it is probable that the consequences of prenatal ED are long-term and intergenerational.

Part 2 Mother-Child Relationship

Mother-Child Bonding

In 1981, Cranley identified maternal-fetal attachment as the relationship that develops between a mother and her unborn baby. This relationship, seen as part of the normative developmental processes of pregnancy and motherhood (Alhusen, 2008), showed that the bond between the mother and child begins far earlier than attachment theorists such as Bowlby (1979) proposed. Since then, studies have examined the risk and protection of prenatal attachment, identifying factors such as mood disorders and family support, respectively (see Alhusen, 2008 for a critical review). However, studies examining whether childhood abuse influences this attachment relationship are limited.

Stark Stigger et al. (2020) found that childhood abuse or neglect negatively impacted maternal-fetal attachment. Emotional neglect and emotional abuse had the greatest impact on the attachment relationship, suggesting that these previous adverse emotional experiences may exert a more substantial impact on attachment through internalized negative self-beliefs (Wright et al., 2009). If the mother's childhood experience includes criticizing and rejecting experiences or an absence of socioemotional development (Glaser, 2002), this will likely influence their internalized beliefs and self-representations (Malone et al., 2010). These beliefs may disrupt normative development processes, including developing maternal self-representations (Malone et al., 2010). Given that maternal-fetal attachment is an important developmental task of pregnancy, it is conceivable that it would predict postnatal behavior and bonding; however, few studies have examined this (Alhusen, 2008).

Notwithstanding this, there is a plethora of research on mother-infant bonding (i.e., the affective tie between mother and child). The significance of this mother-child relationship was the focus of Bowlby and Ainsworth's early work on attachment (Bowlby, 1979). According to attachment theory, caregivers play a key role in the development of internal models of the relational world, and when impaired, parent-child

bonding can be an influential factor in the pathogenesis of mental health problems (Otowa et al., 2013).

So far, findings support the association between poor parental bonding for abuse survivors and their offspring (Farre-Sender et al., 2018). Muzik et al. (2013) examined bonding six months postpartum in a sample of women with child abuse and neglect histories ($N = 97$) and women ($N = 53$) with no such history. While bonding disturbance was associated with prior child maltreatment, their findings indicated that psychopathology associated with maltreatment posed a greater risk to bonding than maltreatment alone. Moreover, and importantly, bonding impairment improved over time for all women regardless of their history, suggesting that bonding is a normative process independent of emotional disturbances.

In the early stages of the mother-child relationship, breastfeeding is an important aspect of maternal bonding. Breastfeeding has long-term health benefits for the mother and child (Victora et al., 2016) and contributes to early bonding and attachment (Linde et al., 2020). Regardless of child abuse history, women tend to have equal intentions to breastfeed (Elfgén et al., 2017); however, for many child abuse survivors, the intimacy of this experience, such as suckling or skin-to-skin contact, can trigger PTSD symptoms (e.g., disassociation or recurrence of traumatic memories) and influence their ability to persevere. Therefore, while many survivors may initiate breastfeeding, they may be unable to continue for extended periods (Coles et al., 2016; Elfgén et al., 2017).

Beyond the early bonding experience, child abuse survivors often report more parenting difficulties than others. Empirical evidence confirms more intrusive, impulsive, and hostile behaviors for women with physical or sexual abuse histories than other women (DiLillo & Damashek, 2003; Moehler et al., 2007). More broadly, studies into child abuse, neglect, and witnessing family violence confirm a link between ELM and maternal hostility toward their children (Bailey et al., 2012). Savage et al.'s (2019) meta-analysis (32 studies, 17,932 participants) demonstrated the negative impact of past abusive experiences on parenting behavior. Negative and potentially abusive parenting and parenting characterized by poor attachment/bonding had stronger relationships with ELM than positive parenting. More specifically, the relationship

between emotional and/or physical abuse and parenting behavior was more robust than other abuse types (child sexual abuse was not statistically significant). The implications of impaired parenting behavior extend to the child's development and well-being such that these children may be more likely to have behavioral problems, poorer adult educational attainment, less positive social behavior, and greater negative affect and defiant noncompliance (Leerkes et al., 2009; Raby et al., 2015).

These intergenerational effects were demonstrated in a large-scale parenting study ($N = 8292$), which noted that mothers with a child sexual abuse history reported greater negativity and less maternal confidence in their relationship with their children (Roberts et al., 2004). Furthermore, compared to children of mothers with no abuse, the children of abused women had higher levels of hyperactivity and greater conduct, peer, and emotional problems. Additional analysis identified maternal anxiety and confidence mediated the relationship between the mother's sexual abuse history and children's conduct problems. These findings demonstrate the far-reaching consequences of child sexual abuse that extend into adulthood (mental health and parenting) and intergenerationally, showing that the relationship between prior abuse and parenting is complex.

Emotional availability is a key aspect of parenting behavior and may be altered by ELM. For example, research points to mothers who have experienced severe childhood abuse or those with remitted depression and a history of abuse being emotionally unavailable (i.e., less sensitivity, responsiveness, involvement) to their children compared to non-maltreated women (Fuchs et al., 2015; Moehler et al., 2007). Relatedly, the fast and accurate recognition and response to a child's emotional cues, such as facial expressions of emotions, may be altered for mothers with an ELM history. ELM-related alterations in the neural correlates of facial emotion processing were confirmed in a recent meta-analysis (20 studies, Hein & Monk, 2017) that found enhanced amygdala activation (a region associated with emotion) for maltreated individuals relative to controls. These findings suggest that ELM-related alterations may impact emotion regulation and increase the risk of later psychopathologies (i.e., depression, anxiety). Furthermore, ELM was associated with enhanced activations in other brain areas, such as the superior temporal gyrus (relative to controls), a region associated with social perception and cognition.

Therefore, while these ELM-related brain changes may be adaptive in childhood (by providing a means of identifying threatening emotions in their environment), they may impact their socioemotional functioning and, by extension, their parenting in later life.

Intergenerational Abuse

It has long been proposed that early experiences of child abuse can lead to the intergenerational transmission of abuse (Widom, 1989). That is, a mother abused in childhood may have greater potential to harm her child. One mechanism proposed for the intergenerational transmission of abuse is the mother's projection of negative self-representations onto their child (Möhler et al., 2001). This abuse transmission was illustrated in a case study describing a young mother with intense fears of her potential for violence. Her own abusive experiences, when projected onto her child, placed the child at greater risk of abuse, with the child's behavior interpreted as abusive toward the mother.

However, the literature specifically examining this intergenerational transmission of abuse is limited. Further, published studies are inconsistent in their findings. For instance, Appleyard et al. (2011) found that childhood physical or sexual abuse indirectly increased the risk of the mother abusing her child mediated by substance use. In contrast, Bert et al. (2009) noted that a history of childhood emotional abuse increased the potential for child abuse and a greater acceptance of abuse/neglect in first-time mothers. Childhood physical abuse similarly increased the risk for older mothers. Choi (2018) found that childhood emotional abuse indirectly influenced child harm exposure through postpartum depression but had no significant findings for childhood physical or sexual abuse. These differential outcomes may reflect a lack of sensitivity in the analyses (i.e., type II error), with some samples having a low prevalence of abuse types.

Despite these limited findings, that a parent's upbringing is influential in their parenting beliefs and behaviors is less disputed. Indeed, parents with a history of physical abuse are more likely to use punitive or harsh punishment, considered abusive (e.g., punching when angry), than those

with mild physical abuse (Kim et al., 2010; Pears & Capaldi, 2001). Previous research also supports the hypothesis that a parent's level of functioning in their parent-child relationships is predicted by their experience of harsh parenting during their childhood (Brook et al., 2002; Conger et al., 2003). Theoretically, this is consistent with social learning theory, as victims of familial abuse would lack a positive parenting role model and thus have less opportunity to observe and model positive parenting (DiLillo & Damashek, 2003).

Revictimization

Consistent with the cycle of violence, a large body of evidence supports the proposition that childhood abuse is a risk factor for revictimization in the general population (Walker et al., 2019). This victimization, usually by an intimate partner, can be physical, sexual, emotional, or coercive control (WHO, 2011). For example, Butler et al. (2020) found that those who experienced childhood physical abuse were twice as likely (than controls) to experience past year violence and three times more likely to have experienced intimate partner violence (IPV) or sexual violence since 16 years of age. Furthermore, this risk increased exponentially relative to the frequency of childhood abuse (e.g., OR = 6.89 for multiple types of child abuse and sexual violence victimization). Moreover, in a recent meta-analysis of child maltreatment and IPV victimization (Li et al., 2019), differential effects were noted dependent on the child abuse type. These findings are consistent with theoretical explanations that propose that early sexual experiences increase a woman's vulnerability to later victimization through mechanisms such as traumatic sexualization (discussed in more detail in Chap. 3) or a propensity for higher alcohol use (Koss & Dinero, 1989).

Being pregnant is not a protection against IPV and may actually increase the risk for IPV in some instances. For example, pregnancy can create additional demands and stress on a relationship (e.g., increased financial concerns). Unwanted or unplanned pregnancies can further exacerbate this stress (Li et al., 2019; WHO, 2011). IPV experienced during pregnancy is of particular concern as it places both the mother

and developing child at risk. Physical abuse is often targeted toward the woman's abdomen, potentially jeopardizing the pregnancy (WHO, 2011), and the physiological effects of stress associated with IPV can have epigenetic effects. These factors can contribute to preterm birth and increase the risk of miscarriage, perinatal death, and maternal mortality (WHO, 2013). Experiencing IPV during pregnancy has also been associated with increased negative health behaviors such as consuming alcohol, drugs, and smoking (WHO, 2011).

Childhood sexual abuse has been associated with a higher likelihood of lifetime and current IPV and is a risk factor for abuse in the current pregnancy. Pregnant women have been identified as having more than a two-fold increased risk of lifetime IPV (relative to no abuse), and multiple childhood abuse experiences increased this risk exponentially with more than a sevenfold risk of lifetime physical and sexual IPV (Barrios et al., 2015). Concerningly, the risk of experiencing IPV in the past year, which would include the current pregnancy, was more than threefold. Gartland et al. (2016), in an Australian study of 1507 nulliparous women, found that those who experienced physical or sexual abuse in childhood had increased odds of fearing their intimate partner during the current pregnancy (OR = 2.7 and 2.0, respectively). When assessed postpartum in the first year, these women with a child physical or sexual abuse history still had double the risk of experiencing any IPV.

There is also evidence to suggest that different childhood abuses are related to different types of IPV types during pregnancy. For example, Barnett et al. (2018) examined 832 pregnant women and found that childhood emotional abuse was a more potent risk factor for emotional IPV, and childhood physical and sexual abuse were stronger risk factors for physical IPV or sexual IPV (than emotional abuse and neglect). Barrios et al. (2015) noted that a history of child physical and sexual abuse increased the likelihood of experiencing physical and sexual IPV in the past year (aOR = 3.33). These findings suggest the importance of understanding the distinct effect of different abuses, as this knowledge may lead to more effective interventions in adulthood (Li et al., 2019).

Part 3. The Childbirth Experience

Studies into childhood sexual abuse have dominated research on child abuse and childbirth. Childbirth can trigger past abuse memories, which, for some, is the first reemergence of traumatic memories since childhood (Leeners et al., 2013). Post-traumatic stress reactions can occur when women with child sexual abuse experiences feel overwhelmed by the multiple procedures and intrusive vaginal exams that can occur during pregnancy (Leeners et al., 2016; Rhodes & Hutchinson, 1994). These experiences can be re-traumatizing, which can be understood as a recurring cycle for a pregnant woman with a history of sexual abuse. The cyclical nature of re-traumatization was conceptualized by Dallam (2010), who proposed four interrelated processes: threats of safety, exposure to triggers, post-traumatic stress reactions, and avoidant coping. For example, a woman sexually abused in childhood may become hypersensitive to threats of safety during situations where she feels vulnerable (e.g., during intrusive vaginal examinations) or lacks control, such as being in a position of powerlessness (Coles & Jones, 2009; Leeners et al., 2007). When triggered, women may dissociate to defend against feeling threatened and overwhelmed, with some women describing disassociation as helpful in suppressing unpleasant memories or emotions (Leeners et al., 2013). However, some women may avoid prenatal care visits as they fear re-traumatization or feel disillusioned or discouraged by previous encounters. Avoidant coping, however, is not optimal for their prenatal care.

Given these issues, it is unsurprising that many child abuse survivors fear childbirth. Women with a history of child abuse tend to have a stronger fear of childbirth (FoC) than other women. For example, Heimstad et al. (2006) found that pregnant women ($N = 1452$) who reported childhood physical or sexual abuse had greater FoC than non-abused women. However, no differences were observed for adult abuse. Lukasse et al. (2011) examined a large cohort of multiparous women ($N = 4876$) and found that child abuse was a risk factor for FoC in their second pregnancy, with the strongest risk being severe emotional abuse (aOR = 1.58). These prospective studies have modest effects, yet studies examining FoC by parity (i.e., multiparous and primiparous) show that a previous

positive birth experience can potentially lessen FoC. Lukasse et al. (2010) found that for all child abuse types, the risk for severe FoC was stronger for primipara women than multipara women. That is, any child abuse (i.e., physical, sexual, or emotional) increased the odds of severe FoC for primiparas (OR = 2.48) and multiparas (OR = 1.50).

Moreover, the severity of abuse increased the odds exponentially for primiparous women (those who experienced multiple abuse experiences had a fivefold increased risk of severe FoC). However, the same dose-response result was not observed in multiparous women. Of interest, after adjusting for previous negative birth experiences for multiparous women, the risk for severe FoC was attenuated to nonsignificance, indicating that for these women, their FoC was related to a previous negative birth experience rather than to a history of child abuse.

This finding suggests that if primipara women have a positive birth experience, this may attenuate the impact of child abuse history on FoC in subsequent pregnancies. Therefore, given these associations between child abuse and childbirth and the opportunity that a positive birth experience may afford child abuse survivors, sensitive care is critical (see Chap. 7 for a comprehensive coverage of this issue). Health providers who may be emotionally unavailable or perceived as hostile or judgmental can exacerbate a woman's responses to care (Coles & Jones, 2009; Dallam, 2010). The implications of not providing sensitive care for child abuse survivors place them at increased risk of re-traumatization and avoidance of medical care (Coles & Jones, 2009; Dallam, 2010; Leeners et al., 2013).

Summary and Conclusion

Survivors of child abuse have a greater risk of poor prenatal health than other women. This includes general health with an increased risk for the propensity for prenatal substance use, potentially further exacerbating health-related issues. In addition, psychologically, survivors may be at a higher risk for continued ED symptomology, which can have far-reaching consequences for the unborn child. These risks may result in further prenatal care utilization. While the evidence does not point to a specific type of child abuse that predominantly increases these health risks, studies

have generally focused on childhood sexual abuse for historical reasons (Chap. 2 reviews these reasons). However, the absence of evidence for physical and emotional abuse highlights the need for additional research. It is important to acknowledge that pregnancy could be a consequence of sexual abuse, and in such situations, there are severe implications for both the mother and unborn child (e.g., a higher likelihood of low maternal-fetal attachment and high levels of maternal distress). However, examining this issue was beyond the scope of this chapter.

Emotional abuse may be the most potent risk factor for poor relationship development or attachment due to the mother internalizing negative self-beliefs and representations. However, as shown by Muzik et al. (2013), bonding impairment is not fixed and can be improved over time, suggesting that the opportunity for positive interventions exists. Related to mother-child bonding is breastfeeding, and there is no difference between childhood abuse survivors and other women in their intention to breastfeed. However, despite these intentions, the physical experience can often be re-traumatizing, and survivors may not persevere.

In this chapter, we also examined the effect of child abuse on parenting practices. Given the findings presented, theoretical positions such as Bandura's social learning theory provide a basis for explaining these intergenerational impacts. Concerningly, child abuse is linked to more hostile parenting, and the consequences of this parenting (which in itself can be abusive) can result in conduct problems for the offspring of those parents. The intergenerational impact of child abuse is further indicated in studies examining abuse potential. Although limited evidence is available, previous child abuse is a risk factor for that child abusing their offspring in adulthood. Of course, these relationships are complex, and possible mediators include depression, substance use, and age. Again a mother's negative self-representations, internalized from the previous abuse, may also be a mechanism for this abuse potential.

Childhood abuse is also a risk factor for adulthood revictimization, and the implications of this can be far-reaching when experienced during pregnancy. In some cases, the risks may be exacerbated by additional stressors of pregnancy. In addition, research evidence suggests a differential risk with certain abuse types, increasing the risk for certain IPV types in adulthood. These findings highlight the importance of examining

different types of child abuse and their differential effect, as it can assist in developing more effective interventions.

Childbirth can be challenging for child abuse survivors, and some survivors have a severe fear of it. Again this has been studied predominantly for survivors of child sexual abuse. However, Dallam's model, which was developed specifically for child sexual abuse, helps understand the concerns of all abuse survivors. For example, concerns around safety, triggers, post-traumatic reactions, and using avoidance-coping are likely common to all child abuse survivors. In addition, FoC can be common among primipara women with previous abuse histories. However, a positive birth experience provides an opportunity to intervene for subsequent pregnancies.

Based on the evidence presented in this chapter, the need for sensitive care is evident. Sensitive care affords many opportunities to intervene between the ongoing impact of child abuse and these perinatal outcomes. Pregnancy and childbirth are vulnerable periods in the life of women with past child abuse experiences. Addressing this concern and creating a trauma-sensitive pre- and peripartum environment can prevent maternal retraumatization and contribute to a healthier parent-child interaction.

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