

Parental Burnout as a Potential Trauma-Related Process: A Proposed Chronic Relational Trauma Model for Parents of Children with Autism Spectrum Disorder or Attention-Deficit/Hyperactivity Disorder

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Abstract:

Parental burnout, a role-specific exhaustion syndrome, disproportionately affects parents of children with autism spectrum disorder or attention deficit/hyperactivity disorder. The Risk–Resource model, which dominates this field, explains this phenomenon as a chronic imbalance between demands and resources. While this transactional framework is empirically robust, it remains primarily quantitative and does not adequately consider the identity and relational aspects of long-term parenting of a neurodivergent child.

Drawing on attachment theory, ecological developmental theory, the family systems approach and research on complex trauma and toxic stress, this theoretical article identifies five gaps in current models. These include parental identity rupture, grieving for the imagined child and lack of integration with trauma symptomatology already documented in these parents. The article proposes a new model, the Chronic Parental Relational Trauma Model, which is structured in five nested levels and reinterprets parental burnout as a possible manifestation of prolonged exposure to relational stress with no possibility of withdrawal.

While this model lacks direct empirical validation, it generates five testable hypotheses and encourages a rethinking of clinical screening and interventions for these families from a trauma-centred perspective.

Keywords: Parental burnout, chronic relational trauma, autism spectrum disorder, attention-deficit/hyperactivity disorder, attachment theory, chronic parental stress, developmental psychopathology.

1. Introduction

1.1 The emergence of parental burnout as a clinical concern

Since its formalisation in the scientific literature by Mikolajczak, Roskam and their collaborators (Roskam, Raes & Mikolajczak, 2017; Mikolajczak & Roskam, 2018), the concept of parental burnout has spread rapidly within the fields of clinical psychology and family sciences. Defined as a syndrome of intense, chronic exhaustion specific to the parental context — distinct from ordinary parental stress and depression — parental burnout is characterised by emotional and physical exhaustion linked to the parental role; a loss of pleasure and fulfilment in parenting; affective distancing from children; and a contrast with the parent's previous self-image (Roskam, Brianda & Mikolajczak, 2018).

One point of terminology should be clarified from the outset, as it is relevant to some of the literature: publications from the Louvain team do not all agree on the number of dimensions that constitute the syndrome. The original instrument, the Parental Burnout Assessment (Roskam et al., 2018), was developed and validated using a four-dimensional structure, which includes contrast with the parent's earlier self-image. However, later work from the same group (Mikolajczak, Gross & Roskam, 2019) adopts a three-dimensional approach — exhaustion, distancing and a sense of inefficacy — where identity contrast is treated as a correlate rather than a distinct dimension. The present article refers to the four-dimensional structure of the PBA insofar as it is precisely the identity-contrast dimension that underpins its central argument.

Although this syndrome was initially studied in the general population of parents, several subsequent studies revealed its increased prevalence among parents of children with neurodevelopmental disorders, particularly autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD) (Hayes & Watson, 2013). These families face educational, behavioural and relational challenges whose intensity, duration and unpredictability differ qualitatively from those encountered during typical development.

1.2 Prevalence and clinical, family and societal consequences

Parents of children with ASD exhibit significantly higher levels of parental stress than parents of neurotypical children and sometimes even higher levels than parents of children with other disabilities (Hayes & Watson, 2013; Estes et al., 2009). This increased stress is associated with a high prevalence of anxiety and depressive symptoms, sleep problems, and a reduced quality of life for couples and families (Karst & Van Hecke, 2012). Parents of children with ADHD report stress levels comparable to those reported in some studies. These are particularly linked to the child's oppositional behaviours, impulsivity, and difficulties with emotional regulation (Theule, Wiener, Tannock & Jenkins, 2013).

Beyond individual parental suffering, parental burnout in this context has documented effects on family functioning as a whole, including impaired parent-child interactions, an increased risk of neglect and violent parental behaviours (Mikolajczak, Brianda, Avalosse & Roskam, 2018), and a detrimental impact on the parental couple. From a societal standpoint, these families make greater use of health and support services, educational assistance resources, and child protection systems.

1.3 Limits of current conceptualisations

The Risks-Resources Model (Balance Between Risks and Resources, BR², Mikolajczak, Gross & Roskam, 2019) is based on the Transactional Stress Model of Lazarus and Folkman (1984). It proposes that parental burnout occurs when risk factors consistently outweigh available resources. This framework has strong explanatory and predictive capacity and is empirically supported (Mikolajczak et al., 2019; Sorkkila & Aunola, 2020). However, we argue that it is insufficient for capturing the depth of the lived experience of parents of children with ASD/ADHD. Fundamentally quantitative and homeostatic, the model describes an imbalance in workload but does not theorise the impact on identity and relationships when parents are exposed year after year to continuous challenges to their perceptions of parenting, their child and themselves.

1.4 Research question and aims of the article

Our central research question is whether parental burnout in parents of children with ASD/ADHD can be interpreted as not only a consequence of chronic stress, but also a form of chronic relational trauma resulting from prolonged exposure to repeated discrepancies between the expected child, anticipated parental skills, and the parent's self-image and the lived experience.

This article pursues three objectives: (1) to provide a critical overview of current knowledge on parental burnout and its specific features in the context of ASD/ADHD;

(2) to identify points of convergence with parental burnout by drawing on theoretical frameworks from complex trauma, attachment, and developmental psychopathology;

(3) to propose a conceptual model — the Chronic Parental Relational Trauma Model — aimed at enriching clinical understanding of this phenomenon and guiding future empirical research.

2. State of the art

2.1 Parental burnout

2.1.1 History and emergence of the concept

The first clinical intuitions about parental exhaustion date back to research on parental stress in the 1980s (Abidin, 1990). However, it was not until 2017–2018 that parental burnout was established as an autonomous scientific construct, distinct from parental stress and professional burnout, the latter of which has historical origins (Maslach & Jackson, 1981). Roskam, Raes and Mikolajczak (2017) developed a rigorous operationalisation of the construct using the Parental Burnout Assessment, a tool that has been validated in over forty countries (Roskam et al., 2021). This gives the field a rare level of international empirical grounding for such a recent concept.

This rapid dissemination and cross-cultural validation paradoxically had the effect of 'freezing' the theoretical framework around the Risks–Resources model, to the detriment of alternative approaches that could have enriched our understanding of the phenomenon in specific clinical populations, such as families with neuroatypical children.

2.1.2 Definition and constitutive dimensions

Parental burnout is defined as a syndrome characterised by four core symptoms (Roskam et al., 2018; Mikolajczak & Roskam, 2018): (1) intense and chronic emotional and physical exhaustion linked to the role of parenting; (2) a loss of pleasure and fulfilment in the relationship with the child; (3) emotional distancing from children, which may manifest as a mechanical approach to parenting; and (4) a contrast between the parent one used to be and the parent one has become, generating identity dissonance and a sense of shame.

It is this fourth dimension that we find most useful for our purposes as it introduces an identity and narrative dimension without explicitly theorising it, which the Risks–Resources model only develops peripherally.

2.1.3 The Risks–Resources (BR²) Model

The BR² model proposes that parental burnout results from an extended period of imbalance between risk factors (e.g. parental burden, perfectionism, lack of support) and protective factors (e.g. sense of competence, support from a partner, coping strategies). This model is based on the transactional stress model of Lazarus and Folkman (1984), which conceptualises stress as the result of a cognitive evaluation of the discrepancy between perceived demands and perceived resources, rather than as an inherent property of the situation. This gives the model strong theoretical coherence and

demonstrated predictive utility, as supported by many longitudinal studies (Mikolajczak et al., 2019; Sorkkila & Aunola, 2020; Le Vigouroux & Scola, 2018). However, as we will discuss in Section 2.3, this same transactional lineage structurally limits the model's ability to account for the deeper relational and identity dimensions of the phenomenon.

2.1.4 Differentiation from depression and parental stress

Parental burnout shares some surface symptoms with depression, such as fatigue, anhedonia and withdrawal. However, confirmatory factor studies have shown that the two conditions can be distinguished empirically: parental burnout is confined to the parental domain and can coexist with adequate functioning in other areas of life. In contrast, depression affects functioning across the entire psychic system (Mikolajczak et al., 2018). Parental stress, as conceptualised by Abidin (1990), refers to an acute or chronic reaction to a perceived imbalance between demands and resources without necessarily reaching the burnout threshold. Burnout, in turn, represents the ultimate chronic phase of this process, making it a threshold syndrome rather than simply a stress continuum.

Finally, unlike professional burnout, from which it is historically derived (Maslach & Jackson, 1981), parental burnout is characterised by the structural impossibility of 'resigning' from the parental role. This inability to take a step back, which Mikolajczak and Roskam (2018) highlight as a key feature of parental burnout, is a central argument in favour of a trauma-based reinterpretation of the phenomenon. The absence of any legitimate escape from the chronic stressor is one of the structural conditions that facilitates the transformation of chronic stress into a trauma-like experience, as discussed in Section 3.

2.2 Specific parental characteristics associated with ASD and ADHD

Chronic and cumulative educational burden

Parents of children with ASD or ADHD take on an educational responsibility that is characterised by its duration and often non-decreasing nature as the child grows older. This is in contrast to the typical trajectory, in which progressive autonomy naturally reduces parental responsibility (Hayes & Watson, 2013). This burden includes managing routines, accompanying the child to therapeutic appointments, liaising with the school and often maintaining constant vigilance for the child's safety.

Behavioural problems and relational impact

The challenging behaviours documented in a significant proportion of children with ASD and ADHD (Estes et al., 2009) expose parents to repeated situations of disruption, mutual misunderstanding and, sometimes, physical violence. This is an ongoing process that we will later characterise as cumulative relational micro-trauma.

Children's emotional regulation

Difficulties with emotional regulation, which are common in ASD and marked in ADHD, place parents in an almost permanent role as external regulators (Theule et al., 2013). This can be compared to the compassion fatigue experienced by those in helping professions (Figley, 1995), with one important difference: unlike professional caregivers, parents are not granted a protective distance by right or by institution.

Sleep

Sleep problems are common in children with ASD and ADHD (Souders et al., 2009) and affect parental sleep, producing chronic deprivation with well-documented consequences, such as impaired emotional regulation, reduced frustration tolerance, and increased vulnerability to depressive moods

(Cohen, Conduit, Lockley, Rajaratnam & Cornish, 2014). In our view, this factor, which is often treated as peripheral in parental stress models, plays a central role in the chronicity of exhaustion.

Stigmatisation and social isolation

Parents of children with ASD/ADHD report experiencing significant levels of stigmatisation, either first-hand or anticipated (Gray, 2002; Mak & Kwok, 2010). This deprives parents of one of the most robust protective resources in the BR² model — social support — and creates a vicious circle in which isolation increases vulnerability to parental burnout, which in turn leads to greater social withdrawal

Developmental uncertainty

Unlike typical development, whose trajectories are relatively normative, the development of a child with ASD or ADHD is accompanied by persistent prognostic uncertainty (Lord et al., 2018). This uncertainty prevents parents from imagining a stable time horizon, which is one of the psychological factors of what we refer to as ‘never-ending grief’ for the imagined child (Section 3.6).

Parentification into the ‘caregiver’ role

Recommendations for early and intensive intervention can transform the parent into a therapeutic coordinator or even an active co-therapist (Karst & Van Hecke, 2012), thus blurring the boundaries between the parental and caregiver/clinician roles.

2.3 Limits of current models of parental burnout

The BR² model is internally coherent and has predictive validity. However, its transactional architecture is based on a quantitative, homeostatic logic. It models the balance of power between burden and resources, but does not consider the subjective meaning of the lived experience. As emphasised in the literature on complex trauma (van der Kolk, 2014), it is not the objective intensity of a stressor that determines its traumatic potential, but rather its relational nature, repetition and the absence of opportunities for recovery or escape — three characteristics that converge in the situation of parents of children with ASD/ADHD.

This analysis identifies five gaps in the current literature.

Gap 1: lack of theorisation of parental identity rupture

The BR² model includes “identity contrast” as a symptom, but does not theorise how this contrast becomes established. Linking this concept to theories of narrative identity (McAdams, 2001) could help to explain how repeated confrontation with a child who does not conform to expected developmental patterns can fracture a parent’s identity narrative.

Gap 2: The under-theorisation of the imagined child’s bereavement

In clinical practice, the concept of ‘bereavement for the ideal child’ is often informally referred to among parents of children with disabilities. Two distinct traditions have each proposed a framework for this phenomenon in their own way, but neither has been integrated into the parental burnout model. Solnit and Stark (1961), for example, were among the first to describe the grief implied by the birth of a disabled child. More directly still, Olshansky (1962) introduced the notion of ‘chronic sorrow’ to describe a pain in parents of children with intellectual disabilities that never quite closes over and is reactivated at each missed developmental milestone — a concept subsequently taken up and refined by a substantial body of work in nursing care and health psychology (see, for example, Wikler, Wasow & Hatfield, 1981, for one of the earliest empirical validations).

Boss's (1999) concept of 'ambiguous loss', which describes unresolved loss when the lost object remains physically present yet psychologically absent, also remains largely absent from the literature on parental burnout. Therefore, the omission is not due to a general lack of theorisation of parental grief, which has existed for over sixty years, but rather to the lack of its integration into an explanatory model of parental burnout specifically.

Gap 3: Neglect of cumulative effects and qualitative chronicity

The BR² model essentially treats chronicity as a duration-related variable without theorising it as a qualitative transformation in psychological functioning. This is something that complex trauma theorists distinguish as the difference between an isolated traumatic event and cumulative, developmentally unfolding traumatic exposure (Cook et al., 2005; van der Kolk, 2014).

Gap 4: Insufficiency in the face of developmental unpredictability specific to ASD/ADHD

The BR² model was developed and validated primarily on general parental populations, in which stressors remain predictable in nature and trajectory. However, it does not specifically account for the radical unpredictability inherent in the developmental pathways associated with ASD and ADHD. This chronic unpredictability is identified in the trauma literature as a key factor driving hypervigilance and an inability to anticipate (van der Kolk, 2014; Shonkoff, Garner et al., 2012).

Gap 5: There is an incomplete articulation within the field of parental burnout between chronic stress and trauma-like symptomatology. It is important to be precise about the exact nature of this gap, otherwise the argument of this work would be weaker than it actually is. The link between parental exposure to ASD and trauma-like symptoms is not a blank area in itself: several empirical studies, independent of the literature on parental burnout, have directly measured post-traumatic stress symptoms in parents of children with ASD in response to challenging behaviours. Schnabel et al. (2020) report that 18.6% of mothers in their sample met the provisional criteria for post-traumatic stress disorder in response to their child's challenging behaviours. However, these studies do not establish an explicit theoretical link between this documented trauma-like symptomatology and the parental burnout model: the two areas of research currently exist in isolation from each other. In our view, it is this lack of theoretical integration, rather than an absence of empirical indicators of a link between parental ASD exposure and trauma-related experience, that constitutes the most structurally formative gap for the present study.

3. Theoretical foundations of the notion of chronic relational trauma

3.1 Complex trauma: beyond the isolated event

The concept of complex trauma emerged in response to the limitations of the traditional post-traumatic stress disorder (PTSD) model, which was originally designed to account for discrete, circumscribed traumatic events. Cook et al. (2005), in their synthesis for the National Child Traumatic Stress Network, define complex trauma as resulting from exposure to multiple, chronic, interpersonally mediated traumatic events occurring in the context of significant primary relationships and producing lasting alterations across seven domains of functioning: attachment, biology, affect regulation, dissociation, behavioural control, cognition and self-concept.

Complex trauma is distinguished from classical PTSD by its relational and cumulative nature, rather than being event-based. Van der Kolk (2014) emphasises that it is not the objective severity of an isolated stressor that determines its traumatogenic potential, but rather the absence of any possibility

to escape, defend oneself or make sense of repeated experiences of threat or distress within a relationship from which one cannot withdraw.

This definition — chronic exposure, an interpersonally mediated nature, an inability to withdraw and a progressive erosion of multiple domains of psychological functioning — maps rather closely onto the structural situation of a parent of a child with ASD/ADHD: a primary relationship from which one cannot, and often does not want to, disengage; repeated exposure to distressing situations or ruptures in relationships; and an absence of stable resolutions over time. We argue that this structural similarity provides a robust theoretical basis for our reasoning. However, as we will clarify later (section 3.4), it is not sufficient on its own to demonstrate mechanistic equivalence between the two phenomena. Drawing a parallel in terms of structure and identifying underlying mechanisms (including neurobiological ones) are two different things. Only the latter could definitively determine whether we are dealing with genuine causal relatedness or a powerful heuristic analogy. This is precisely what the hypotheses formulated in Section 6 are intended to address.

3.2 Developmental trauma

The concept of developmental trauma (also known as Developmental Trauma Disorder; van der Kolk, 2005) was developed to describe the impact of long-term exposure to adverse relationships during childhood on a child's subsequent development. Although this concept was initially developed to describe the effects on the child, we propose extracting a transferable principle from it: prolonged exposure to an unpredictable relationship in which signals of distress do not receive stable regulatory responses results in cumulative alterations to the system that regulates emotions, regardless of the age or developmental status of the individual experiencing it.

When applied to parents, this principle suggests that prolonged exposure to a parent–child relationship characterised by behavioural unpredictability, frequent absence of expected emotional reciprocity and chronic difficulty in decoding and soothing the child's distress (a phenomenon particularly well-documented in ASD due to peculiarities in socio-emotional communication; Hayes & Watson, 2013) could produce analogous alterations in affective regulation in some parents rather than merely surface-level exhaustion.

3.3 Toxic stress: the biological dimension of chronicity

Shonkoff and colleagues (2012) developed the concept of toxic stress to refer to the prolonged, unregulated activation of the body's physiological stress-response systems in the absence of a sufficiently strong support system. This produces lasting dysregulation of neuroendocrine systems, with documented consequences for long-term physical and mental health.

We consider this concept to be relevant when thinking about the biological dimension of parental burnout among parents of children with ASD/ADHD. The literature already documents objective physiological alterations in this group, particularly with regard to salivary cortisol and inflammatory markers (Seltzer et al., 2010; Lovell, Moss & Wetherell, 2015). This suggests that parental exhaustion is not merely a subjective experience, but is accompanied by a physiological basis comparable to that observed in cases of toxic chronic stress in children.

3.4 Relational trauma: the contribution of attachment theory

According to Bowlby's (1982) attachment theory, the attachment system is activated from birth and aims to maintain proximity to a caregiving figure who is perceived as protective. The quality of early interactions shapes internal working models that influence later relationships. Contemporary

extensions of this theory, including research on caregiving systems (George & Solomon, 1999), suggest that parents also have a behavioural caregiving system whose functioning depends partly on responsive and predictable signals from their children.

When these signals are chronically difficult to decode, atypical or insufficiently reciprocal — an arrangement frequently observed in ASD due to the particularities of non-verbal communication (Hayes & Watson, 2013) — the parental caregiving system is confronted with repeated relational failure. Phenomenologically, this may resemble the state of chronic alertness without stable regulatory strategies available described in the literature on disorganised attachment in children exposed to unpredictable attachment figures (Main & Hesse, 1990). Although this parallel concerns the parental caregiving system rather than the child's attachment system, it nevertheless provides a legitimate theoretical bridge between attachment theory and chronic parental relational trauma.

3.5 Parental Narcissistic Injury

The concept of narcissistic injury originates from the psychodynamic tradition (Kohut, 1977) and refers to an impairment of the idealised self-image when a person's self-representations about themselves and their capacities are repeatedly contradicted by reality. In this context, parental narcissistic injury refers to harm done to the image of the 'competent parent', who is repeatedly confronted with situations that undermine their sense of parental competence and effectiveness.

Unlike a punctuated narcissistic injury, parents of children with ASD/ADHD are exposed to a repetitive cycle of this injury. Consequently, what would typically be considered a psychodynamic mechanism becomes a cumulative process that is more consistent with the logic of complex trauma than isolated narcissistic injury.

3.6 Grief for the imagined child and ambiguous loss

Boss's (1999) concept of ambiguous loss refers to a situation of loss that remains unresolved because the lost object is still physically present but psychologically absent. This concept builds upon and broadens the clinical intuition initially articulated by Olshansky (1962) as 'chronic sorrow' regarding parents of children with intellectual disabilities: a pain that never heals because it is continually reactivated by the discrepancy between the expected and real child.

We propose articulating these two contributions in relation to parents of children with ASD/ADHD. These parents frequently experience a type of grief without closure concerning the imagined child. The real child — present and loved — coexists with the continuously reactivated loss of the fantasised child that preceded diagnosis. This loss does not benefit from the social rituals of recognition and closure that typically support the grieving process (Solnit & Stark, 1961); instead, it is reactivated at each missed or atypical developmental milestone, constituting a chronic, never-ending process of grief.

3.7 Cumulative emotional load and compassion fatigue

The concept of compassion fatigue (Figley, 1995), originally developed for helping professionals repeatedly exposed to others' distress, provides a final theoretical anchor. Figley describes a process of progressive empathic wear that is distinct from classical professional burnout because it is directly tied to the quality of the empathic relationship itself.

As a quasi-permanent emotional regulator of their child's distress, a parent of a child with ASD/ADHD is structurally exposed to a comparable dynamic. However, they lack access to the institutional protective mechanisms (limits on exposure time, supervision and professional distance)

available to helping professionals. In our view, this lack of institutional protection is a major aggravating factor.

3.8 Synthesis: convergences between trauma and parental burnout

Theoretical framework:	Key concepts:	Convergence with parental burnout in ASD/ADHD
- Complex trauma (Cook et al., 2005).	- Chronic, relational exposure without any possibility of withdrawal.	- A parent–child relationship that cannot be disengaged from, involving repeated exposure to the child’s distress.
- Toxic stress (Shonkoff et al., 2012).	- Chronic physiological dysregulation	- Documented alterations in parents' cortisol levels
Attachment theory (Bowlby; George & Solomon, 1999).	- repeated failure of the caregiving system	- atypical child signals and chronic relational failure
- Narcissistic injury (Kohut, 1977).	- Repeated assault on the image of the ideal self	- A persistent sense of parental incompetence
- Ambiguous loss and chronic grief (Boss, 1999; Olshansky, 1962).	- Grief without closure involving a present-absent object	- Ongoing grief for the child as imagined, which is never resolved
- Compassion fatigue (Figley, 1995).	- Empathic exhaustion without institutional protection	- Parental emotional regulation occurring without a protective distance.
- Compassion fatigue (Figley, 1995).	- Empathic exhaustion without institutional protection	- Parental emotional regulation occurring without a protective distance.

Table 1: Synthesis of Theoretical Convergences with Parental Burnout

This synthesis reveals that parental burnout in ASD/ADHD occurs at the intersection of several chronic relational processes, each of which has been documented in isolation in the literature but never integrated into a single model. We propose this integration in the next section.

4. Proposal of a new conceptual model: the Parental Chronic Relational Trauma (PCRT) Model

4.1 General logic of the model

The proposed model is based on the premise that parental burnout among parents of children with ASD/ADHD is not a homogeneous phenomenon that can be explained by an imbalance between demands and resources. Rather, it may be the result of a cascading process in which factors at different levels interact to produce a trauma-like psychological reorganization in some parents, rather than merely functional exhaustion.

This model adopts the general principle of nested systems that influence one another from Bronfenbrenner’s (1979) ecological theory of human development, without replicating the structure of its four environmental systems (micro-, meso-, exo-, and macrosystems) verbatim.

It should be noted that levels 1, 3, 4 and 5 of the PCRTM correspond to environmental systems in the Bronfenbrennerian sense. However, level 2, which refers to parental emotional processes, relates to intrapsychic functioning rather than to an ecological system in the strict sense. The model therefore

combines two distinct logics: an ecosystemic logic for its peripheral levels and a psychological mechanism logic for its central level. This choice is deliberate rather than accidental. The metaphor of nested systems remains useful precisely because the internal psychological processes of level 2 are shaped by the surrounding ecological levels while simultaneously feeding back into them — provided one does not confuse ecological nesting (as described by Bronfenbrenner to situate a constituted individual) with the linkage between environment and psyche, which is what the present model seeks to address.

The model is also aligned with Minuchin's (1974) family systems approach, which emphasises that family subsystems influence one another mutually and cannot be understood in isolation. While it does not claim to replace the BR² model, whose empirical validity remains robust in terms of the quantitative dimension of the phenomenon, it does offer a complementary level of interpretation, focusing on the relational quality and psychological meaning of chronic exposure.

4.2 Level 1 — Child Characteristics

The first level corresponds to characteristics of the child that determine the nature and intensity of the relational stressors to which the parent is exposed. These include the severity and symptom profile of autism spectrum disorder (ASD) or attention-deficit/hyperactivity disorder (ADHD), challenging behaviours, sleep difficulties, features of socio-emotional communication and behavioural unpredictability.

This level should not be interpreted in a deterministic manner. The intention is not to identify the child as the 'cause' of parental trauma, but to acknowledge that certain symptomatic configurations constitute structural conditions that facilitate — without mechanically determining — the initiation of the process described in subsequent levels.

4.3 Level 2: Parental Emotional Processes

This second level forms the psychopathological core of the model. It encompasses the internal processes by which repeated exposure to Level 1 stressors results in a lasting change to parental psychological functioning, via four mechanisms:

Repeated failure of the caregiving system: each parental attempt to interpret and calm the child's distress that does not result in successful regulation constitutes a micro-relational rupture. Repeated over months and years, this accumulation produces a state of chronic hypervigilance.

Cumulative narcissistic injury: each perceived failure of reactive parental competence further damages the parental self-image.

- Chronic, unresolved grief for the imagined child: each missed developmental step reactivates the process of ambiguous loss.

- Cumulative physiological dysregulation: chronic sleep deprivation and prolonged activation of stress systems potentiate the three preceding processes.

According to this model, it is the cumulative interaction among these four mechanisms — rather than their simple additive effect — that constitutes the process whereby ordinary parental stress is transformed into chronic relational trauma.

4.4 Level 3: Family Dynamics

In line with the systemic principle that no family subsystem can be understood in isolation (Minuchin, 1974), this level considers the reciprocal influence of parental exhaustion on family

dynamics, including the quality of co-parenting, its impact on the marital relationship, the position and lived experience of siblings, and the family's communication style when facing shared adversity. There is a clear feedback loop here: severe parental exhaustion at Level 2 typically reduces the quality of co-parenting, which in turn decreases the available mutual support resources and further exacerbates individual exhaustion.

4.5 Level 4: Social and Institutional Context

This level encompasses access to diagnostic and treatment services, the quality of school inclusion, support from the extended social network and exposure to social stigma. It largely determines the extent of the resources available to mitigate the dysregulation described at Level 2. Conversely, substantial diagnostic delays, refusals of school enrolment or pronounced stigmatisation can directly amplify the processes at level 2 by depriving the parent of external regulatory resources.

4.6 Level 5: Cultural Factors

This final level considers cultural representations of disability and parenthood, social norms regarding educational success, and cultural or religious beliefs about what causes the disorder. It moderates the intensity of the parental narcissistic injury described in Level 2.

4.7 Conceptual Figure

- Level 5: Cultural factors (representations of disability, norms of educational success, etiological beliefs) modulate the intensity.

- Level 4: Social and institutional context (access to care, school inclusion, social support) provides or deprives buffering resources.

Level 3: Family Dynamics (coparenting, marital relationship, sibling(s)) ↔ bidirectional feedback loop ↔

Level 2: Parental Emotional Processes (core of the model): failure of caregiving ↔ cumulative narcissistic injury ↔ cumulative physiological dysregulation ↔ chronic grief ↔ chronic parental relational trauma

- Level 2: Parental emotional processes (core of the model): failure of caregiving → cumulative narcissistic injury → cumulative physiological dysregulation → chronic grief → chronic parental relational trauma

- Level 1: Child characteristics (symptom severity, challenging behaviours, sleep difficulties and behavioural unpredictability).

The downward vertical arrows indicate the modulating influence of the higher levels on level 2. The bidirectional arrows indicate reciprocal feedback loops in accordance with the systemic principle of circular causality (Minuchin, 1974).

4.8 Three cross-cutting mechanisms

The MTRCP's most significant contribution lies in its three cross-cutting mechanisms, which link the levels to one another rather than merely stacking them.

- Cumulative process without resolution (cumulation without closure): unlike a stressor that occurs at a specific time and is followed by a recovery phase, each process in level 2 is characterised by the absence of stable resolution.
- Mechanism of deprived withdrawal without legitimate grounds: the parent does not have socially legitimate access to the option of withdrawing from the situation.

- Inter-level reciprocal amplification mechanism: feedback loops between levels 2, 3 and 4 generate an amplification dynamic that explains the process's progressive, self-perpetuating trajectory.

5. Discussion

5.1 Theoretical contributions of the proposed model

The MTRCP makes three contributions to the current literature. Firstly, it shifts the focus from a quantitative logic of imbalance between demands and resources, to a qualitative logic of cumulative psychological transformation. This is consistent with advances in developmental psychopathology (Cicchetti, 2010). Secondly, it suggests integrating theoretical frameworks that have previously been used separately in literature on parental burnout, such as attachment, ambiguous loss, narcissistic injury and compassion fatigue, into a single, coherent model. Thirdly, it introduces the notion of cross-cutting mechanisms, providing an intermediate level of analysis between describing isolated risk factors and merely asserting relatedness to trauma.

5.2 Comparison with Existing Models

The MTRCP does not refute the BR² model (Mikolajczak et al., 2019), but rather refines it. While the BR² model addresses the question of 'how much', the MTRCP focuses on answering 'how' and 'why' some parents, despite facing equivalent challenges, exhibit a qualitatively different clinical presentation. Compared with approaches centred exclusively on parental stress (Abidin, 1990), the MTRCP incorporates a temporal and cumulative dimension. Compared with family resilience models (Walsh, 2003), it provides a necessary counterpoint by explicitly theorising rupture and negative chronicisation processes.

5.3 Contribution to clinical psychology and family psychopathology

The model's main contribution to clinical psychology lies in legitimising a trauma-centred therapeutic approach for parents, who have so far primarily been directed towards psychoeducational programmes or support groups focused on stress management. In the context of family psychopathology, the model encourages a re-evaluation of parental burnout, viewing it not as an individual pathology but as a systemic phenomenon involving feedback loops that must be identified and addressed, in line with Minuchin's structural family therapy (1974).

5.4 Differential relevance for ASD and ADHD

The mechanisms at level 1 likely do not unfold identically across the two disorders. In autism spectrum disorder (ASD), socio-affective reciprocity features may make the mechanism of repeated caregiving failure more salient. In attention-deficit/hyperactivity disorder (ADHD), impulsivity and difficulties in behavioural self-regulation may engage the mechanism of cumulative narcissistic injury more strongly. This differentiation remains a working hypothesis rather than an established finding at this stage; it is addressed by hypothesis H3 in Section 6.

6. Limitations

This theoretical proposal raises several caveats. Firstly, and most fundamentally, it has not been subject to any direct empirical validation; each of its five levels and three cross-cutting mechanisms currently remain structured hypotheses rather than demonstrated findings. Furthermore, the literature used to construct the model is predominantly from North America and French-speaking Europe, thereby limiting its initial cross-cultural scope. Caution should therefore be exercised regarding its

applicability to family contexts in which the structure of the extended family or cultural representations of disability differ substantially from those that produced this literature.

A third limitation concerns the nature of the exercise itself. Building an integrative model from seven distinct theoretical frameworks carries the risk of selecting elements from each framework that confirm the overarching thesis, rather than seeking elements that could contradict it systematically. We attempted to mitigate this risk by clarifying the distinction between structural parallelism and mechanistic identity in Section 3.1. However, this methodological limitation inherent to theoretical synthesis work must be acknowledged rather than minimised.

Finally, the model does not address an issue that should be examined in future research: not all parents of children with ASD/ADHD exhibit symptoms of chronic relational trauma. The current model also does not yet explicitly theorise the resilience factors that may protect some parents from this trajectory, beyond mentioning buffering resources at level 4. A more refined integration with family resilience models (Walsh, 2003) would require further development.

7. Clinical implications:

Screening: Screening parental burnout solely with tools focused on functional exhaustion may fail to capture the trauma dimension of the phenomenon in some parents. Therefore, clinicians should remain attentive to markers suggestive of a trauma component, such as relational hypervigilance, depersonalisation of the parental bond, marked social avoidance and discourse centred on unresolved grief.

Prevention: The model highlights the importance of early intervention at levels 4 and 5, including reducing diagnostic delays, supporting school inclusion and combatting social stigmatisation.

Psychological support: Individual therapy for parents should include specific time to work through the chronic grief of the imagined child, separate from the usual work on stress management and coping strategies.

Parenting guidance programmes could incorporate a component aimed at narcissistic restoration to interrupt the cycle of cumulative narcissistic injury.

Systemic interventions should not be limited to the parent experiencing distress, but should include the family system as a whole, particularly the marital dyad and siblings.

Institutional support: The model advocates structured respite services to socially and institutionally legitimise temporary withdrawal from the parental role.

8. Research Agenda

The MTRCP is proposed as a theoretical and testable framework rather than an empirically established model. Its empirical evaluation therefore requires research designs capable of examining the proposed pathways, mediating and moderating mechanisms, and potential differences across diagnostic, relational, institutional, and cultural contexts. Five hypotheses are derived from the model.

H1: Association between parental burnout and trauma-related symptomatology

Parents reporting high levels of parental burnout, as assessed using the Parental Burnout Assessment (PBA), are hypothesized to report higher levels of trauma-related symptomatology than parents experiencing high parental stress but low levels of parental burnout.

The experience of **deprivation of legitimate withdrawal** is proposed as a potential mediating mechanism in this association.

Recommended design: A large-sample comparative study including a parental-burnout group, a high-stress/low-burnout group, and, where feasible, a low-stress/low-burnout comparison group. Mediation analysis could be used to examine whether deprivation of legitimate withdrawal statistically accounts for part of the association between parental burnout and trauma-related symptomatology.

H2: The mediating role of cumulative parental self-related injury

The relationship between the frequency of challenging child behaviors (Level 1) and the severity of parental burnout (Level 2) is hypothesized to be partially mediated by cumulative injury to parental self-representation, conceptualized within the model as **cumulative narcissistic injury**.

Perceived social support (Level 4) is proposed as a potential moderating variable, such that greater perceived social support may attenuate the association between cumulative parental injury and parental burnout.

Recommended design: A longitudinal study with repeated measurements of child-related challenges, parental self-related injury, perceived social support, and parental burnout. Longitudinal mediation and moderation analyses would allow examination of temporal ordering and conditional associations among these variables.

H3: Differential pathways in parents of children with ASD and ADHD

The relative contribution of the proposed mechanisms of **repeated caregiving-system failure** and **cumulative parental self-related injury** to parental burnout may differ between parents of children with ASD and parents of children with ADHD.

Specifically, the model predicts that the caregiving-system pathway may account for a greater proportion of variance in parental burnout among parents of children with ASD, whereas the self-related injury pathway may account for a greater proportion among parents of children with ADHD. These differences constitute empirical predictions rather than established characteristics of the two diagnostic groups.

Recommended design: A comparative study involving sufficiently large ASD and ADHD samples, using structural equation modelling to estimate and compare the relative strength of the proposed pathways across groups. Multi-group structural equation modelling could be used to test whether relevant path coefficients differ between the two groups.

H4: Moderating role of the institutional context

The model hypothesizes that early access to diagnosis and specialised services (Level 4) may attenuate the association between child symptom severity (Level 1) and the intensity of chronic parental relational trauma.

This moderating effect is expected to remain observable after accounting for relevant socioeconomic characteristics.

Recommended design: A multi-site comparative longitudinal study involving families exposed to different levels of diagnostic and specialised-service accessibility. Moderation analyses could examine whether the strength of the association between child symptom severity and chronic parental relational trauma varies as a function of access to diagnosis and specialised care, while controlling for socioeconomic factors and other relevant covariates.

H5: Dyadic and systemic feedback between parental burnout and couple relationship functioning

The model hypothesizes a reciprocal longitudinal association between parental burnout and couple relationship functioning. Specifically, higher parental burnout in one partner is expected to be associated with subsequent reductions in couple relationship satisfaction, while lower relationship satisfaction is expected, in turn, to be associated with subsequent increases in parental burnout.

Recommended design: A dyadic longitudinal study involving both partners, with repeated assessments over at least two measurement waves. Actor–Partner Interdependence Models (APIM) and/or cross-lagged panel models could be used to examine temporal associations within and across partners and to determine whether the proposed feedback loop is supported by the data.

Cross-cultural research

Given the role assigned to cultural factors (Level 5), cross-cultural research represents an additional component of the proposed research agenda. Comparative studies across Western, Arab, and North African contexts may be particularly informative, given potential differences in cultural representations of disability, extended-family structures, social support systems, and access to specialised services.

Such studies should assess **measurement invariance** before comparing the levels or structural relationships of the proposed constructs across cultural groups. This would help determine whether observed differences reflect genuine variation in parental experiences or differences in the interpretation and measurement of the constructs themselves.

Taken together, these hypotheses provide a staged empirical program for evaluating the MTRCP. Initial comparative and longitudinal studies could establish whether the proposed constructs are empirically distinguishable and whether the hypothesized associations are supported. Subsequent dyadic, multi-site, and cross-cultural studies could examine the generalizability and boundary conditions of the model. Importantly, empirical findings may support, modify, or challenge the proposed pathways; the purpose of the research agenda is therefore not to confirm the model a priori, but to determine which elements of the framework are empirically supported and which require revision

9. General Conclusion

This article proposed a theoretical reappraisal of parental burnout among parents of children with ASD or ADHD. Starting from the observation that the Risk–Resource model does not fully capture certain identity-related and relational complexities of parenthood, we identified five gaps in the current literature. The fifth gap, in particular, concerns the lack of a theoretical link between two bodies of research that have, until now, largely developed independently.

Based on this analysis, we developed a set of converging theoretical frameworks to propose the Model of Chronic Parental Relational Trauma, structured around five nested levels and organized through three cross-cutting mechanisms. The main contribution of this work lies in extending predominantly quantitative and homeostatic conceptualizations of parental burnout toward a more qualitative, process-oriented perspective—one that accounts for the relational and identity-related dimensions of prolonged exposure to the specific challenges associated with ASD and ADHD, as well as their potential connection to trauma processes.

The proposed model remains a theoretical construction that has not yet undergone direct empirical validation. Its cross-cultural relevance, in particular, still needs to be established through comparative work. The five hypotheses formulated in Section 8 represent the necessary next steps for evaluating its empirical validity. More broadly, this work invites the scientific community to move beyond a strict opposition between stress- and trauma-oriented models, and to explore their potential integration.

Nevertheless, the proposed model should be interpreted with an appropriate degree of theoretical and clinical caution. Chronic parental relational trauma is introduced here as a heuristic, testable framework—not as an established clinical construct or diagnosis, and not as equivalent to post-traumatic stress disorder (PTSD) or complex PTSD (CPTSD). Moreover, the structural parallels drawn between chronic parental burnout and trauma processes do not, in themselves, establish causal relationships or mechanistic equivalence between the two phenomena.

The model should likewise not be interpreted deterministically. The challenges of raising a child with ASD or ADHD do not necessarily lead to trauma-related responses; individual, familial, social, institutional, and cultural differences may instead shape distinct trajectories of resilience and adaptation. At this stage, the model's primary value lies less in explaining parental burnout than in generating hypotheses that can be empirically tested. Longitudinal, comparative, dyadic, and cross-cultural studies are needed to clarify what the proposed mechanisms actually represent—whether distinct pathways, overlapping processes, or clinically relevant dimensions. Such evidence would be necessary before the model could be considered for translation into psychometrically validated assessment tools or trauma-focused clinical interventions.

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