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Broken trust – Institutional betrayal and posttraumatic distress in mothers of children with neuropsychiatric disorders

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ABSTRACT

Objective: Mothers of children with autism or mental health disorders may be at risk for anxiety symptoms and posttraumatic stress symptoms (PTSS) following exposure to traumatic events that relate to their children's upbringing. Furthermore, according to the trauma betrayal theory, mothers' experience of institutional betrayal that result from institutions' failure to fulfill their obligations may take another toll on their well-being and may exacerbate their symptomatology. Yet, thus far no study has explored institutional betrayal among parents of children with disabilities in general, nor among mothers of children with autism or mental health disorders, in particular. Bridging this knowledge gap, this study explored the unique contribution of institutional betrayal in explaining anxiety symptoms and PTSS among mothers of children with autism or mental health disorders.
Methods: An online survey was conducted among Israeli parents using self-report measures. The sample consisted of 178 mothers: 58 mothers of children with autism and 120 mothers of children with mental health disorders.
Results: Results indicated that institutional betrayal was associated with elevated levels of PTSS and anxiety symptoms. Moreover, institutional betrayal among the mothers explained anxiety symptoms, as well as intrusion and negative alterations in mood and cognitions symptoms, above and beyond the effects of mothers' age and education, type of disability of the child, and number of traumatic events related to the child's upbringing.
Conclusion: The present results suggest that institutions' failure to fulfill their obligations may increase vulnerability to posttraumatic distress among mothers of children with neuropsychiatric disorders.

Raising a child with a neuropsychiatric disorder, such as autism or a mental health disorder, presents significant challenges and demands for parents (Crowe and Brinkley, 2015; Hayes and Watson, 2013). Compared to parenting a typically developing child, this role is often more complex and taxing, involving a wide array of personal and social difficulties (Curran et al., 2001; Resch et al., 2010; Werner and Shulman, 2015). In most cases, mothers serve as the primary caregivers, shouldering the majority of responsibilities associated with the child's care. As a result, they are particularly susceptible to heightened levels of stress (Masefield et al., 2020). Research has shown that mothers of children with neurodevelopmental disorders report significantly higher levels of parental stress than fathers (Oelofsen and Richardson, 2006). In light of these findings, the present study focuses on mothers raising children with autism or mental health disorders.

In addition to the heightened stress associated with the unique challenges of raising a child with a disability, mothers in this context also appear to be at increased risk for trauma exposure. Evidence suggests that parents of children with disabilities are more frequently exposed to traumatic events related to their children's upbringing, such as witnessing a severe accident or serious self-harming behavior (Xiong et al., 2022a,b). Moreover, a recent study of mothers of children with autism or mental health disorders supports this perspective, indicating that these mothers experience a greater number of traumatic events related to their child's upbringing compared to mothers of children without disabilities (Lahav & Shalev, under review).

Trauma exposure is a prerequisite for trauma-related symptomatology, such as posttraumatic stress symptoms (PTSS; American Psychiatric Association, 2013; Friedman et al., 2011). Nonetheless, exposure to trauma is also associated with various mental health problems (Sayed et al., 2015), including anxiety symptoms (Hogg et al., 2023; Marqueses et al., 2023; Spinhoven et al., 2014). The current study explored both posttraumatic stress symptoms and anxiety symptoms

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among mothers of children with autism or mental health disorders in the aftermath of trauma.

Posttraumatic stress symptoms comprise four clusters (APA, 2013). The intrusion cluster signifies the experience of past trauma reoccurring in the present and includes flashbacks, intrusive memories, and nightmares. The avoidance cluster involves efforts to avoid external or internal reminders of the trauma, such as thoughts, conversations, activities, or situations reminiscent of the traumatic experience. The negative alterations in cognition and mood cluster denotes negative beliefs about oneself, others, or the world, along with persistent negative emotions such as guilt and shame. Lastly, the alterations in arousal and reactivity cluster includes symptoms such as irritability, angry outbursts, and hypervigilance.

Research among mothers of children with mental health disorders or autism has revealed elevated levels of anxiety (e.g., Middeldorp et al., 2016; Scherer et al., 2019; Schnabel et al., 2020). Similarly, evidence indicates high rates of PTSS in this population. A systematic review found that 24 % of parents of children with autism exhibited posttraumatic stress symptoms (Hinde et al., 2025), while a study involving families with children who have psychiatric disorders indicated that 63 % experienced PTSS (Shalev, under review). Furthermore, recent studies that included parents of children with autism and ADHD revealed associations between the number of traumatic events related to children's upbringing and PTSS (Xiong et al., 2022a,b).

While exposure to a greater number of traumatic events may put mothers at risk for anxiety symptoms and posttraumatic stress symptoms, the quality of their interactions with institutions related to their children's upbringing could further intensify their distress. According to betrayal trauma theory (Smith and Freyd, 2013), individuals develop trust or dependence on institutions, perceiving them as sources of attachment and expecting them to provide safety and security (Lahav and Ben-Ezra, 2024; Mayseless and Popper, 2007). When these institutions fail to meet their obligations —either through deliberate acts, such as actively committing a transgression or violation against individuals, or through acts of omission, such as failing to implement appropriate policies or adequately address the needs of trauma survivors–this creates an institutional betrayal that exacerbates distress among trauma survivors (Smith and Freyd, 2013).

Most studies on institutional betrayal have focused on interpersonal trauma, such as sexual assault and intimate partner violence, that occurred within institutional contexts (e.g., on campuses or in the military), among individuals who are members of the institution. The findings of these studies have supported the betrayal trauma theory and documented various negative outcomes of institutional betrayal, including dissociation, sexual dysfunction, trauma-related outcomes (Smith and Freyd, 2013), health problems (Smith and Freyd, 2017), depression (Smith et al., 2016), attempted suicide (Monteith et al., 2016), anxiety (Lee et al., 2021; Smith and Freyd, 2013), and posttraumatic stress symptoms (Lahav et al., 2025; Lee et al., 2021). Few studies exploring other types of trauma, such as the COVID-19 pandemic, revealed a similar relationship between institutional betrayal and increased posttraumatic distress (Adams-Clark and Freyd, 2021; Christl et al., 2024).

Nonetheless, no study thus far has explored the implications of institutional betrayal for the well-being of parents of children with disabilities in general, or of mothers of children with neuropsychiatric disorders in particular. In fact, to the best of our knowledge, only one qualitative study has addressed institutional betrayal in the context of disability. This study, which was conducted among twelve students with disabilities, revealed feelings of betrayal by their academic institutions due to a return to exclusionary policies after the COVID-19 pandemic (Owenz et al., 2024). Therefore, it remains unclear whether mothers of children with autism or mental health disorders experience institutional betrayal, and whether this betrayal contributes to their anxiety symptoms and PTSS in the aftermath of trauma exposure.

This subject is highly important because mothers of children with autism or mental health disorders appear to be at risk of exposure to traumatic events related to their children's upbringing (Lahav & Shalev, under review; Xiong et al., 2022a,b). These mothers often interact with various institutions, such as healthcare providers, welfare services, social security services, and the educational system, as part of raising their children. A failure on the part of these institutions to fulfill their obligations–such as creating an environment that legitimizes aggressive behavior, negligence, or abuse towards children with disabilities, or withholding adequate treatment—can result in institutional betrayal, which may be particularly distressing for the mothers.

The present study aimed to fill this gap by exploring the implications of institutional betrayal for anxiety symptoms and posttraumatic stress symptoms among mothers of children with autism or mental health disorders. To depict mothers' global sense of institutional betrayal, we examined their overall experiences with various formal institutions (or their representatives) that they interact with during their children's upbringing. These include health institutions (such as physical and mental health systems, physicians, and psychotherapists), welfare services, social security services, and educational services. To explore the unique contribution of institutional betrayal in explaining anxiety symptoms and PTSS, its effects were assessed after controlling for mothers' age and education, the type of disability of the child (autism vs. mental health disorders), and the number of traumatic events related to the child's upbringing to which the mothers were exposed. Based on the aforementioned literature, the following two hypotheses were explored: 1) Institutional betrayal would be related to anxiety symptoms and PTSS among mothers of children with autism or mental health disorders, and 2) Institutional betrayal would significantly contribute to explaining anxiety symptoms and PTSS among mothers of children with autism or mental health disorders after accounting for mothers' age and education, the type of disability of the child (autism vs. mental health disorders), and the number of traumatic events related to the child's upbringing.

1. Method

Participants and procedure. An online survey was conducted among a convenience sample of Israeli parents. The survey was accessible through Qualtrics, a secure web-based data collection system. It took an average of 35 min to complete and was open from May 17, 2023, to September 1, 2023. Participation was anonymous, and no data were collected that linked participants to recruitment sources. The Tel Aviv University institutional review board (IRB) approved all procedures and instruments.

Clicking on the link to the survey directed potential respondents to a page that explained the study's purpose, described the nature of the questions, and included a consent form. Participants were informed that the survey was voluntary and that they could skip any questions or exit at any time. Additionally, contact information for the research team and several Israeli organizations that provide support and treatment for parents of children with disabilities was provided. The Qualtrics platform's built-in option, 'Prevent Ballot Box Stuffing,' was utilized to avoid duplicate entries in the survey. Furthermore, to detect potential fraudulent entries from bots, records associated with duplicated IP addresses in the dataset were discarded.

The study was presented as research examining how parents of children with and without disabilities cope with stressors. A Facebook advertisement was used to recruit participants. Facebook users were eligible for this study if they were ≥18 years old, had children, and were living in Israel. The advertisement included a headline, main text, and a link to the survey.

A total of 2022 parents (1900 of whom were mothers) responded to the survey's questionnaires, of which 773 (38.2 %) were parents of children with disabilities. This subgroup was predominantly composed of mothers (n = 710, 91.8 %), with only 61 participants (0.08 %) identifying as fathers. Since the current study aimed to explore mothers'

experiences and considering the potential differences in posttraumatic stress that may arise between genders (Christiansen and Berke, 2020; Olff, 2017), fathers were excluded from the study.

The present sample consisted of 178 mothers of children who had received formal diagnoses of disabilities, had been exposed to at least one traumatic event related to their children's upbringing, and reported involvement with institutions surrounding their children.

Among them, 58 reported having a child with autism, while 120 reported having a child with a mental health disorder. The age of the children ranged from 3 to 46 years, with an average age of 19.52 years (SD = 10.29). Mothers of children with mental health disorders reported a variety of primary diagnoses, including mood disorders (24.5 %), attention-deficit/hyperactivity disorders (17.9 %), personality disorders (16.9 %), obsessive-compulsive and related disorders (13.4 %), anxiety disorders (11.3 %), psychotic disorders (9.4 %), and trauma-related disorders (6.6 %). Among mothers of children with autism, 31 % indicated that their child had also been diagnosed with a mental health disorder, although autism was identified as the primary condition. Mothers' ages ranged from 29 to 80 (M = 50.96, SD = 10.80). The majority had 1 to 3 children (80.9 %) and were married (70.8 %). Most participants had a bachelor's degree or higher (70.8 %), with an average of 16.95 years of education (SD = 3.42), and were employed (68.6 %); 58.5 % reported having an average income or above.

1.1. Measures

Background characteristics. Participants completed a brief demographic questionnaire that assessed age, education, income, relationship status, disability status, number of children, whether their children have disabilities, and the types of those disabilities.

Institutional betrayal. Perceived institutional betrayal was measured using an adapted version of a new questionnaire developed by Bachem et al. (2020), which was partially based on the Institutional Betrayal Questionnaire-Health (Smith, 2017). First, participants were provided with examples of different institutions they may have interacted with, such as social security services, welfare services, child development centers, special educational services, mental health systems, and physical health systems. They were then asked whether there had been any involvement of these institutions in their upbringing of children with disabilities. Participants who indicated such involvement were asked to specify the institutions that had been involved.

Next, participants were presented with 16 items describing successes or failures of the institutions in fulfilling their obligations (e.g., "The institutions acted transparently"; "The institutions betrayed my trust in them"; "Their actions reflect interests other than enhancing my children's safety and wellbeing"; "The institutions covered up events of malpractice"). Participants rated their agreement with each of the 16 items on a five-point Likert scale, ranging from 1 (completely disagree) to 5 (completely agree). The total score was calculated by summing the responses to all of the items. This scale demonstrated good internal consistency for the total score in the present study (α = 0.97).

Posttraumatic stress symptoms. PTSS were measured using the PCL-5 (Weathers et al., 2013). This 20-item self-report measure asks participants to indicate the extent to which they experienced each symptom in the past month, using a five-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The original version of the PCL-5 was retained in its entirety, with only a minor modification to the instructions to focus on trauma related to participants' children's upbringing. Specifically, the original wording, "Below is a list of problems that people sometimes have in response to a very stressful experience," was revised to: "Below is a list of problems that people sometimes have in response to a very stressful experience, such as the traumatic event related to your children's upbringing that you previously reported."

Items correspond to the PTSD symptom criteria in the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM–5; APA, 2013). Research suggests that a cut-off score of 33 is a useful threshold for indicating clinical symptomatology (Bovin et al., 2016). The PCL-5 demonstrates high internal consistency and test-retest reliability (Bovin et al., 2016). In this study, the internal consistency reliability coefficients were .89, .82, .89, and .86 for intrusion, avoidance, negative alterations in mood and cognition, and hyperarousal symptoms, respectively.

Anxiety symptoms. Levels of anxiety symptoms were assessed using the anxiety subscale of the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2001). The BSI-18 is a self-report symptom checklist that consists of 18 items, each describing a psychiatric symptom. The anxiety subscale includes six items. Participants were asked to indicate the extent to which they had been bothered by each symptom in the previous week, using a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The mean score on the subscale reflects the respondent's level of anxiety symptoms, with higher scores indicating greater symptoms. Additionally, the raw scores were converted to T scores, with a cutoff point of 63 indicating psychopathology on the anxiety subscale (Derogatis, 2001). The BSI-18 has demonstrated adequate convergent and discriminant validity, as well as good reliability (Derogatis, 2001). In this study, internal consistency reliability was high (α = 0.88).

1.2. Covariates

To account for the implications of the child's disability type in explaining PTSS and anxiety symptoms among the mothers, this variable was treated as a covariate. Additionally, evidence indicates that individuals' age (Christiansen and Berke, 2020; Olff, 2017), education (Brewin et al., 2000), and the number of traumatic events to which individuals are exposed (Xiong et al., 2022a,b) are related to PTSS; therefore, these variables were also treated as covariates: The following variables were also considered as covariates: 1) mothers' age; 2) mothers' education (in years); 3) child's disability type (mothers of children with autism vs. mothers of children with mental health disorders); and 4) number of traumatic events. All variables were assessed through the demographic questionnaire, except for the number of traumatic events.

The number of traumatic events experienced by participants while caring for their children was assessed using the Parenting Trauma Checklist (PTC; Xiong et al., 2022). This scale aligns with the definition of "traumatic events" per *DSM-5* Criterion A and consists of 17 items (e.g., "Witnessing a life-threatening situation involving your child" and "Fearing that your child would die while waiting for care"). In the present study, a Hebrew version of the PTC was utilized (Lahav & Shalev, under review). Additionally, for the purpose of this study, two items addressing physical or sexual abuse of the child by other children or authority figures were included. Participants were asked to rate whether they experienced each event (yes = 1, no = 0), with the total number of traumatic events ranging from 0 to 19. The PTC demonstrated good construct validity (Xiong et al., 2022b).

1.3. Analytic strategy

Analyses were performed using SPSS version 29, and there were no missing data. To explore the relationships between institutional betrayal, PTSS, and anxiety symptoms, Pearson correlation analyses were performed. Hierarchical linear regression models were used to assess the unique contribution of institutional betrayal in explaining PTSS and anxiety symptoms. The models consisted of three blocks: the first included age, education, and child's disability type; the second included the number of traumatic events; and the third included the level of institutional betrayal. Within each block, all variables were introduced simultaneously into the model. The assumption of normality of residuals for the linear regression model was satisfied, as confirmed by the Kolmogorov-Smirnov test.

2. Results

Participants reported the involvement of several institutions in their children's upbringing: social security (37.6 %), physical health systems (34.3 %), mental health systems (31.5 %), schools and the Ministry of Education (20.8 %), the welfare system (12.4 %), and local municipalities (2.81 %). More than a third of participants reported the involvement of two or more institutions (n = 68, 38.28 %). The average level of institutional betrayal was 39.96 (SD = 18.08). The majority of the sample (n = 110, 61.8 %) reported at least one manifestation of institutional betrayal, and over a third of the sample (n = 62, 34.8 %) reported five or more manifestations of institutional betrayal. An examination of the mothers' responses revealed that, although their experiences of institutional betrayal were extensive and encompassed a wide range of manifestations, certain perceptions were particularly common, with endorsement rates ranging from 82.6 % to 88.8 %. These included the beliefs that the institutions did not act transparently, did not act responsibly, and did not do their best to ensure their child's safety and wellbeing. In contrast, the items with the lowest levels of endorsement—ranging from 56.7 % to 59.6 %—included the perceptions that the institutions' actions reflected interests other than enhancing their children's safety and wellbeing, that the institutions lied or withheld the full truth, and that they handled private information about their child carelessly or irresponsibly.

As mentioned, all participants were exposed to at least one traumatic event related to their children's upbringing. The average number of traumatic events experienced was 7.03 (SD = 3.32). The most prevalent traumatic events reported by the mothers were: a medical emergency involving the child (70.2 %, n = 125), witnessing a life-threatening situation concerning the child (60.7 %, n = 108), receiving a diagnosis of a life-threatening disability for the child (53.4 %, n = 95), hearing about a life-threatening event affecting the child (46.1 %, n = 82), seeing the child undergo a medical procedure (44.9 %, n = 80), fearing that the child would die while waiting for care (43.8 %, n = 78), witnessing serious self-harming behavior by the child (43.3 %, n = 77), and hearing about physical or sexual abuse of the child by other children (40.4 %, n = 72).

The average anxiety symptom score was 1.26 (SD = 0.95), with 27 participants (15.2 %) meeting the anxiety criteria. Among the total sample, 75.3 % (n = 134) reported at least one intrusion symptom, 58.4 % (n = 104) reported at least one avoidance symptom, 84.8 % (n = 151) reported at least one symptom reflecting negative alterations in mood and cognition, and 88.8 % (n = 158) reported at least one hyperarousal symptom. Nearly half of the sample (42.7 %, n = 76) exhibited trauma-related symptoms above the cutoff, indicating clinically significant symptomatology.

2.1. Institutional betrayal and PTSS

As shown in Table 1, institutional betrayal was significantly related to all clusters of PTSS and anxiety symptoms, with small effect sizes (r ranging from 0.13 to 0.30). Higher levels of institutional betrayal correlated with increased levels of intrusion, avoidance, hyperarousal, and negative alterations in mood and cognition, as well as anxiety symptoms. Additionally, posttraumatic stress symptoms were positively related to anxiety symptoms, with small to moderate effect sizes (r ranging from 0.28 to 0.48).

Additional Pearson correlation analyses were conducted to explore the relationships between institutional betrayal and clinically significant PTSS and anxiety symptoms. The results indicated that institutional betrayal was significantly related to both clinically significant PTSS (r = 0.28, p < .001) and anxiety symptoms (r = 0.13, p < .05), with small effect sizes.

Table 1
Inter-correlations between institutional betrayal, PTSS, and anxiety symptoms (n = 178).

	1	2	3	4	5	6
1. Institutional betrayal	–					
2. Intrusion	.30***	–				
3. Avoidance	.19**	.66***	–			
4. Negative alterations in mood and cognition	.26***	.66***	.59***	–		
5. Hyperarousal	.21**	.69***	.52***	.70***	–	
6. Anxiety symptoms	.13*	.48***	.28**	.41***	.45***	–

*p < .05; **p < .01; ***p < .001.

2.2. The effects of institutional betrayal in explaining PTSS and anxiety symptoms

Results of the regression models are presented in Table 2. The five models were significant, explaining 22.6 % of the variance in intrusion symptoms, 13.3 % of the variance in avoidance symptoms, 23 % of the variance in hyperarousal symptoms, 17.6 % of the variance in negative alterations in mood and cognition, and 21.4 % of the variance in anxiety symptoms (see Table 2).

Age was negatively associated with the severity of PTSS clusters and anxiety symptoms, while the number of traumatic events was positively associated with these symptoms: older mothers tended to report less severe symptoms, and mothers who experienced more traumatic events reported more severe symptoms. Mothers' education was negatively associated with intrusion symptoms, avoidance symptoms, and anxiety symptoms. In contrast, the child's disability type (autism vs. mental health disorders) was not significantly associated with PTSS or anxiety symptoms.

More importantly, the results indicated that institutional betrayal significantly contributed to the explanation of variance in intrusion, negative alterations in mood and cognition, and anxiety symptoms. It also had a nearly significant effect (p = .058) on accounting for variance in avoidance symptoms. These effects remained significant after controlling for age, education, child's disability type, and the number of traumatic events–the greater the institutional betrayal, the higher the symptom levels.

3. Discussion

The current study investigated, for the first time, the contribution of institutional betrayal in explaining posttraumatic stress symptoms and anxiety symptoms among mothers of children with autism or mental health disorders. The results indicated that the majority of the sample reported at least one manifestation of institutional betrayal, and that overall levels of institutional betrayal were related to PTSS and anxiety symptoms among the mothers. Furthermore, institutional betrayal made a unique contribution to explaining elevated levels of intrusion, negative alterations in mood and cognition, and anxiety symptoms, beyond the effects of age, education, child's disability type, and the number of traumatic events.

The current findings align with previous studies on survivors of interpersonal trauma, which have revealed a link between institutional betrayal and negative outcomes among these survivors (Lahav et al., 2025; Lee et al., 2021; Monteith et al., 2016; Smith et al., 2016; Smith and Freyd, 2013). The present results further suggest that the phenomenon of institutional betrayal also applies to mothers of children with disabilities who experience traumatic events related to their children's upbringing, indicating that such betrayal is associated with posttraumatic distress in this population.

Mothers of children with autism or mental health disorders appear to be at risk for exposure to traumatic events related to their children (Lahav & Shalev, under review; Xiong et al., 2022). This includes witnessing their children being at risk of severe injury or death due to medical conditions or accidents (Xiong et al., 2022) or becoming aware of their children being physically or sexually abused by peers or

Table 2
The effects of institutional betrayal in explaining PTSS and anxiety symptoms (n = 178).

	Intrusion		Avoidance		Negative alterations in mood and cognition		Hyperarousal		Anxiety symptoms	
	β	R^2	β	R^2	β	R^2	β	R^2	β	R^2
Step 1										
Age	−.11	.04	−.13	.04	−.16	.03	−.22**	.05*	−.35***	.16***
Education (years)	−.13		−.14		−.02		−.07		−.18*	
Child's disability type	.13		.02		.14		.14		.01	
Step 2										
Age	−.13	.15***	−.15	.08***	−.19*	.12***	−.27***	.17***	−.36***	.04**
Education (years)	−.16*		−.16*		−.05		−.10		−.20**	
Child's disability type	.07		−.02		−.09		.07		−.02	
Number of traumatic events	.40***		.28***		.35***		.42***		.20**	
Step 3										
Age	−.16*	.03**	−.17*	.02	−.21**	.03*	−.27***	.02	−.38***	.02*
Education (years)	−.14*		−.15*		−.03		−.09		−.18**	
Child's disability type	.06		−.04		.07		−.06		−.03	
Number of traumatic events	.34***		.24**		.29***		.38***		.16*	
Institutional betrayal	.20**		.15		.20**		.13		.15*	

**p < .01 **p < .01 ***p < .001.

caregivers (Jones et al., 2012). While exposure to trauma is known to be associated with PTSS and anxiety symptoms, the failure of institutions to fulfill their role and provide support for these mothers was also linked to increased PTSS and anxiety symptoms among them.

Given the cross-sectional nature of the present study, two primary explanations may account for the observed association between institutional betrayal and symptoms of posttraumatic stress and anxiety. One possible explanation is that the mothers' distress following trauma exposure negatively influenced their perceptions of institutional interactions. Trauma exposure has been shown to disrupt individuals' fundamental assumptions about the world, leading to a diminished sense of safety, trust, and meaning (Janoff-Bulman, 1992; Schuler and Boals, 2016). Moreover, individuals who develop posttraumatic stress symptoms frequently exhibit maladaptive cognitions, including negative views of the self, others, and the world (American Psychiatric Association, 2013). Consequently, it is plausible that mothers of children with autism or mental health disorders who experience heightened levels of PTSS or anxiety may be more likely to perceive their interactions with institutions negatively, attributing malevolent intent or neglect even in ambiguous or neutral circumstances.

Conversely, the second explanation suggests that experiences of institutional betrayal may have exacerbated the mothers' distress. Previous studies have indicated that parents of children with autism and mental health disorders often face a lack of support and availability from various services. Parents of children with autism have reported struggles in their efforts to obtain adequate services for their children (e.g., Osborne and Reed, 2008; Safe et al., 2012) and have expressed low satisfaction with these services (Bitterman et al., 2008; Liptak et al., 2006). Similarly, studies conducted among parents of children with mental health disorders revealed limited service availability, bureaucratic difficulties in accessing services, and a lack of information and referral sources for services and treatments (Carbonell et al., 2020). Additionally, parents reported feeling excluded by the system due to not being involved in treatment planning for their children (Jivanjee et al., 2009; Leung et al., 2022). The current findings imply that such negative experiences with institutions not only pose obstacles for these mothers in meeting their children's needs but also put them at risk for posttraumatic distress. Institutional betrayal specifically contributed to explaining elevated levels of intrusion, negative changes in mood and cognition, and anxiety symptoms, independent of the effects of age, education, child's disability type, and the number of traumatic events.

The harmful effects of institutions' failure to fulfill their obligations may stem from mothers' sense of resource depletion. According to the conservation of resources theory (Hobfoll, 1989), exposure to trauma can lead to a negative spiral of resource loss, which intensifies survivors' vulnerability to distress (Hobfoll et al., 2016). Thus, mothers of children with autism or mental health disorders who are exposed to trauma and encounter failures by institutions to meet their obligations may experience resource depletion that further exacerbates their symptoms.

Alternatively, as suggested by betrayal trauma theory (Smith and Freyd, 2013), the institutions' failure to provide safety and security may create a sense of betrayal, which can be further traumatizing for the mother. Our findings indicated that institutional betrayal was related to PTSS and anxiety symptoms and made a unique contribution to explaining these outcomes after accounting for age, education, child's disability type, and number of traumatic events. Specifically, institutional betrayal had a significant effect on explaining elevated levels of intrusion, negative alterations in mood and cognition, and anxiety symptoms, with a nearly significant effect on explaining avoidance symptoms. The exception was regarding hyperarousal symptoms, for which the effect of institutional betrayal was non-significant.

The present findings imply that mothers of children with autism or mental health disorders who experience institutional betrayal–such as when social institutions (e.g., health care providers, welfare, or educational services) doubt the information they provide, invalidate their experiences, blame them, or withhold adequate treatment and resources–may struggle to overcome traumatic events related to their children. The breakdown of mothers' trust in various institutions, which are supposed to assist them in raising their children with disabilities, may fuel their re-experiencing of past trauma, heighten their efforts to avoid trauma reminders, and deepen their pessimistic views and negative emotions, such as fear, anger, or shame. Moreover, similar to the harmful effects of a failure of attachment figures to fulfill their roles, betrayal by social institutions may shatter mothers' basic sense of safety and security and may exacerbate anxiety symptoms.

At the same time, our findings indicated that although institutional betrayal was related to elevated hyperarousal symptoms, its effect was non-significant after accounting for age, education, child's disability type, and the number of traumatic events. Two explanations might be offered for these findings. The first is that while institutional betrayal contributes to hyperarousal symptoms, the effect of the number of traumatic events is particularly strong and therefore overshadows that of institutional betrayal. Alternatively, it may be that hyperarousal symptoms are not exacerbated by institutional betrayal, unlike other posttraumatic stress symptoms. This idea is inconsistent with previous studies that have documented the implications of institutional betrayal for hyperarousal symptoms (Lahav et al., 2025). However, those studies were conducted among survivors of different types of trauma (i.e., intimate partner violence) and not among caregivers of children with disabilities. Therefore, future studies exploring the link between institutional betrayal and PTSS cluster symptoms are needed.

Although the current findings yielded interesting results, this study

had several limitations that should be considered. First, the cross-sectional design restricted the ability to determine the directionality of the relationships identified in the study. Second, although the present study was the first to examine institutional betrayal among mothers of children with disabilities, it assessed only a general sense of institutional betrayal. The study did not explore levels of institutional betrayal across specific institutions, which may be a limitation. This approach prevented the identification of institutions perceived as most responsible for betrayal and limited the ability to suggest targeted interventions. Therefore, we strongly recommend that future research assess institutional betrayal both overall and separately for each relevant institution. Third, the study relied on convenience sampling and self-report measures, which may be subject to response bias and shared-method variance. Fourth, the study focused exclusively on Israeli mothers of children with autism or mental health disorders. This limits the generalizability of the findings and does not allow for the exploration of potential differences in institutional betrayal between mothers of children with disabilities and those of children without disabilities. Fifth, while the inclusion of mothers of children with a broad range of mental health disorders and the diverse challenges associated with autism spectrum disorder offers a comprehensive overview, it limits the ability to capture disorder-specific nuances. This heterogeneity may mask distinct experiences, stressors, or coping mechanisms associated with specific diagnoses. Finally, this study did not examine other potentially influential variables, such as peritraumatic reactions (Dokkedahl and Lahav, 2023), perceived threat (Dokkedahl and Lahav, 2024), or mothers' pre-existing PTSS or anxiety symptoms. These factors may interact with mothers' symptomatology following traumatic events related to their children's upbringing. To further elucidate the phenomenon of institutional betrayal and its implications for posttraumatic distress, future studies should measure additional risk factors, assess institutional betrayal, PTSS, and anxiety symptoms over time, and include self-report measures and clinical assessments among parents of children with and without disabilities from diverse cultural backgrounds.

Despite these limitations, this study documents for the first time the implications of institutional betrayal for posttraumatic stress symptoms and anxiety symptoms among mothers of children with autism or mental health disorders. The current results suggest that mothers of children with disabilities depend on social institutions, which not only affects their ability to meet their children's special needs but is also crucial in shaping their own well-being. When institutions neglect these mothers by acting negligently or failing to provide the help and services to which they are committed, it creates a profound sense of betrayal. This form of betrayal serves as a substantial obstacle to mothers' recovery, exacerbating their psychopathology in the aftermath of trauma exposure.

Therefore, the current findings underscore the urgent need to address institutional betrayal on multiple levels. First, it is essential to provide staff with training aimed at improving their interactions with mothers of children with disabilities and fostering a validating, safe, and supportive environment that facilitates the recovery of these mothers from trauma related to their children. In addition, it is equally important to implement broader policy changes that actively involve parents in shaping institutional policies and participating in advisory roles, ensuring that their voices and lived experiences inform systemic practices. Together, these approaches can reduce the risk of institutional betrayal, enhance accountability, and promote the well-being and recovery of mothers navigating trauma in the context of their children's conditions.

CRediT authorship contribution statement

Hadas Stricher-Stern: Writing – original draft, Conceptualization. **Anat Shalev:** Writing – original draft, Conceptualization. **Yael Lahav:** Writing – original draft, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

Ethics approval statement

This study was approved by the Tel Aviv University institutional review board IRB (Approval number: no. 0006565–2, Date: 21/04/2024). All procedures involving human participants were conducted in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments.

Declaration of competing interest

No potential conflicts of interest were reported by the author(s).

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Data availability

The authors do not have permission to share data.

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