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Informal peer support in special education waiting areas: a qualitative case study of parents' experiences

Erhan Alabay[1] · **Hazal Ersal**[2] · **Nuray Oncul**[3]

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Abstract

This study examines naturally occurring interactions among parents waiting for their children in special education and rehabilitation centers in Türkiye, conceptualizing these interactions as forms of informal peer support. A qualitative case study design was employed, involving semistructured interviews with 40 parents who regularly remained in institutional waiting areas. Content analysis revealed three categories of support: informational support, psychological cohesion, and social connection and adjustment. Parents exchanged experience-based information about diagnosis, educational needs, institutional procedures, and legal rights, while shared experiences also provided empathy, emotional relief, reassurance, and a sense of belonging. Some parents described repeated encounters that had developed into close and enduring relationships that extended beyond the institutional setting, whereas others maintained more limited or superficial interactions. The findings suggest that waiting areas may function not only as spaces of temporary waiting but also as informal psychosocial environments in which peer support can emerge. Institutional waiting spaces could therefore be organized in ways that facilitate voluntary peer interaction while respecting parents who prefer limited social engagement.

Highlights

- Informal parent interactions provide informational, emotional, and social support.
- Shared experiences foster empathy, emotional relief, belonging, and hope.
- Parents described waiting spaces as settings for informal support networks.
- Not all parents seek close relationships; some interactions remain superficial.
- Peer relationships may extend beyond institutions into enduring social ties.

Keywords Special education · Family · Social support · Informal peer support

Introduction

Parents of children with disabilities require substantial support from the government, society, and relevant institutions in navigating their children's educational and developmental processes (Petriwskyj et al., 2016). Families' essential requirements during this process include access to financial resources, information and services, engagement in school and community, and social support (Resch et al., 2010). Social support encompasses the connections formed between individuals who have shared experiences. Parents of children with disabilities may benefit emotionally from social support and connections with others who share similar experiences (Hassanein et al., 2021; Lee et al.,

✉ Erhan Alabay
erhan.alabay@sbu.edu.tr

Hazal Ersal
hazalersal1@gmail.com

Nuray Oncul
noncul@anadolu.edu.tr

[1] Department of Child Development, University of Health Sciences, Istanbul, Türkiye

[2] Independent Researcher, Bilecik, Türkiye

[3] Department of Special Education, Anadolu University, Eskişehir, Türkiye

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2024). Peer support, a form of social support, serves as a vital resource for families of children with disabilities, facilitating both knowledge exchange and emotional empowerment. Furthermore, as in many other countries, limitations in disability policies in Türkiye may restrict families' access to essential social and structural support.

Disability status in Türkiye

According to a report released in April 2023 by the Ministry of Family and Social Services, there are 2,511,950 individuals registered with disabilities in Türkiye's National Disability Data System, with 775,012 categorized as 'severely disabled' (Ministry of Family and Social Services, 2023). By category, 40.6% had chronic illnesses, followed by mental conditions (17.1%), orthopedic issues (13.8%), vision impairments (9.5%), hearing impairments (8%), and mental/emotional disorders (7.6%). These figures represent solely officially registered individuals. A distinct survey conducted by TÜİK in 2021 revealed a disability rate of 6.9% among those aged 3 and above, amounting to approximately 4.9 million people, not including children aged 0–3 (Turkish Statistical Institute [TÜİK], 2022). Inconsistencies among sources arise from systemic deficiencies in national disability data collection frameworks (Çetin, 2020; Oral et al., 2016). A significant number of individuals with disabilities remain unregistered, with unofficial estimates indicating that the overall population may be nearly 9 million, as corroborated by numerous NGOs (Accessible Living Association, 2024; Confederation of Persons with Disabilities in Türkiye, 2020). The 2022 Türkiye Health Survey provides additional age-specific data, revealing that children (ages 2–14) predominantly encounter learning and mobility challenges, whereas adults (ages 15 and older) report elevated incidences of functional limits, including difficulties with stair climbing, vision, and cognitive functions (Yurtsever Kılıçgün, 2024).

Social support for families of children with disabilities

Upon receiving their child's diagnosis, parents make considerable efforts to address their developmental and educational requirements. Families may experience considerable financial and emotional challenges during this process. These challenges may be compounded when children have co-occurring conditions; for example, attention deficit hyperactivity disorder has been reported to be common among students with learning disabilities (Al-Shekaili et al., 2025). Families encountering diverse obstacles in domains such as information access, service use, financial strain, and social engagement also endure elevated stress levels (Copeland & Lasater, 2018; Emam et al., 2023; Priego-Ojeda & Rusu, 2023; Resch et al., 2010; Rose et al., 2025). These problems and the resulting stress highlight the need for social assistance within families. Lazarus and Folkman's (1984) theory of stress and coping posits that social support and resources are crucial in determining the emotion-focused and problem-focused strategies individuals employ in coping with stress. Social assistance may be provided by immediate family members, professionals, educational entities, nongovernmental organizations, municipal authorities, and healthcare institutions, as well as effectively exchanged among families with similar experiences. Individuals who undergo the same process can more effectively comprehend each other's requirements and provide guidance on the basis of their experiences. Ha et al. (2011) stated that social connections, experience sharing, and support sharing established with parents who have similar experiences are also important components of social support. Bronfenbrenner's (1979) ecological systems theory posits that individuals sharing similar experiences might unite to offer social assistance at the microsystem and mesosystem levels. In this environment, parents can unite to alleviate feelings of isolation, offer emotional support, exchange knowledge, and develop practical solutions to everyday challenges such as daycare and transportation.

Drawing on Lazarus and Folkman's Stress and Coping Theory and Bronfenbrenner's Ecological Systems Theory, this study views the institutional waiting room not simply as a physical space, but as a social setting in which coping resources and supportive relationships may develop. From a stress and coping perspective, informal exchanges among parents may support problem-focused coping through practical information sharing and emotion-focused coping through empathy and reassurance (Lazarus & Folkman, 1984). From an ecological perspective, repeated interactions in the waiting space may strengthen parents' immediate social environment and foster connections between family and service contexts (Bronfenbrenner, 1979). Together, these perspectives helped frame the focus of the study and guided the interpretation of the findings without predetermining the coding categories.

The literature usually features studies focused on offering social support to parents of children with disabilities who share comparable experiences. A study by Bray et al. (2017) demonstrated that peer support for parents of children with disabilities, facilitated through group gatherings, positively impacted their psychological distress and coping ability. A systematic study by Sartore et al. (2021) revealed that peer support therapies for parents and caregivers of children with disabilities enhanced emotional well-being, diminished

stress and anxiety, and markedly alleviated social isolation. Multiple studies have illustrated the beneficial effects of peer support interventions for parents of children with disabilities (Chakraborti et al., 2021; Collings et al., 2020; Hassanein et al., 2021; Lancaster et al., 2024; McCrossin & Lach, 2022). More recent evidence further supports the value of parent-to-parent peer support. A systematic review by Lancaster et al. (2023) found that peer-support programs may reduce parental distress and improve well-being and quality of life, although the authors emphasized the need for more rigorous research designs. Similarly, Postma et al. (2024) reported that individual parent-to-parent support may provide emotional, psychological, and practical benefits for parents of children with developmental disabilities. These recent findings reinforce the importance of shared lived experience as a central component of effective peer support. In several nations, initiatives have been developed to systematically provide such assistance. In the United States, national organizations (e.g., parent-to-parent USA) and federally funded programs (e.g., parent training and information centers) have been established to empower parents of children with disabilities (Dodds, 2021; Lee et al., 2024). Although state-sponsored family education, counseling, and parent-focused psychosocial programs are available in Türkiye, official programs primarily emphasize professional guidance and psychoeducation rather than structured parent-to-parent peer support (Ministry of National Education, 2025; Ministry of Family and Social Services, 2025). Nonetheless, while waiting for their children at special education and rehabilitation centers, families interact with others who have had similar experiences and discuss a range of issues. These spontaneous connections can evolve into informal social support mechanisms, fostering a sense of solidarity among parents.

While existing literature has extensively documented the benefits and psychosocial value of peer support for parents of children with disabilities (e.g., Bray et al., 2017; Sartore et al., 2021), much of this research has focused on intentional, formally organized, or professionally facilitated forms of peer support. Comparatively less attention has been given to how unstructured physical spaces within service institutions may naturally develop into informal psychosocial support environments. Studies conducted in Türkiye have frequently focused on parental burden, social isolation, and the broader need for social support (e.g., Bora, 2021; Şahin et al., 2025), but the relational processes through which shared waiting spaces facilitate naturally occurring peer connections remain insufficiently examined. Thus, an important gap remains in understanding how the experience of waiting, combined with repeated and unscripted encounters in a shared institutional setting, may contribute to the emergence of informal psychosocial support among parents. By examining repeated, naturally occurring interactions among parents in special education waiting spaces, this study extends the existing peer support literature beyond formally organized interventions and provides insight into parents' perspectives on how informal support emerges, what forms it takes, and what functions it serves within everyday institutional contexts.

The present study

Rather than examining peer support as a formally organized intervention, this study focuses on how repeated and unstructured encounters in institutional waiting spaces may give rise to informal psychosocial support among parents of children with disabilities. Specifically, it examines how a space primarily designed for waiting may acquire a secondary social function through shared experiences, repeated contact, and naturally occurring interactions among parents. In doing so, the study seeks not merely to demonstrate that parents provide support to one another, but to explore how parents perceive and describe the emergence of such support, the forms it takes, and the role of the institutional waiting environment. Accordingly, the study contributes to the peer support literature by shifting attention from organized support programs to the everyday relational processes through which informal support networks may develop within service settings. Accordingly, the study addressed the following research question: How do parents of children with disabilities describe the role of repeated interactions in special education and rehabilitation center waiting areas in the emergence and functioning of informal peer support?

Method

Research design

This study uses the case study method, a qualitative research approach. A case study facilitates a comprehensive examination of occurrences within their authentic context (Creswell, 2007; Merriam, 2013). Data were gathered from three separate special education and rehabilitation centers, with a focus on naturally occurring peer support among parents during their wait for their children. The case study design was selected because the study examined informal peer support within a specific, real-life institutional context. In this study, peer support was not a formal program but developed naturally among parents who regularly waited in the designated areas of special education and rehabilitation institutions. The case was bounded by the institutional setting, the

waiting areas, and the shared experience of parents waiting for their children. More specifically, the bounded case was defined as the naturally occurring informal interactions and peer-support experiences of parents who regularly remained in the waiting areas of special education and rehabilitation centers in Bilecik, Türkiye. The three participating centers were treated as institutional data-collection sites within the same bounded case rather than as separate cases. Accordingly, the study was not designed as a comparative multiple-case study. This design allowed us to examine how repeated interactions among parents contributed to information sharing, emotional support, and the development of social relationships. The inclusion of three special education and rehabilitation centers allowed the same phenomenon to be examined across different institutional settings while maintaining a common case boundary. Thus, the case study design was appropriate for understanding how and under what conditions informal peer support developed in these everyday institutional settings.

Study group

This study employed criterion sampling, a purposive technique, to select participants who fulfilled particular criteria corresponding to the research objective (Patton, 2014). The criteria set forth for this study were as follows: (a) being a parent of a child with a disability, (b) the child having been enrolled in the same special education and rehabilitation center for a minimum of one year, (c) waiting in the designated area of the special education and rehabilitation center, and (d) serving as the primary caregiver of the child, either as the mother or the father. The one-year enrollment criterion was adopted for three reasons. First, parents of newly enrolled children may still be experiencing the emotional impact of the diagnostic process. Second, they may not yet have adapted to the institutional environment. Third, they may not yet have had sufficient repeated contact with other parents in the waiting areas to describe informal peer interactions and their consequences.

This research was carried out in Bilecik, a relatively small province in Türkiye with a population of 228,495 (Bilecik Governorship, 2024). Bilecik Province has four independent special education and rehabilitation centers, each functioning in separate facilities. Three of these centers participated in the study, and each participating center contained at least one designated parent waiting area. The fourth center was visited and informed about the purpose of the study but declined to participate. Fourteen participants were recruited from Center 1, 16 from Center 2, and 10 from Center 3. All three centers were private institutions; public special education schools were not included because they did not have designated waiting areas for parents. In all three centers, the parent waiting area was a separate room within the institution, furnished with seating and tables. Children attended four to six 40-minute sessions per visit, so parents typically spent between 160 and 240 min at the center on each visit, two to four days per week. Although all centers offered transportation services, participating parents regularly chose to remain in the waiting areas during their children's sessions. These three centers served as separate data-collection sites within the same bounded case and were not conceptualized as independent cases Fig. 1.

During the study, all three participating centers were visited, and interviews were conducted with 40 volunteer parents. Of the 40 participants, 38 were mothers and two were fathers. Participants ranged in age from 24 to 52 years. Most participants were high school graduates, and their perceived household income levels were generally described as modest. The children with disabilities ranged in age from 2 to 19 years.



Fig. 1 Examples of parent waiting areas in the participating special education and rehabilitation centers

Data collection and ethical principles

Ethical approval for the study was obtained from the relevant institutional ethics committee prior to data collection (November 28, 2024; Decision No. 14/46).

This study included a demographic questionnaire and semistructured interviews for data collection. The demographic form comprised 14 closed-ended questions pertaining to both the parent and child, addressing variables such as gender, age, educational attainment of both parents, marital status, spouse's occupation, number of children, type of disability, child's age, age at diagnosis, and duration of enrollment in special education.

The semistructured interview format was created following a literature review and was assessed by four specialists, two in special education and two in child development. The experts validated its content and suggested minor grammatical adjustments, which were subsequently applied. The completed document comprised eight open-ended questions concerning parental interactions with other families throughout the waiting time, the nature and substance of these discussions, perceived advantages, and emotional effects. To avoid presupposing that interactions were beneficial, several questions explicitly invited both positive and negative accounts. For example, participants were asked whether they felt close to other parents or preferred to remain distant, whether they considered their conversations with other parents beneficial or harmful, and whether they would or would not like to increase these interactions, and why. The full interview guide is provided in Appendix.

A 22-minute pilot interview was conducted with the mother of a 7-year-old child with autism spectrum disorder. The questions were found to be clear and appropriate, leading to further interviews. The pilot interview was not included in the final dataset. Data were collected between May and July 2025. Prior to data collection, the researchers contacted the participating special education and rehabilitation centers by phone and visited the institutions to inform families about the study. The directors of the participating centers were informed about the study and facilitated initial contact only by introducing the researcher to parents in the waiting areas. After the director left, the researcher explained the study to parents without the presence of institutional staff and met individually with those who wished to participate. Informed consent was obtained by the researcher. Parents were explicitly informed, both verbally and in the written consent form, that participation was entirely voluntary, that declining to participate would have no effect on the services their children received, and that they could withdraw at any time without giving a reason. The institutions were not informed of which parents participated, and they had no access to the interview recordings or transcripts. Interviews were conducted individually in a private room, with only the researcher and the participant present. All eligible parents who were approached agreed to participate. Voluntariness at the institutional level was also evident in the fact that one of the four centers in the province declined to take part in the study. We acknowledge, however, that initial contact through institutional management may have created a subtle sense of obligation for some parents, despite these safeguards. No payment or other incentive was provided. Data collection continued until data saturation was reached, defined as the point at which no new relevant codes or themes emerged from the interviews. Data collection and analysis proceeded concurrently, and the researchers reviewed and updated the list of codes after each interview. No new codes emerged after the 35th interview; the remaining five interviews (36–40) produced only codes that had already been identified. Data collection was therefore concluded after the 40th interview, when data saturation was considered to have been reached (Francis et al., 2010; Guest et al., 2006). Individual interviews were held in designated rooms with parents who provided informed consent, including for audio recordings used only for transcription. The interviews lasted an average of 23 min and 13 s (range = 6–27 min), and only three interviews lasted less than 10 min. Although interview length varied considerably, shorter interviews were not automatically considered inadequate. The shortest interview was retained because the participant responded to all core interview questions, provided clear and relevant accounts of interactions with other parents, and addressed the key domains explored in the interview guide. Some participants expressed their experiences concisely and required fewer follow-up prompts, whereas others elaborated more extensively. Accordingly, interview adequacy was evaluated on the basis of the relevance, completeness, and substantive content of participants' responses rather than duration alone. Nevertheless, the relatively brief duration of some interviews is acknowledged as a limitation because it may have restricted the depth with which certain experiences were explored. The data collection was conducted by a researcher proficient in qualitative methods, residing in Bilecik—the study's target area—and possessing a thorough understanding of its social, cultural, and familial dynamics. This familiarity facilitated the establishment of trust and supported a more natural interview environment. Three researchers proficient in qualitative research cooperatively performed the data analysis. The interviewer holds a master's degree in child development and has experience using qualitative methods in previous

thesis and published research, including semistructured interviews and fieldwork. The interviewer's familiarity with the local context was considered both a strength and a potential source of bias. While it facilitated rapport and a natural interview environment, it also carried the risk that shared assumptions about local family dynamics could shape the questions asked and the interpretation of participants' accounts. Several steps were taken to address this. The interviewer had no prior personal or professional relationship with the participants or the participating centers. All interviews followed the same semistructured interview guide; follow-up probes were used only when responses required clarification and were formulated in a neutral, non-leading manner. After each interview, the interviewer recorded brief notes and kept a research journal documenting initial impressions and possible assumptions. During the analysis, the other two researchers, who did not conduct the interviews, resided outside Bilecik, and had no personal acquaintance with the participants, independently coded the transcripts and provided an outsider perspective. Coding disagreements and interpretations were discussed among the three researchers until consensus was reached.

Before each interview, the participants were informed about the study's purpose in a clear and understandable manner. Written and verbal consent was obtained voluntarily. The interviews took place individually in designated rooms within private educational institutions. The researcher took care to protect the participants' privacy, ensure their psychological well-being, and avoid influencing their responses. Audio recordings were used solely for transcription, and the content was anonymized for analysis.

The interview transcripts were independently analyzed by three researchers with experience in qualitative research. The researchers first reviewed the transcripts and identified codes based on the participants' accounts. Interrater agreement was assessed using the percentage agreement method. Agreement was recorded when all three researchers assigned the same code to a coding unit, whereas any discrepancy among the three coders was classified as disagreement. Percentage agreement was calculated using the formula Agreement / (Agreement + Disagreement) × 100. Of the 498 coding units, 436 were coded identically by all three researchers, yielding an overall agreement rate of 87.55%. Coding disagreements were subsequently discussed among the researchers until consensus was reached. In addition, Fleiss' kappa was calculated to account for chance agreement among the three coders (observed agreement = 0.910), yielding $\kappa = 0.880$, indicating almost perfect agreement (Landis & Koch, 1977).

To enhance the trustworthiness of the findings, the analysis involved independent coding by three researchers, comparison and consensus discussion of coding decisions, and reflexive consideration of potential interpretive bias. In addition, the findings were grounded in participants' accounts and supported with verbatim quotations to maintain a clear connection between the interpretations and the original data.

Analysis of data

All interviews with the parents were transcribed verbatim, without any alterations or corrections. All interviews were conducted in Turkish, the native language of both the participants and the researchers, and the analysis was carried out on the original Turkish transcripts. Only the quotations presented in this article were translated into English by one of the researchers. To ensure accuracy and preserve meaning, the translations were reviewed by a second person, and discrepancies were resolved through discussion. Minor grammatical adjustments were made to improve readability without altering the meaning of participants' statements. The researchers reviewed the transcripts several times. The data were analyzed using inductive content analysis; that is, codes were derived from the participants' accounts rather than from a predetermined coding scheme. The analysis proceeded in four steps. First, the three researchers read all transcripts several times to become familiar with the data. Second, each researcher independently assigned codes to the coding units, defined as meaningful segments of a participant's response expressing a single idea; a total of 498 coding units were identified across the 40 transcripts. Third, the researchers compared their codes, discussed discrepancies until consensus was reached, and agreed on a final list of 20 codes. Fourth, codes that were conceptually related were grouped into three categories (informational support, psychological cohesion, and social connection and adjustment) under the overarching theme of social support. The theoretical frameworks informed the interpretation of the categories but did not determine the codes. The findings were further enhanced by directly integrating the parents' views to guarantee that the participants' perspectives were represented. To protect confidentiality, each participant was assigned a code (P1–P40), and each quotation is reported with the participant's code, parental role, and center (e.g., P16, mother, Center 2). The main themes, categories, codes, and illustrative quotations are presented in Table 1.

In addition, during the revision process, all transcripts were re-examined specifically for negative, ambivalent, or limiting accounts of peer interaction, with particular attention to responses to the questions asking whether conversations with other parents were beneficial or harmful and whether participants would or would not like to increase these interactions. These accounts are reported in a separate subsection of the Results.

Table 1 Overview of the main themes and categories, codes and quotations

Theme	Category	Code	Quotations
Social Support	Informational Support	Health-related information	"They tell you things like 'go to this doctor,' 'visit that department,' or 'this doctor is better.' They were very helpful when it came to choosing a doctor." (P18, mother, Center 1)
		Child's development and education	"We talk about the children's developmental difficulties and problems." (P4, mother, Center 1)
		Child's diagnosis	"If a new family joins us, we ask about their child's diagnosis." (P29, mother, Center 1)
		Institutional procedures and processes	"We talk about the Guidance and Research Center and the assessment reports." (P27, mother, Center 3)
		Family attitudes, approaches, and behaviors	"I wasn't a patient person, but thanks to my friend, I've become much more patient." (P11, mother, Center 2)
		Daily life practices and home arrangements	"I also receive support on nutrition because these children often have a limited diet. We're trying to overcome that. Have you managed it? How did you do it? How can we make progress? We support each other in this way." (P4, mother, Center 1)
		Social resources and alternative support	"When they tell us about courses or events happening in the city, we go too." (P40, father, Center 1)
		Legal rights	"They told me to apply to social services and get a disability card so we did." (P33, mother, Center 2)
	Psychological Cohesion	Mutual understanding and empathy	"It's nice to have people who truly understand you." (P25, mother, Center 3)
		Emotional relief	"I feel better and more positive when I'm here." (P31, mother, Center 1)
		Providing moral support	"Being here lifts my mood." (P30, mother, Center 2)
		Sense of belonging	"That is why I do not feel alone." (P1, mother, Center 2)
		Hope for the future	"None of the families here are hopeless. We all give each other hope." (P8, mother, Center 3)
		Normalization of the caregiving experience	"At first, I was truly withdrawn and kept thinking I couldn't do it. However, now I've adjusted, and things are going truly well." (P17, mother, Center 1)
	Social Connection and Adjustment	Superficial conversations	"We talk with the other families, but the conversations don't go very deep." (P38, mother, Center 2)
		New friendships	"We're making new friendships here." (P12, mother, Center 3)
		Distant relationships	"I keep my distance from some of the families here." (P5, mother, Center 2)
		Regular social gatherings	"Sometimes we go on picnics or go fishing with the families here." (P34, mother, Center 1)
		Mutual support and solidarity	"I share what I have with her, and she shares what she has with me." (P23, mother, Center 2)
		Relationships developed through children's interactions	"We meet up with other families so the kids can connect with each other." (P10, mother, Center 3)

Results

The interviews identified three main categories within the theme of social support: informational support, psychological cohesion, and social connection and adjustment. The coding procedure was guided by participant statements. All categories and codes are illustrated in Fig. 2.

Informational support category

The Informational Support category illustrates how parents use their shared waiting time to exchange practical, experience-based knowledge across multiple areas of caregiving. As presented in Table 1, these exchanges included health-related information, child development and education, diagnosis, institutional procedures, family attitudes and behaviors, daily life practices, social resources, and legal rights. Rather than functioning as isolated topics, these forms of information sharing collectively provided parents with an accessible source of practical guidance grounded in the experiences of others facing similar circumstances.

A substantial part of this support concerned children's health, diagnosis, development, and education. Parents exchanged recommendations about physicians and services, discussed developmental and educational challenges, and drew on the experiences of parents whose children had similar diagnoses. As one parent explained, "*There is a parent here who is slightly more experienced than us; their child also has Down syndrome and is older than our children. They have always supported us.*" *(P16, mother, Center 2).* Such exchanges suggest that experiential knowledge from other parents may become particularly meaningful when families are navigating uncertainty surrounding diagnosis and intervention.

Informational support also helped parents navigate institutional procedures, social resources, and legal entitlements. Parents shared information about assessment reports, hospital procedures, available services, disability-related benefits, and opportunities that some families had previously been unaware of. One participant stated, "*We were unaware of some of our rights before coming here. We did not know about the free education and courses that children could benefit from. As we came here, we learned from other parents and from each other, and we are now benefiting from it.*" *(P22, mother, Center 3).* In this sense, informal peer interaction functioned not only as information exchange but also as a practical resource for navigating complex service systems.

Finally, parents exchanged strategies related to family attitudes, behavioral challenges, nutrition, screen use, and other aspects of everyday life. These discussions indicate that informational support extended beyond formal services and into the daily realities of caregiving. Taken together, the findings suggest that the informational function of these interactions lies not simply in the amount of information exchanged, but in the accessibility and experiential relevance of knowledge shared by parents who are confronting similar challenges.

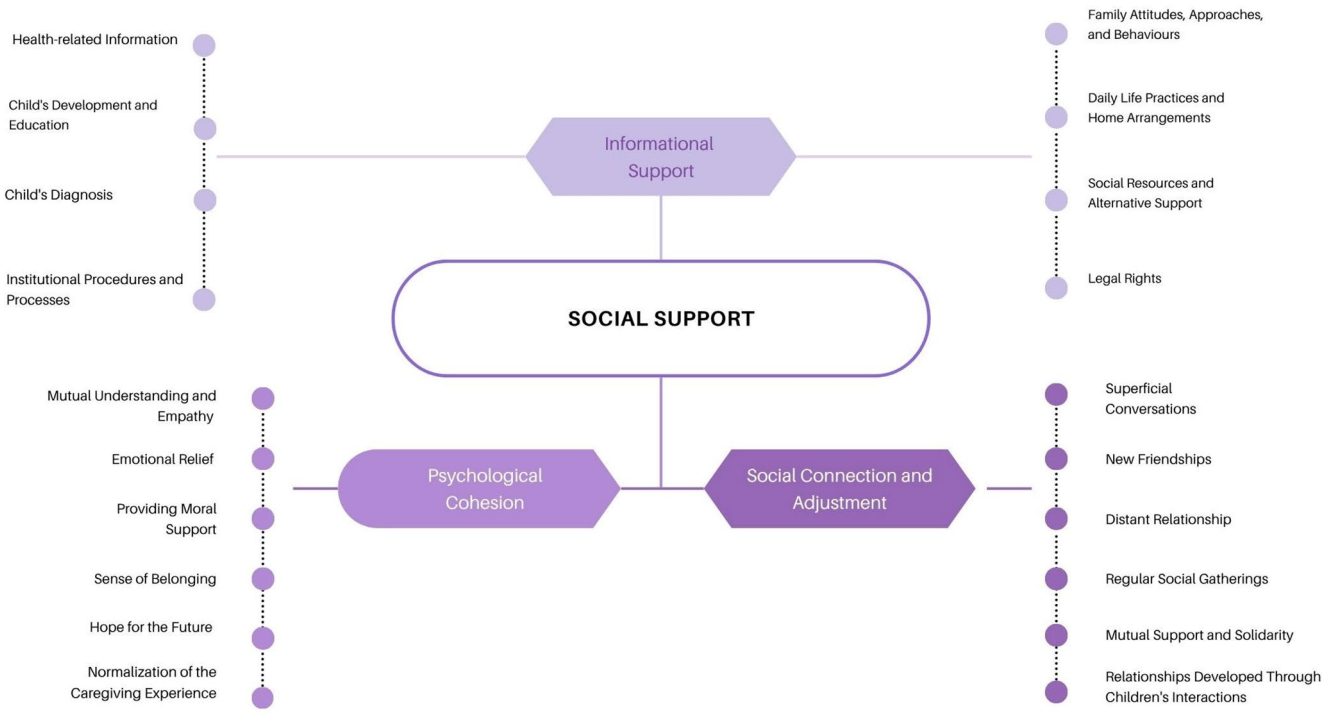

Fig. 2 Categories and codes obtained from the analysis of the interviews

Psychological cohesion category

Psychological Cohesion emerged as a central psychosocial function of the informal interactions among parents. As shown in Table 1, this category included reciprocal understanding and empathy, emotional relief, moral support, belonging, hope for the future, and normalization of the caregiving experience. Rather than representing separate emotional reactions, these experiences appeared to form an interconnected process through which parents felt understood, emotionally supported, and less isolated.

A particularly important aspect of this process was the sense of being understood by others who had faced similar challenges. Shared experience appeared to create a form of mutual recognition that parents did not always encounter in their wider social environments. One participant described the other parents as a "second family" and stated, "*I can cry on their shoulders because they understand me without judging me.*" *(P3*, *mother*, *Center 1)*. Such accounts indicate that empathy within these informal relationships may reduce emotional isolation and create a psychologically safe space for expressing distress.

Emotional relief was also closely linked to belonging and hope. Parents described feeling more positive after conversations, receiving encouragement from more experienced families, and recognizing that they were not alone in their difficulties. As one participant stated, "*I realized I am not alone. Everyone experiences similar things*, *not just me.*" *(P39*, *mother*, *Center 3).* Observing the progress of other children and hearing the experiences of other families also appeared to strengthen optimism about the future.

Several parents also described, retrospectively, how their experiences had changed over time, linking repeated interactions with other parents to normalization and psychological adjustment (e.g., P17, mother, Center 1). Experiences that were initially perceived as overwhelming or isolating became more understandable when parents encountered others living through similar circumstances. In this sense, Psychological Cohesion may be interpreted as more than emotional reassurance; it reflects a process through which shared experience, empathy, belonging, and hope collectively contribute to parents' psychological adaptation.

Social connection and adjustment category

Social Connection and Adjustment reflects the relational dimension of informal peer support and the varying degrees of social closeness that developed among parents in waiting spaces. As presented in Table 1, interactions ranged from superficial conversations and deliberately distant relationships to new friendships, routine gatherings, reciprocal collaboration, and relationships extending beyond the institution. Rather than representing a uniform outcome, these patterns suggest a relational continuum in which repeated contact may create opportunities for connection, while the depth of that connection depends on parents' willingness, trust, and perceived compatibility.

Importantly, repeated physical proximity did not necessarily lead to meaningful social bonds. Some parents described interactions as limited, superficial, or obligatory. One participant stated, "*We keep our distance. You are only here because you have to be*, *and you feel obliged to chat*, *but I would call it a forced conversation.*" *(P9*, *father*, *Center 2)*. Such accounts indicate that shared space alone is insufficient to generate peer support and that some parents may intentionally maintain interpersonal boundaries.

For other parents, however, repeated encounters gradually developed into routines, friendships, and reciprocal relationships. Parents described how shared activities, practical exchanges, and regular meetings turned waiting time into a form of social participation. Parents described sharing food, clothes, information, and even medication when needed, suggesting that relationships could move beyond emotional companionship toward concrete forms of mutual assistance.

Children's interactions also served as an important pathway through which relationships between parents were initiated or strengthened. As children played or spent time together, parents gained additional opportunities to meet outside the institution and maintain contact. Taken together, these findings suggest that Social Connection and Adjustment represents the relational process through which repeated encounters may remain superficial for some parents but develop into trust, reciprocity, friendship, and sustained social bonds for others.

Ambivalent and limiting aspects of peer interaction

Although the interview guide explicitly asked whether conversations with other parents were beneficial or harmful, none of the participants described direct conflict, gossip, or exclusion by other parents; exclusion was mentioned only in relation to relatives, and several participants stated explicitly that these interactions had not been harmful. Nevertheless, participants' accounts revealed several ambivalent and limiting aspects. First, exposure to other families' difficulties could be emotionally burdensome: "Sometimes I am affected by the situations of the children of friends I feel close to; I cry, and for two or three weeks my mind stays with them. I can take on my friend's burden" (P35, mother, Center 1). Some parents therefore deliberately limited their involvement: "I can no longer tolerate even the smallest negativity; I don't want to hear anything bad" (P3, mother, Center 1). Second, maintaining relationships was

described as demanding: "Keeping up relationships with everyone is very tiring. We are already very busy with our children, and we don't have much time" (P1, mother, Center 2). Third, parents were selective about whom they engaged with: "Not everyone has to get along with everyone. There are inevitably people we don't connect with; you just say hello to them" (P34, mother, Center 1). Fourth, social comparison was common and double-edged. Many parents described feeling grateful when they encountered children with more severe difficulties, yet such encounters could also be distressing ("Sometimes it makes you sad and affects you; I don't want to encounter such things too often," P30, mother, Center 2), and seeing older children with the same diagnosis could raise worries about the future ("Will mine be like this when he grows up? Will he become aggressive?" P35, mother, Center 1). Finally, participants recognized that informally exchanged information was not always reliable: "Since everyone has a different opinion, you shouldn't take all of it into account; what worked for them may not work for us" (P38, mother, Center 2). Some parents described filtering such advice through their own judgment, but advice also extended to medication use, suggesting that inaccurate or potentially risky information may circulate within these networks.

Discussion and recommendations

This study explored how parents described naturally occurring interactions in special education and rehabilitation center waiting areas and the informal peer support they perceived to emerge from these interactions. The findings revealed three interconnected dimensions—informational support, psychological cohesion, and social connection and adjustment—suggesting that waiting spaces can acquire a psychosocial function when repeated encounters enable information exchange, emotional recognition, and relational continuity. Importantly, this process was not universal; some parents maintained interpersonal distance or experienced interactions as superficial.

Parents communicate and share counsel concerning their children's health, growth, education, and diagnoses, as well as thoughts on institutional procedures, familial perspectives, everyday living, social resources, and legal entitlements. The breadth of information exchanged may reflect gaps in parents' access to timely, accessible, and experience-relevant guidance. Parents without sufficient direction from official institutions concerning the diagnostic process and access to suitable therapeutic and educational choices often turn to other families with comparable experiences for information (Al-Daihani & Al-Ateeqi, 2015). In Türkiye, substantial disparities and inequalities exist at both the policy and implementation levels regarding the provision of accurate, legal, and accessible information to parents of children with disabilities (Kerkez & Birimoğlu Okuyan, 2025; Sani-Bozkurt et al., 2022; Sardohan-Yıldırım & Akçamete, 2014). Consequently, parents may view other families with similar experiences who attend the same institution as readily accessible sources of practical knowledge. Because all participants had attended their center for at least one year, many described informal support from the dual perspective of former newcomers and current experienced parents. Some accounts referred retrospectively to the early period of enrollment (e.g., "At first, I was truly withdrawn and kept thinking I couldn't do it"; P17, mother, Center 1), and parents also described initiating contact with families who had recently joined the center (e.g., "If a new family joins us, we ask about their child's diagnosis"; P29, mother, Center 1). This suggests that experienced parents may act as informal guides for newcomers, although the perspectives of newly enrolled parents themselves were not captured in the present study. These interactions mitigate challenges in information availability and enhance stress management (Alsem et al., 2017). Mackintosh et al. (2005) discovered that parental information exchange is prevalent and regarded as more trustworthy and practical than information acquired from professionals. Ainbinder et al. (1998) also highlighted in their study that parents regard one another as "reliable allies" and that the exchange of information between parents represents an important form of support. Consistent with these studies, the present findings indicate that parents valued information derived from lived experience because it was immediately applicable to everyday caregiving and service-navigation challenges. However, unlike studies examining formally organized peer-support programs, the information exchange identified here emerged spontaneously through repeated encounters in institutional waiting spaces. This distinction suggests that practical peer knowledge may develop even in the absence of structured facilitation.

The second category identified in the study is psychological cohesion. In this situation, parents express empathy, offer emotional support, bolster one another's morale and optimism, perceive a sense of solidarity, and normalize the experience through conversations in waiting areas. Families of children with disabilities derive essential psychological support from these social relationships. These families often encounter social marginalization and isolation, resulting in psychological effects (Baumgardner, 2019; Currie & Szabo, 2020). These informal gatherings of parents with shared experiences may provide emotional relief and psychological support. Lumsden et al. (2019) asserted that parents developed a sense of hope and regarded the process as more manageable due to emotional support. Collings et al. (2020) and Chakraborti et al. (2021) highlighted that

these relationships positively influence the sense of belonging, emotional solidarity, and normalization of experiences. Lancaster et al. (2024) demonstrated that peer support programs significantly enhance parents' psychological well-being and self-efficacy over time. The present findings are broadly consistent with this literature, particularly regarding emotional relief, belonging, normalization, and hope. A notable distinction, however, is that these psychosocial benefits were reported within naturally occurring relationships rather than within professionally facilitated or formally organized support programs. This suggests that repeated informal contact with parents who share similar experiences may itself function as an accessible psychosocial resource. These findings indicate that natural surroundings, such as waiting spaces, serve as sources of knowledge and functional social networks that offer emotional support.

The third category identified in the study is Social Connection and Adjustment. Families with similar experiences in the same special education setting may develop social closeness and form strong relationships. Many participants indicated that they had established new friendships, convened regularly, and fostered a spirit of sharing and unity. Some parents described these peer relationships as especially close, in some cases comparing them favorably with relationships in their wider family networks. Such accounts suggest that shared experiences may foster a distinctive sense of understanding and closeness among some parents. Gorlin et al. (2016) reported that this circumstance has increased the significance of friendship dynamics, known as 'blended families.' Mueller et al. (2009) discovered that parents regard other families in support groups not as friends but as family members. Conversely, certain people prefer to maintain more distant social relationships, potentially due to social reticence, trust deficits, or adverse social encounters (Currie & Szabo, 2020). Importantly, physical proximity alone does not guarantee meaningful peer support. Some interactions remain superficial or obligatory, suggesting that informal support may depend on interpersonal dynamics—such as trust, reciprocity, and readiness to engage—rather than mere spatial co-location. These findings both support and extend previous research. Similar to earlier studies, some parents described strong relational bonds and a sense of family-like closeness, whereas others preferred limited or distant interaction. The coexistence of these patterns is important because it indicates that informal peer support should not be understood as an inevitable outcome of shared space. Rather, the present findings suggest that repeated contact creates an opportunity for support, while trust, reciprocity, personal preference, and willingness to engage appear to shape whether such interactions develop into meaningful relationships. Consequently, institutional waiting spaces may function differently across parents, fostering meaningful support for some while remaining emotionally neutral or less supportive for others. Moreover, the obligation to care for a child with a disability constrains parents' time and energy, hindering their ability to form social connections, which may further reduce opportunities for social participation and the development of supportive relationships (Caicedo, 2014; Mikolajczak et al., 2019).

Two levels of evidence should be distinguished in interpreting these findings. At the level of what participants directly reported, the three categories were often intertwined within the same accounts. For example, a parent who described receiving guidance from a more experienced parent also described this relationship as a continuing source of support (P16, mother, Center 2). Some participants also described changes in their own experience retrospectively, such as feeling withdrawn when they first arrived and more adjusted after repeated contact with other parents (P17, mother, Center 1). At the level of interpretation, we propose that the three categories may operate as mutually reinforcing processes. Repeated encounters may first create opportunities for practical information exchange; as parents recognize shared experiences, such exchanges may contribute to emotional relief and reassurance; and these experiences may, in turn, strengthen belonging and trust, allowing some relationships to become more enduring. From a stress and coping perspective, this interpretation suggests a movement from access to practical coping resources toward emotional regulation and perceived support (Lazarus & Folkman, 1984), whereas an ecological perspective highlights how repeated interactions within a shared institutional setting may create a supportive relational environment (Bronfenbrenner, 1979). However, this proposed sequence is a theoretical interpretation derived from participants' retrospective accounts collected at a single point in time. The present design cannot establish the temporal order of these processes or causal relationships among them, and longitudinal and observational studies are needed to examine whether informal peer support develops in this way.

Viewed together, participants' accounts suggest that waiting areas may function as informal psychosocial micro-communities. Parents described repeated co-presence, shared experiences, information exchange, emotional recognition, and reciprocal support, suggesting that a space originally intended only for waiting may also serve as a relational environment with its own routines, expectations, and supportive ties. Importantly, this function is not automatic, as some parents remain distant or experience interactions as superficial. Thus, the psychosocial function of the waiting space emerges through repeated and meaningful interaction rather than through physical proximity alone.

The findings also extend the two theoretical frameworks that guided the study. With respect to Lazarus and Folkman's

(1984) Stress and Coping Theory, the Informational Support exchanged among parents may facilitate problem-focused coping, whereas the empathy, emotional relief, and encouragement reflected in Psychological Cohesion may support emotion-focused coping. However, the findings suggest two refinements. First, coping resources are typically conceptualized as being mobilized through deliberate help-seeking, whereas the support described here became available largely without being sought, as a by-product of repeated co-presence in a shared setting. This suggests that the physical and temporal organization of everyday settings may determine which coping resources are available, independently of individuals' intentional coping efforts. Second, the same interactions often served problem-focused and emotion-focused functions simultaneously and could also carry costs. Social comparison with other families, for example, frequently enabled positive reappraisal of parents' own circumstances (Wills, 1981), but exposure to other families' difficulties could also be emotionally burdensome or raise worries about the future. Peer interaction may therefore be better understood as a coping resource with both benefits and costs, whose net effect depends on parents' emotional resources and on their ability to regulate their level of involvement. This is consistent with the view that support from experientially similar others operates partly through empathic understanding and social comparison (Thoits, 2011), while highlighting that these same mechanisms can also increase emotional strain.

With respect to Bronfenbrenner's (1979) Ecological Systems Theory, institutions such as special education and rehabilitation centers are usually conceptualized as microsystems of the child. The present findings suggest that the waiting area, a space not designed for parents' social needs, may come to function as a secondary microsystem for parents themselves, in which recurring face-to-face interactions, roles (e.g., experienced parents guiding newcomers), and relationships develop. At the same time, this setting appeared to act as a mesosystemic link between the family and the wider service system, as information about assessment procedures, reports, services, and legal rights circulated among parents. Taken together, these observations suggest a proposition for future research: service settings designed for children may generate derivative microsystems for their caregivers, and the spatial arrangements and routines of these settings may shape caregivers' access to coping resources. Future studies could test this proposition by comparing settings that differ in the availability and design of waiting spaces.

Consequently, parents described the organic connections formed while awaiting their children as providing multifaceted types of social support, including informational assistance, psychological cohesion, and social bonding. Translating these findings into practice, however, involves a tension: the support described by parents appeared to derive much of its value from being spontaneous, voluntary, and parent-driven, and formal institutional structures could alter these qualities. Organized activities may introduce expectations of participation, make parents who prefer limited interaction feel pressured, blur interpersonal boundaries, and raise concerns about confidentiality when personal experiences are shared in institutionally arranged settings. Institutions should therefore aim to facilitate rather than formalize peer support. At the environmental level, waiting areas could be designed to allow both interaction and privacy, for example by providing comfortable shared seating alongside quieter spaces and by offering accessible information on services and rights. Any more structured opportunities, such as optional parent meeting groups, should be parent-led, clearly voluntary, and free of any link to children's services, and they should not replace the informal interactions that occur naturally in waiting areas. Similarly, experienced parents who wish to welcome newly enrolled families could be supported to do so informally, as "parent support ambassadors," with clear boundaries regarding confidentiality and the limits of their role, and without being expected to provide professional advice. Professionals could remain available on request to help parents verify health-, education-, and rights-related information exchanged informally, without taking control of these interactions. At the policy level, the Ministry of National Education (2025) and the Ministry of Family and Social Services could consider parent-to-parent initiatives as a complement to existing professional programs. Future research should examine whether and how such initiatives can be introduced without undermining the spontaneity, autonomy, and informal character that parents valued in naturally occurring peer support.

Limitations

Several limitations should be considered when interpreting the findings. First, the study was conducted in Bilecik, Türkiye, and the findings are therefore context-specific and should not be generalized beyond similar institutional and sociocultural settings without caution. Second, the gender distribution of the sample was highly unbalanced: 38 of the 40 participants were women and only two were fathers. Consequently, the findings predominantly reflect mothers' experiences and perspectives regarding informal peer support in institutional waiting spaces. The limited representation of fathers restricts the extent to which the findings can capture possible gender-related differences in how parents initiate, experience, or interpret informal peer support. Future studies should therefore seek more gender-balanced samples and

examine whether mothers and fathers differ in their patterns of peer interaction and support. Third, the inclusion criteria required participants to regularly remain in the institutional waiting areas. This may have introduced selection bias, as parents who stay in these spaces may be more willing or able to engage with other parents than those who leave the institution during their children's sessions. Therefore, the experiences of parents who do not routinely use waiting areas may not be represented in the findings. In addition, although the one-year enrollment criterion was adopted to ensure that participants had adapted to the institutional environment and had sufficient experience of interacting with other parents, it excluded parents in the early stages of diagnosis and service navigation. The support needs of these parents may be more urgent and qualitatively different, for example involving a greater need for basic diagnostic and procedural information and for emotional reassurance. The findings may therefore primarily reflect the perspectives of more experienced parents, who could describe peer support both as former newcomers and as current providers of support. Future studies should include newly enrolled parents to examine how informal peer support is experienced at the point of entry into special education services. Moreover, given the qualitative case-study design and its focus on a specific institutional and regional context, the findings are not intended to be statistically generalized to other special education institutions or regions. Furthermore, participants' children varied considerably in age (2–19 years), diagnosis, and duration of service use. Because the study was designed to explore how informal peer support emerges rather than to compare subgroups, the forms of support were not examined according to these characteristics. Future studies could investigate whether the nature and intensity of peer support differ by child age, diagnosis, duration of service use, or other family characteristics. In addition, the three centers were treated as data-collection sites within a single case, and a systematic center-level comparison was not conducted. Because all centers were structurally similar private institutions, the findings may not reflect settings with different physical arrangements or public institutions. Future studies could compare institutions with differing spatial and organizational characteristics. Fourth, although interviews lasted an average of approximately 23 min, three interviews lasted less than 10 min. Although these interviews addressed all core interview questions and data adequacy was assessed at the level of the overall dataset, their brevity may have limited the depth with which some participants' experiences, particularly more complex experiences such as belonging, trust, and normalization, could be explored. In addition, although several safeguards were used to protect voluntariness, the fact that initial contact was facilitated by center directors and that all approached parents agreed to participate may indicate some degree of social desirability or perceived obligation, which could have contributed to the predominantly positive accounts. Finally, the study relied on parents' self-reported, retrospective interview accounts rather than direct observation of interactions in the waiting areas. Future research combining interviews with naturalistic observation or longitudinal approaches could provide a more detailed understanding of how informal peer support develops and changes over time.

Appendix A

Semistructured interview guide

Instruction: "I am going to ask you some questions. When answering, please consider the interactions you have with other parents while waiting for your child at the special education and rehabilitation center."

1. Do you talk with other families while waiting for your child at the institution? What kind of communication do you have with these families? How would you describe this communication?
2. Do you feel close to the other families here? Are you like friends, or do you remain more distant? How would you describe this relationship?
3. What do you usually talk about with other families while waiting for your child? What topics do you discuss?
4. Do you think your conversations with other families are beneficial or harmful to you? If you think they are beneficial or harmful, could you explain in what ways?
5. Have you learned any new information from other families? What kind of information? Did this information contribute to your child's development and education? Did it contribute to your family life, and if so, how?
6. How does talking with the parents here make you feel? Do these conversations provide you with emotional or psychological support? Could you tell us about it?
7. Would you like to increase or improve your interactions with other parents in the waiting area? Why or why not?
8. Is there anything else you would like to add or any experience you would like to share?

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Declarations

Ethical approval This study was approved by the relevant ethics committee and was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was granted by the Scientific Research Ethics Committee of the University of Health Sciences on November 28, 2024 (Approval No. 33822).

Informed consent Informed consent was obtained from all participants included in the study.

Consent to publish The authors give their consent for the publication of this manuscript in the journal if it is accepted for publication.

Conflict of interest The authors declare that there is no conflict of interest.

Use of generative AI During the preparation of this manuscript, the authors used generative AI tools to support translation, language editing, and the identification of relevant literature. The authors checked all sources suggested by these tools against the original publications. No AI tools were used for data collection, data analysis, or the interpretaion of findings. The authors reviewed and edited all content and take full responsibility for the content of the publication.

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