Navigating Adolescence: Lived Experiences and Psychological Support Needs of Individuals with Special Needs

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ABSTRACT

This study aims to explore the experiences and support needs of parents raising adolescents with special needs during adolescence. The research was designed within a phenomenological qualitative framework. The participants consisted of 12 parents eight mothers and four fathers of children diagnosed with autism spectrum disorder, hearing impairment, intellectual disability, or physical disability. Data were collected through semi-structured interviews and analyzed using a thematic analysis approach. Five main themes were identified: (1) parents' perspectives on their children's adolescence, (2) the impact of disability type on the adolescent experience, (3) parental reactions, (4) transformations in parental roles, and (5) information and support needs. The findings indicate that adolescents with special needs undergo similar physical, emotional, and behavioral changes to their typically developing peers; however, the ways these changes are expressed vary depending on disability type, communication skills, and social context. Parents reported difficulties in distinguishing whether certain behaviors stemmed from adolescence or from the child's disability. Additionally, lack of information, limited access to professional support, and insufficient social support emerged as significant challenges in managing this developmental period. The results highlight parents' need for systematic information and training programs, access to multidisciplinary professional guidance, and robust social support networks. Strengthening parental guidance plays a critical protective role in ensuring that adolescents with special needs experience a safe and healthy developmental transition.

Keywords: Adolescence, Individuals with Special Needs, Parental Experiences, Support Needs

INTRODUCTION

From infancy onward, individuals must acquire specific skills to effectively cope with the challenges they encounter throughout life and maintain their well-being. Adolescence is a particularly critical period in this regard, as it constitutes a stage of physical, cognitive, and socio-emotional maturation. Accomplishing the developmental tasks of this period plays a key role in shaping individuals' future lives. Undoubtedly, adolescence is one of the most dynamic phases of human development. While physical changes are visibly rapid, they are accompanied by transformations in other developmental domains as well. As individuals enter adolescence, they experience changes not only in their bodies and bodily functions but also in their cognitive abilities, modes of thinking, value systems, moral reasoning, personality, and social relationships. Although these transformations occur in youth with special needs in ways similar to their typically developing peers, their manifestation may also be shaped by the specific nature and consequences of their disabilities. These differences naturally influence both how adolescents perceive themselves and how others perceive them (Bartin, 2020; Stankova & Trajkovski, 2021).

Adolescence is a challenging yet natural and essential developmental period during which individuals must cope with a wide range of issues. This period also involves notable gender-related differences. The onset and conclusion of adolescence may vary depending on cultural, social, geographical, and climatic factors. Human development is characterized by continual change and growth, with the most profound developmental shifts occurring during adolescence. Due to the rapid physical, cognitive, and socio-emotional changes experienced during this stage, it is often considered a period of instability for young people (Gander & Gardiner, 2004). Defining the exact age boundaries of adolescence is a complex process. UNESCO identifies adolescence as spanning ages 15 to 25. At the same time, the World Health Organization defines it as a transitional stage from childhood to youth, between ages 10–19, and youth as ages 15–24, with young people encompassing ages 10–24 (Özmen, Çetinkaya, & Akil, 2016). Factors such as geographic climate, genetic structure, socioeconomic conditions, and individual differences influence the onset of adolescence. This stage is characterized by physical, sexual, and psychosocial changes, and adolescents are expected to adapt to these changes, establish their identities, and adopt behaviors that align with their gender and societal expectations (Thomas et al., 2016).

The American Psychiatric Association (APA, 2021) defines adolescence as a period of multidimensional development, encompassing sexual, physiological, social, and cognitive domains, typically occurring between the ages of 10 and 19, while acknowledging individual differences. Often conceptualized as a turbulent transition to adulthood, adolescence involves not only psychological changes but also biological and social transformations that profoundly affect individuals (Özteke Kozan & Hamarta, 2019). Adolescents with special needs often face greater challenges in accessing accurate and high-quality information, particularly regarding sexual development (Çifci Tekinarslan & Eratay, 2013). They may struggle to understand when, where, and under what circumstances gender-appropriate behaviors should be displayed. Additionally, due to the impact of their disabilities, they may not perceive socio-cultural cues through observational learning in the same way as their typically developing peers. Although children with special needs may differ in other developmental areas, it has been noted that they undergo similar processes to their peers during adolescence (Güven, 2021). Typically developing adolescents often acquire information about adolescence through peers, parents, and environmental observation. In contrast, adolescents with special needs may be at increased risk of engaging in unsafe sexual behaviors and may face various physiological and psychological challenges, including heightened vulnerability to diseases (Maart & Jelsma, 2010). Consequently, these adolescents require the guidance of parents and teachers to navigate this period safely and effectively.

A review of the international literature (Kenny et al., 2021; Mackin et al., 2016; Reaven et al., 2009; Stankova & Trajkovski, 2021; Stokes, Newton, & Kaur, 2007) reveals that parents of children with special needs often express concerns regarding their children's adolescent developmental processes and report that their children have more limited interactions with their environments than typically developing peers. Parents also report a need for psychological support, including sexual education, developmental guidance, and mental health assessments. Research conducted in Turkey similarly focuses on identifying parents' knowledge and attitudes toward their children's adolescence (Bartin, 2020; Çifçi Tekinarslan & Eratay, 2013; Doğru & Yıldırım Doğru, 2021; Güven, 2021). Overall, findings indicate that adolescents with special needs require support in various domains, particularly sexual education and self-care skills. Parents often lack formal education on these topics and rely primarily on personal experiences. At this point, it is emphasized that raising a child with special needs entails specific educational and psychological requirements (Oktar & Yıldız, 2019).

Adolescence, characterized by the intertwining of physical, sexual, and psychosocial changes, requires adolescents to adapt, develop their identities, and conform to societal expectations. Even for typically developing adolescents, adjusting to the psychological and physiological changes of this period can be challenging; for adolescents with special needs, these challenges can be particularly intense. The developmental changes experienced during adolescence often compel parents—who may have previously adapted to their child's special needs—to re-engage in a demanding adjustment process. This can diminish parents' coping abilities, leading some to withdraw socially, avoid sharing their difficulties with other family members, and face severe mental health problems such as depression (Bartin, 2020; Stankova & Trajkovski, 2021). To address these issues effectively, it is crucial to identify parents' current experiences and support needs. Based on these considerations, the present study aims to examine the experiences of parents of adolescents with special needs during their children's adolescence and to identify their psychological support needs.

What are the experiences of parents of adolescents with special needs regarding their children's adolescence?

How does the type of special need shape parents' experiences and perceptions of the adolescent developmental process?

How do these experiences and needs differ according to parental role (mother/father) and the child's type of special need?

METHOD

Research Design

This study employed a phenomenological research design and a qualitative research approach. Phenomenology aims to reveal individuals' subjective experiences of a specific phenomenon and the meanings they attribute to these experiences. In this context, the central phenomenon of this research is the perceptions and interpretations of parents of adolescents with special needs regarding their children's adolescence. The study was structured in two stages to identify both the shared essence of the phenomenon and its contextual variations based on parental role (mother or father) and type of disability (Autism Spectrum Disorder [ASD], Hearing Impairment [HI], Intellectual Disability [ID], and Physical Disability [PD]): Identifying the shared phenomenon: In the first stage, experience patterns common to all participants were identified, independent of parental roles and disability types. Deepening contextual variations: The second stage examined how the shared phenomenon manifested differently across parental roles and various types of disabilities. The purpose of this second stage was not to compare the core of the phenomenon but to enrich its meaning by describing the different ways it was experienced in distinct contexts.

Participants

Participants were selected through maximum variation sampling, ensuring diversity in parental roles and the types of disabilities among children. This diversity was intentionally sought to enable a comprehensive understanding of both the shared dimensions of the phenomenon and its contextual variations. The study group consisted of 12 parents of adolescents with special needs (eight mothers and four fathers). The distribution of their children's disability types was as follows: 3 parents of children diagnosed with Autism Spectrum Disorder (ASD), 3 parents of children with Hearing Impairment (HI), 3 parents of children with Intellectual Disability (ID), and 3 parents of children with Physical Disability (PD). Including three parents from each disability category was not intended for intergroup generalization; instead, it aimed to generate context-specific insights. Demographic information about the participants is presented in Table 1.

Table 1. *Demographic Information of Participants*

Participant	Age	Gender	Marial Status	Type of Child's Disability	Educational Setting of the Child	Child's Age
A1	42	Female	Married	HI	School for the Hearing Impaired (Boarding)	13
A2	53	Female	Married	HI	School for the Hearing Impaired (Boarding)	15
A3	45	Female	Married	HI	Inclusive Education	14
A4	62	Female	Married	ASD	Special Education School	20
A5	51	Female	Divorced	ID	Special Education School	17
A6	42	Female	Married	ID	Special Education School	15
A7	64	Female	Divorced	PD	Inclusive Education	20
A8	57	Female	Married	PD	Inclusive Education	16
B1	49	Male	Married	ASD	Inclusive Education	18
B2	55	Male	Married	ASD	Special Education School	14
B3	59	Male	Married	ID	Special Education School	19
B4	52	Male	Married	PD	Inclusive Education	15

Data Collection Instruments and Procedure

Data were collected through semi-structured interview forms developed by the researchers. Three subject-matter experts reviewed the interview questions, and based on their feedback, two pilot interviews were conducted to refine the language, question sequencing, and overall flow for improved clarity and coherence. Subsequently, two rounds of interviews were conducted with each participant. Interviews took place in settings where privacy could be ensured, such as participants' homes, the researchers' offices, or cafés, depending on the participants' preferences.

First-stage interviews (shared phenomenon):

The first-stage interview protocol addressed parents' observations of developmental changes during adolescence, shared responses, parental roles, support needs, and issues of privacy. Additionally, themes spontaneously raised by participants during the interviews such as those related to social media—were incorporated into the analysis even if they were not included in the original questions.

Second-stage interviews (contextual elaboration):

The second stage explored how the shared themes identified in the first stage varied according to parental role (mother/father) and type of disability (Autism Spectrum Disorder [ASD], Hearing Impairment [HI], Intellectual Disability [ID], and Physical Disability [PD]). During these interviews, participants were invited to revisit experiences they had previously shared and to elaborate on how these experiences might have been shaped by their child's disability type or their parental role. Probing questions included examples such as: "Which aspects of this experience do you associate with your child's [diagnosis]?" and "How did being a mother/father shape your responsibilities during this process?"

First-stage interviews lasted between 40 and 55 minutes (average ≈ 48 minutes), while second-stage interviews lasted between 30 and 45 minutes (average ≈ 37 minutes), totaling approximately 17 hours of recorded data. All interviews were audio-recorded with participants' consent. Demographic information was collected through a separate form (see Appendix 2), which covered variables such as parental role, marital status, child's diagnosis, age, educational placement (e.g., mainstream inclusion, special education, schools for the deaf), and other sociodemographic characteristics. In addition to interview recordings, researchers maintained journals throughout the data collection process. These journals included pre- and post-interview observations, emotional reactions, reflections on perceived biases, and methodological notes.

Data Analysis

Interview data were analyzed using thematic analysis in line with the core principles of phenomenological research. The analytical process was structured to mirror the study's two-stage design. Prior to data collection, each researcher documented their existing thoughts, expectations, and assumptions in a journal, which was continuously updated throughout the research process. Initial coding and identification of main themes were carried out following the first-stage interviews, after which the second-stage interviews commenced. All audio recordings were transcribed verbatim by three researchers, and a separate file was created for each participant. The transcripts were prepared for analysis and organized using NVivo 11. Independent coding was carried out by the researchers for both the first and second stages. Codes with similar content were clustered to generate subthemes and overarching themes. Regular consensus meetings were held to discuss and resolve differences until a complete agreement was reached.

As a result, five main themes and 17 subthemes were identified (see Appendix 3). Findings were reported at two levels: (1) shared phenomenon, and (2) contextual variations. Frequency counts (e.g., "7/12", "3/8") were presented only to indicate prevalence; depth and diversity of meaning, rather than numerical distribution, guided the interpretation. Each theme was illustrated with direct quotations from participants.

Trustworthiness (Credibility and Validity)

Several strategies were employed to ensure the trustworthiness of the study: Data triangulation was achieved through a two-stage interview design that incorporated both parental roles and four disability types. Independent coding followed by consensus sessions was conducted to enhance analytical rigor. Thick description was used to convey contextual richness, supported by direct quotations in the findings section. Researchers maintained reflective journals throughout the process to identify and bracket their preconceptions and biases.

Ethical Considerations

Before each interview, participants were informed both verbally and in writing about the research purpose, the voluntary nature of their participation, their right to withdraw at any time, the audio recording procedures, and the confidentiality of their data. Informed consent was obtained from all participants. Pseudonyms (e.g., A1, B3) were used to protect identities in reporting. All data were stored in secure digital environments and were used solely for research purposes.

FINDINGS

In this study, data were collected to explore the experiences of parents of adolescents with special needs regarding their children's adolescence. The data were analyzed and structured in accordance with the two-stage design of the phenomenological approach. The findings reflect parents' experiences at both the shared phenomenon level and through contextual variations. In the first stage, themes were identified to capture parents' shared experiences of their adolescents' developmental processes, independent of parental roles (mother/father) and types of special needs (Autism Spectrum Disorder [ASD], Hearing Impairment [HI], Intellectual Disability

[ID], and Physical Disability [PD]). These themes were analyzed from a holistic perspective, revealing common experiential patterns across participants. In the second stage, the analysis focused on how these shared phenomena varied according to parental roles and types of special needs. The content of the themes identified in the first stage was revisited and elaborated. In some cases, new themes or subthemes emerged that were specific to particular types of special needs or parental roles. However, as the number of participants for each disability type was limited to three, and mothers were more frequently represented than fathers, the contextual differences were necessarily analyzed at a descriptive level with limited representativeness for both disability types and parental roles.

The findings from both stages were examined in an integrated manner, addressing overlapping and divergent aspects. This analysis was structured under five main themes: the adolescent developmental process from the parents' perspective, the impact of special needs on the adolescent developmental process, parental responses to adolescence, parenting roles during adolescence, parental needs regarding their child's adolescence. Table 2 presents the themes and related subthemes as derived from participant narratives, highlighting both shared experiences and similarities and differences across parental roles and types of special needs.

Table 2. *Distribution of Themes According to Common and Contextual Differences*

Themes and Subthemes	Common Theme (Phase 1)	Types of Special Needs				Parent	
		ASD	HI	ID	PD	Mother	Father
1. Adolescents' Pubertal Processes from the Parents' Perspective							
1.1. Physical changes	12/12	3/3	3/3	3/3	3/3	8/8	4/4
1.2. Emotional and behavioral changes	9/12	3/3	2/3	2/3	2/3	6/8	¾
1.3. Transformation in privacy and sexuality perceptions	9/12	3/3	2/3	2/3	2/3	6/8	¾
1.4. Social media use and the impact of digital environments	10/12	3/3	3/3	2/3	2/3	7/8	¾
2. Impact of Disability Type on the Pubertal Process							
2.1. Behaviors deviating from social norms		3/3	2/3	2/3	0/3		
2.2. Communication difficulties		3/3	3/3	1/3	0/3		
2.3. Concealing disability		0/3	1/3	0/3	3/3		
2.4. Peer relationships and social participation		3/3	3/3	3/3	3/3		
3. Parental Responses to the Pubertal Process							
3.1. Uncertainty about how to respond	12/12					8/8	4/4
3.2. Emotional reactions	11/12					8/8	¾
3.3. Culturally coded responses to sexuality	9/12					6/8	¾
4. Parental Roles During Adolescence							
4.1. Preparation and adaptation to the process	9/12					6/8	3/4
Early preparation and awareness						6/8	
Reactive adaptation							3/4
4.2. Transformation of parental roles	12/12					8/8	4/4
4.3. Role burden and fatigue	6/12					6/8	0/4
5. Parents' Needs Regarding the Pubertal Process							
5.1. Information and education	12/12					8/8	4/4
5.2. Professional support	7/12					5/8	2/4
5.3. Social support and sharing	3/12					3/8	0/4

Table 2 focuses on the shared themes (Stage 1) that reflect everyday experiences common to all participants (n = 12), regardless of their parental role or type of special need. Among the participants, eight were mothers and four were fathers. With respect to the type of special need, there were three parents in each group: Autism Spectrum Disorder (ASD), Hearing Impairment (HI), Intellectual Disability (ID), and Physical Disability (PD). The numerical indicators (e.g., “7/12”, “12/12”) in the table represent the number of participants who expressed views corresponding to a particular subtheme out of the total number of participants. Additionally, subthemes are also numerically disaggregated by parental role and type of special need. For example, “3/3” indicates that all three parents of children with a specific disability (e.g., ASD) mentioned that subtheme, while “5/8” indicates that five out of eight mothers expressed views relating to the subtheme. These numerical frequencies are used not for statistical generalization, but rather to indicate the prevalence of shared experiences and contextual variations within the sample.

Theme 1: Adolescence from the Parents’ Perspective

This theme captures how parents of adolescents with special needs observe and make sense of their children’s adolescent development. It consists of several subthemes, including physical changes, emotional and behavioral changes, transformations in perceptions of privacy and sexuality, and the influence of social media and digital environments. These subthemes are structured at the level of the shared phenomenon, and no notable experiential differences were observed across parental roles or types of special needs.

Physical Changes

Parents described typical gender-related physical transformations observed during adolescence. For boys, these included voice deepening, the growth of facial hair, and height increases; for girls, menstruation, breast development, and height growth were highlighted. These observations suggest that physical changes generally follow typical developmental trajectories, rather than being shaped by the type of special need. Parents frequently emphasized these parallels: “These were actually the same things we saw with his older brother [typically developing].” (A6, ID) “I think facial hair, mustaches—those are the same for all children. I do not think there is a difference.” (B1, ASD) Some parents noted minor differences in the pace of development but considered these within the normal range of individual variation: “He entered puberty a bit late, I think. But eventually he did. When I was a teenager, some of my friends matured earlier, some later. It was normal, just different.” (A3, PD)

Emotional and Behavioral Changes

Emotional and behavioral changes were analyzed together, as parents’ narratives revealed that these two dimensions were often intertwined. The focus was not on underlying psychological mechanisms, but on parents’ observations and the meanings they attributed to these changes. Most parents reported that their children exhibited emotional fluctuations and behavioral shifts, including quick temper, shouting, social withdrawal, sudden mood swings, and defiance of authority. For example: “He gets angry very quickly now. He challenges me a lot, though he is a bit more restrained with his father.” (A8, PD) “He spends hours in his room. When we go in, he gets angry; when we call him, he does not come. One minute he talks, the next he does not.” (B2, ASD) Several parents observed that behaviors that were previously milder or short-lived became more intense during adolescence, with greater mood variability: “He is more aggressive now. He used to throw or break things sometimes, but now [during adolescence] he even tries to hit.” (A6, ID) Four parents reflected on the difficulty of distinguishing whether certain behaviors stemmed from their child’s special needs or from typical adolescent development: “[…] His older brother did not have these kinds of issues.” (A6, ID) “We were rebellious and defiant during our teenage years, too, and thought we were better than our parents. Now he is doing the same, and I wonder—is this because of his special condition, or is it just a result of adolescence? I cannot tell what is normal and what is not.” (B3, ID)

Transformations in Privacy and Sexuality Perceptions

Nine out of the twelve parents reported significant increases in their children’s need for privacy and curiosity about sexuality during adolescence. These changes manifested through questions and curiosity about the body, marriage, romantic relationships, and appearance, as well as behaviors such as seeking private spaces. For example, some parents mentioned frequent statements such as: “He keeps saying, ‘I am going to get married, when will I get married?’ all the time.” (B3, ID) “She used to ask whether she would ever have a boyfriend, or say ‘No one will love me.’” (A7, PD) Others observed questions about romantic behaviors: “He had a friend at school—he asked, ‘I love [girl’s name], can I kiss her?’” (A6, ID) “He would ask his cousin, ‘What do you do with your girlfriend?’” (A1, HI) Parents also described bodily curiosity and anxiety, particularly among boys: “One morning something happened—it is a boy thing—you know, and he got a bit panicked and asked his father, ‘What happened?’” (B2, ASD) Some parents observed increased attention to clothing, appearance, and personal space: “I used to pick out her clothes and she would wear them. Now she chooses herself, tries many on, wants flashier outfits. If I say something is too revealing, she sulks and gets upset.” (A3, HI) Others noted growing demands for personal space, such as wanting to be alone in their rooms, locking doors, or spending extended periods in the bathroom: “She started spending much more time in the bathroom. I do not know what she was doing for so long, and I do not want to know.” (A4, ASD) “He started saying that his sibling should leave the room, that he wanted to stay alone.” (A8, PD) Across different types of special needs, parents consistently described transformations in perceptions of privacy and sexuality that are characteristic of adolescence.

Use of Social Media and the Influence of Digital Environments

This subtheme reflects how parents observe and make sense of their adolescents’ presence on social media and in digital environments. Participants reported an increasing interest in these platforms, noting that this interest may be linked to needs for social interaction and a desire for approval/being liked. Illustrative quotations from each disability group are presented below: A mother described her child’s social media use as follows: “He has a lot of ‘friends’ and sends requests to everyone. He does not understand that they are strangers, and he also sends messages—he wants to talk.” (A5, ID) A father emphasized his child’s active use of social media and phone applications, highlighting the desire to be liked and to interact socially: “He constantly posts his own photos on Instagram […] There are these apps—he edits the photos, puts things on them, places them here and there […] He is so happy when his friends like them. He does it to be liked and expects comments as well. He comments on everyone’s photos, and when he gets comments, he is thrilled. He keeps checking who liked and who commented.” (B1, ASD) Another mother explained how her child uses social media/digital platforms to seek social validation and interaction: “He spends much time on it […] Sometimes he draws things like cake pictures and sends them to relatives asking what they think—he pesters them. It is childish, but he wants to share; if someone says it is nice, that is it—he is over the moon.” (A1, HI) A father of a child with PD reflected an increased interest in digital media and the urge to be present on social platforms: “With adolescence, that phone never left his hand—well, it still does not… Everyone has an account, so he wanted one too.” (B4, PD) Distinctively, all adolescents with PD were reported to prefer posting photos in which their disability was not visible. As this appears specific to one disability group, it is treated under Theme 2 (Impact of Disability Type on Adolescence) as the “concealment of disability” subtheme. All parents who emphasized their children’s heightened interest in social media and digital platforms during adolescence also shared concerns about the risks and the challenge of monitoring usage: “He once met up with someone he got to know from [Instagram]. I am terrified. It is so hard to monitor constantly—so many arguments, so much turmoil.” (A7, PD) “We finally disabled comments on her photos, and the profile is private; still, she adds anyone and everyone, and it turns into something nonsensical—she is so easily influenced.” (B2, ASD) Overall, the patterns identified in this subtheme transcend the type of disability and represent shared experiences across all groups.

Theme 2: Impact of Disability Type on the Adolescent Process

This theme delineates how different disability types are reflected in adolescents’ experiences of puberty. Having three participants from each disability group supports a context-sensitive reading of these experiences; however, it does not allow for comparative generalizations across groups. Accordingly, findings that emphasize a specific disability type are interpreted at a contextual level, taking into account representational limitations. The theme, therefore, includes representative experiential domains that vary by disability type. Where at least two of three participants in a group referred to the same issue, it was treated as a representative emphasis for that group. Subthemes include deviations from social norms, communication difficulties, concealment of disability, peer relations, and social participation, some showing shared features and others diverging by disability type.

Deviations from Social Norms

This subtheme captures behaviors exhibited by some adolescents with special needs that are not socially sanctioned or are contextually inappropriate. According to parents, such patterns were especially salient among adolescents in the ID and ASD groups, with similar instances observed among HI adolescents who had boarding-school experience. Several parents reported that expressions of sexual curiosity could be unchecked or contextually inappropriate. For example, a mother stated: “When he sees kissing on TV, he tries to kiss the screen, so we change it right away […] He gets uncomfortably close to men […]” (A5, ID) Another parent noted: “How can I put it… Sometimes he says inappropriate words that he has heard said in totally unrelated settings. He can approach women in a way that’s… well, disturbing. We find ourselves in tough situations, you know?” (B2, ASD) A parent of an HI adolescent attending a boarding school reported: “When he sees bare feet, he immediately looks and tries to touch them—he even did it to his teachers.” (A2, HI) Another parent in the same group recounted: “He went into the school infirmary, and they caught him engaging in inappropriate behavior with a stuffed toy. We had no idea what to say.” (A1, HI)

Thus, among two HI adolescents with boarding-school experience, parents reported behaviors that could be considered deviations from social norms. It is not possible within the scope of this study to determine whether these behaviors are systematically associated with the boarding-school context, individual characteristics, or chance. Findings should therefore be interpreted with the limitations of the sample and context in mind. Overall, however, such behaviors appear to deviate from social norms and become more visible in certain disability groups.

Communication Difficulties

Findings indicate that all parents of adolescents reported communication difficulties in the ASD group (3/3) and the HI group (3/3). In contrast, only one parent in the ID group (1/3) referred to such difficulties, and none in the PD group (0/3) did so. Parents emphasized that these communication issues stem from the nature of the disability, predate adolescence, and persist during this period. All ASD parents noted challenges with initiating and maintaining communication, establishing eye contact, and understanding abstract language (e.g., humor, innuendo). A father explained: “Say someone makes a joke or a remark—he does not get it and misunderstands. ‘Why did he say this? No, he said it because of that…’ We could listen to this for a whole year. Trying to explain does not really help.” (B1, ASD) A mother added: “He still cannot talk while looking into people’s eyes, and sometimes he talks to himself while talking to others. Then the other person is like, ‘What are you saying?’ and the conversation ends—it does not progress, that is what I mean.” (A…, ASD)* In the ID group, only one parent described communication issues similar to those in ASD, particularly difficulty with understanding abstract expressions: “Sometimes I just do not know what to say. You cannot communicate normally. One day I told him, ‘You are always so stubborn,’ and he literally stared at his nose in the mirror.” (B3, ID) In the HI group, all parents evaluated communication in relation to their child’s language modality. Parents of two adolescents educated in schools for the hearing impaired reported that their children use sign language; as hearing parents who initially did not know sign language, they experienced early difficulties but later learned: “He cannot communicate with people who do not know sign language. We struggled a lot at first; I still cannot say we have fully mastered it, but now we understand and can explain it. […] As for sensitive or private topics, we usually cannot talk in depth—when something comes up, we discuss it together with the teachers.” (A2, HI) For the HI adolescent educated in a mainstream setting with a cochlear implant and oral language, the parent attributed difficulties to limitations in speech intelligibility: “There are some sounds he cannot produce. He is much better than before, but if he is not understood while talking, he gives up.” (A3, HI) In the PD group, no parents reported communication problems during adolescence. *If you prefer, I can standardize this code to match the original (e.g., A6, ASD) once you confirm the intended participant label for this quote.

Concealment of Disability

Findings indicate that behaviors related to concealing one’s disability during adolescence are closely tied to identity formation, peer relationships, and the need for social acceptance. This subtheme emerged prominently in the PD group, whereas no parents in the ASD or ID groups referred to this issue. Within the HI group, only the family of the adolescent educated in an inclusive setting with a cochlear implant mentioned concealing the device. At the same time, the other HI parents did not report relevant experiences. Parental narratives highlight how adolescents with PD sought to conceal visible signs of their disability physically. For example, one mother noted: “He always wears long sleeves on top so that the prosthesis will not be seen.” (A7, PD)

Peer Relationships and Social Participation

All parents shared various experiences regarding their adolescents’ peer relationships and social participation, though the patterns varied depending on the type of disability, educational setting, and the characteristics of peers. Parents of all adolescents with ASD and ID consistently reported that their children faced frequent challenges in peer interaction and participation. One adolescent with ASD was educated in an inclusive setting, while the other two attended or were attending vocational special education schools. All three adolescents with ID were enrolled in vocational special education schools. Accordingly, the parent of the adolescent in the inclusive setting stated: “He has always kept his distance from his peers; he would not just join in. It is no different now [during adolescence].” (B1, ASD) Parents of adolescents attending vocational schools emphasized that their children had no typically developing friends, and their social experiences were limited to peers with similar disabilities. They also noted that these interactions were primarily confined to the school environment, with few sustained social relationships outside: “They would play together at school, but he never once said he wanted to meet anyone outside.” (A5, ID) “There are no real friendships, and I doubt he even wants that.” (A4, ASD) Similarly, parents of the two HI adolescents with boarding-school experience explained that their children mainly interacted with peers who had similar characteristics, which seemed to meet their social needs: “He meets up with his friends from school and socializes with them. Honestly, that is enough for him. He is happy with those friends, so I do not see the need for more—friends are friends, after all.” (A1, HI) In contrast, parents of the HI adolescent in inclusive education and all parents of adolescents with PD described both positive and negative experiences, depending on how typically developing peers reacted: “He has friends he gets along with really well, but there were also times he came home crying because people looked at him differently.” (B4, PD) Overall, most parents reported that the difficulties in peer relationships remained stable throughout adolescence and reflected the ongoing impact of the disability, rather than changes associated with adolescence itself.

Theme 3: Parental Reactions to Adolescence

This theme explores how parents respond to the developmental changes their children experience during adolescence. While some reactions reflect shared phenomena, notable differences between maternal and paternal experiences emerged at the subtheme level. Specifically, “not knowing what to do” and “culturally coded responses to sexuality” represented shared subthemes, whereas emotional responses were expressed more intensely by mothers. Fathers more frequently displayed avoidance or postponement behaviors within the “ignoring/postponing” subtheme.

Not Knowing What to Do

All parents expressed experiencing moments of uncertainty and helplessness, particularly regarding behaviors that deviated from social norms. Illustrative quotes include: “We did not know what to say.” (A1, HI) “Sometimes I just do not know what to say.” (B3, ID) “I cannot tell what is normal and what is not.” (B3, ID)

Emotional Responses

Mothers were generally more open in expressing their emotional reactions to their children’s adolescence, whereas fathers tended to provide practical descriptions rather than emotional narratives. Mothers reported feelings of anxiety, sadness, surprise, anger, and sometimes guilt: “When I saw my daughter got her period, I got very emotional. I thought, ‘She is grown up now; everything will be different.’ I was scared and anxious at the same time.” (A5, ID) “Sometimes she sulks and goes to her room. I get angry, but I also wonder if hugging her would fix it. I try not to show it, but sometimes I cannot hold back my tears.” (A4, ASD) “I cannot stand seeing her cry; I never want her to be sad.” (A3, HI) “I was mostly anxious. She would say things like ‘No one will ever want me,’ and I would get genuinely worried but tried not to show it.” (A7, PD) Fathers, in contrast, often framed their reactions through behavioral descriptions or matter-of-fact reflections: “I get furious when he makes those gestures.” (B2, ASD) “Honestly, I do not know what I felt. We were used to everything already; it was clear adolescence was not going to be easy.” (B3, ID) “I would talk with my wife and tell her not to overthink—it happens. Of course, it affects you, but…” (B4, PD)

Culturally Coded Responses to Sexuality

This subtheme highlights how cultural and social norms shape parents’ responses to their adolescents’ sexual curiosity and behaviors. Parents often relied on culturally coded expressions such as “shame,” “forbidden,” or “unspeakable” to set behavioral boundaries. For example: “She gets too close to men—we say it is shameful, but she does not understand.” (A5, ID) “We try to explain that such behavior is forbidden at school, but sometimes it happens at home too—touching and such. I do not always know how to react, so I hand him something to distract him.” (A1, HI) One mother of a PD adolescent described using a trusted intermediary for sexual topics rather than addressing them directly: “We do not talk about these topics—neither of us. I usually direct him to a younger relative I trust, who is experienced and married, rather than talking about it myself.” (A7, PD)

Theme 4: Parenting Roles During Adolescence

This theme focuses on how parents conceptualize and adjust their roles as their adolescents with special needs navigate puberty. Findings indicate that parents continuously reassess and reposition their roles in response to growing demands for independence and new situations associated with adolescence. Parenting roles expand from care and protection to include guidance, boundary management, and support for autonomy, reflected in three subthemes: preparation and adaptation, transformation of parenting roles, and role burden and strain.

Preparation and Adaptation

Most mothers (n = 6) and some fathers (n = 3) reported developing plans and strategies to prepare for adolescence and adapt to new needs. Mothers described early awareness and proactive preparation: “I kind of knew from his older brother, and you can tell from peers. We noticed it early—we were prepared, I would say. But sometimes being prepared is not enough.” (A6, ID) “When he started growing taller and his voice deepened, I did some research, talked to his teacher, and told my husband.” (A1, HI) “I talked to her beforehand about menstruation in case it happened at school. Because of her arm, we practiced at home—putting on and taking off pads. She kept one in her bag for a long time.” (A7, PD) Fathers tended to react as situations arose, often prompted by mothers: “My wife noticed it first. She said, ‘I think he has got hair down there; he asked about shaving.’ So I had to talk to him.” (B2, ASD) “Usually, my wife tells me what they talked about and asks what we can do. I tell him, ‘If you have any questions, you can ask me,’ but I do not go into detail—just so he knows I am here.” (B4, PD)

Transformation of Parenting Roles

Both mothers and fathers described taking on new responsibilities in areas of personal care and guidance, particularly related to menstruation, shaving, body hair, and hygiene: “We still struggle with the private area—he cannot do it himself, he gets anxious. I show him, I do it, but it is not quite right.” (B1, ASD) “She manages her hygiene now, but she still needs constant reminders and prompts.” (A5, ID) Some parents described increasing physical and emotional distance during adolescence: “She would not sleep without hugging me before; now she does not even want me to sit next to her.” (A4, ASD) Others intentionally withdrew from specific tasks to respect privacy or gender norms: “I leave hygiene-related things to his father, to avoid embarrassment. I just prepare the materials.” (A2, HI) “His mother handles it—she is a girl, after all.” (B3, ID) These patterns reflect how responsibilities are shaped by both parent and child gender and cultural expectations.

Role Burden and Strain

This subtheme was particularly salient among mothers. Six out of eight mothers described the added responsibilities and constant vigilance required during adolescence as physically and mentally taxing. Fathers did not explicitly mention such experiences. Mothers stated: “It is exhausting to keep track of both schoolwork and puberty-related issues. It feels endless.” (A6, ID) “Coming home from work, wondering what new issue might arise—it can feel suffocating at times.” (A1, HI) These reflections suggest that the parenting role during adolescence, especially for mothers, involves increased workload and emotional strain.

Theme 5: Parents’ Needs Regarding Their Child’s Adolescence

This theme encompasses the needs articulated by parents of adolescents with special needs in response to the challenges they encounter during the adolescent period. The subthemes are derived from both shared parenting experiences and role-differentiated needs (i.e., mother and father). Across parental roles, information and training needs, and the need for professional support emerged as standard, shared requirements. The need for social support and sharing was reported only by mothers.

Information and Training Needs

All participants (12/12) identified this as a central need. Parents emphasized difficulties in accessing accurate, clear, and actionable information concerning both adolescence and disability-specific issues: “I want to know many things, but we just don’t. How should we act, how should we approach? We need guidance.” (A3, HI) “We need information in every sense. I try to attend trainings when I hear about them, but there are so many topics—adolescence, disability, school situation—none of them address each one, and when it is presented like a book, it does not help.” (A4, ASD) “I am terrified of sexual abuse—if someone could explain how I can protect my child, I think I would feel relieved.” (A5, ID) “We have tried to do some things, but you do not know if it is right. We try to explain things to him—does he understand or not? It would be good to learn the proper way.” (B1, ASD) “Ours is more of a physical issue; maybe the problems are not as big as others’, but… In the moment—something happens and I am like, ‘What do I say, what do I do?’ That is when I really need information.” (B4, PD)

Need for Professional Support

Five of the eight mothers and two of the four fathers stated that they require ongoing, reliable professional guidance to cope with the processes that arise during adolescence. Parents sought not one-off briefings, but continuously accessible, multidisciplinary support to help them understand and manage both adolescence-specific changes and disability-related characteristics. This expectation included regular consultation from professionals such as physicians, teachers, and psychologists: “Yes, we need information, but not once in a while—if only there were a free psychologist or a teacher we could reach anytime.” (B4, PD) “The teacher at school is invaluable, but there are topics they do not know much about—like sexuality. We should be able to ask an expert what might happen.” (A5, ID) “We have a doctor [psychiatrist], but appointments are far apart. When there are sudden behavior changes, I do not know what to do—I need someone to consult.” (A4, ASD) “Our family physician is kind, but does not know much about adolescence in special education—well, it is medicine. Our teacher at the rehab center helps with the educational side, but when adolescence and special education intersect, you want someone more authoritative.” (B1, ASD) “My child is hearing-impaired, but I have never seen someone who can do it all—knows sign language, can talk with the child, understands adolescence, private matters, and education together.” (A2, HI) “…If there were a hotline we could reach anytime to get correct information—so we or our children could ask urgent questions—that would be great.” (A7, PD) These statements articulate a strong expectation for an accessible, continuous, and multidisciplinary support network.

Need for Social Support and Sharing

Although voiced by a smaller subset of participants, this need emerged across school types and is therefore noteworthy. Three mothers whose children attended inclusive settings explicitly emphasized the importance of spaces to share feelings with families facing similar experiences: “My child is in inclusion, but he is the only one with special needs in class, so we sometimes feel very alone. Meeting mothers like me who would understand—just to talk—would be so helpful.” (A8, PD) Mothers whose children attended schools for the hearing impaired or special education schools also reported that contact with other parents was helpful: “When there are similar friends, you can also find similar families. Just chatting helps. Of course, you cannot always talk about specific adolescent issues, but even general conversation can lift your spirits.” (A4, ASD) “We meet other parents ourselves, but I wish time were set aside for us so that it would not be left to our own efforts—so we could have regular meetings where our concerns are shared.” (A5, ID) In summary, while the call for social support and sharing was most clearly expressed by mothers in inclusive settings, the positive experiences reported by mothers in special schools suggest that peer connection and mutual support constitute a widely applicable parental need, regardless of school type. Notably, no fathers mentioned this need in our data.

DISCUSSION AND CONCLUSION

The findings of this study provide a multidimensional account of the parental experiences of adolescents with special needs during puberty. Overall, the results are consistent with the existing literature while also revealing unique variations shaped by disability type, sociocultural context, and family dynamics.

Parents generally described the physical changes their children experienced during adolescence as similar to those observed in typically developing peers. This finding supports the results of Thomas et al. (2016), who noted that the development of secondary sexual characteristics follows a similar biological trajectory in young people with disabilities. However, many parents reported difficulty in distinguishing whether certain behaviors stemmed from the nature of adolescence or the nature of the disability. This ambiguity aligns with Stankova and Trajkovski's (2021) assertion that complex interactions between biological and social factors shape behavioral changes observed in adolescents with autism spectrum disorder (ASD). Thus, while parental experiences confirm the universality of biological processes during adolescence, the interpretive uncertainty they expressed reflects differences specific to the disability context.

The findings further indicate that adolescents with special needs exhibit typical developmental features such as emotional fluctuations, a search for autonomy, increased privacy needs, and curiosity about sexuality. These results align with the universal psychosocial patterns of adolescence identified by Gander and Gardiner (2004) and Thomas et al. (2016). However, the expression of these characteristics varies according to the type of disability and the individual's communication abilities. In particular, among adolescents who have difficulty interpreting social cues or have limited language skills, curiosity and sexual behaviors may manifest in contextually inappropriate ways. As highlighted in the literature (Kenny et al., 2021), a lack of sexual education and limited communication skills can increase vulnerability to risky behavioral patterns.

Parents' approaches to issues of privacy and sexuality were found to be heavily shaped by cultural codes. In line with Çifci Tekinarslan and Eratay (2013), families in the Turkish context tend to adopt reserved attitudes toward sexual development, which limits adolescents' access to accurate information. The present study corroborates this picture by revealing parents' frequent use of terms such as "shameful" or "forbidden" when responding to sexual behaviors. Accordingly, the needs associated with the sexual development of adolescents with special needs encompass not only biological but also communicative and cultural dimensions.

One of the study's unique findings concerns the variation of adolescent experiences according to disability type. In the ASD and intellectual disability (ID) groups, behaviors deviating from social norms and communication difficulties were more pronounced. This supports the findings of Stokes, Newton, and Kaur (2007), who reported that difficulties in understanding abstract language among adolescents with ASD can lead to social inappropriateness. In the hearing impairment (HI) group, communication modalities directly affected family interactions; communication breakdowns were observed between adolescents and parents who did not know sign language. This finding aligns with Stankova and Trajkovski's (2021) observations that auditory limitations have a significant influence on social participation. In the physical disability (PD) group, body image concerns and sensitivity to social visibility came to the fore, with adolescents attempting to conceal their disabilities. This behavioral pattern supports Maart and Jelsma's (2010) emphasis on body image and social acceptance challenges among physically disabled adolescents.

Educational settings (special education schools, boarding schools, or inclusive classrooms) also emerged as important contextual factors shaping adolescent experiences. For ASD and ID groups, social environments were primarily confined to special education settings, which limited opportunities for social interaction. For the HI group, boarding schools provided a homogeneous social environment, which, in some respects, served as a protective factor. In contrast, adolescents in inclusive classrooms encountered both supportive and discriminatory responses from their peers. These findings highlight the multi-layered structure of peer relations, which are shaped by both the type of disability and the educational context (Kenny et al., 2021; Avşaroğlu & Gilik, 2017).

Across all parents, the pervasive sense of "not knowing what to do" illustrates a significant lack of information and preparedness regarding the new situations encountered during adolescence. This supports Bartin's (2020) findings concerning parents' lack of guidance and information during this period. Gender-based differences in parental roles were also evident. Mothers tended to be more proactive, seeking information and planning, whereas fathers were typically more reactive and engaged later in the process. This pattern aligns with findings from Çifci Tekinarslan and Eratay (2013) and Oktar and Yıldız (2019).

Gender roles also influenced parental involvement in intimate care: mothers were more active with their daughters, while fathers assumed more responsibilities with their sons. Additionally, mothers experienced heightened fatigue and emotional burden due to increased responsibilities, whereas fathers expressed such emotional strain to a lesser degree. This resonates with Bartin's (2020) emphasis on how the resilience of mothers is retested during their child's adolescence.

The most prominent parental need identified in this study was access to informative and guiding education on adolescence. The inadequacy of existing information sources forces parents to rely on trial-and-error approaches, which heightens anxiety. This finding echoes Kenny et al. (2021) and Bartin (2020), who highlight parents' lack of knowledge regarding sexuality, privacy, and adolescence. In addition, parents expressed a need for continuous professional consultation mechanisms, consistent with Mackin et al.'s (2016) findings on parental demand for accessible professional support. Notably, parents of children in inclusive settings emphasized the importance of social support and parent networks, aligning with Peker et al. (2015), who underscore the role of family solidarity in psychological well-being.

In conclusion, the findings demonstrate that universal developmental patterns of adolescence are preserved within the context of special needs; however, the type of disability, educational context, and cultural norms significantly shape the expression of these patterns, parental interpretations, and risk profiles. Parents' lack of information and guidance, combined with their emotional burden, has a direct impact on adolescents' healthy and safe navigation of puberty.

Recommendations

Schools and guidance units should regularly offer culturally sensitive puberty, privacy, and sexuality education tailored to different disability types. Practical home-based guidelines (e.g., creating private spaces, developing anger management plans, establishing digital media rules) should be tailored to each student's specific needs. Regional "Adolescence Support Centers" should be established, bringing together education, health, and social service professionals to provide families with continuous and free counseling. Curriculum content on privacy, sexuality, and digital safety tailored to disability types should be integrated and disseminated. Teacher education programs should include a "Puberty in Individuals with Special Needs" course, and case-based in-service training should be offered to practitioners. Parent support groups should be formed in collaboration with municipalities and NGOs to facilitate peer learning and mutual support. A national monitoring system based on parent and student feedback should be implemented to evaluate the effectiveness of these programs.

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