# ISCTE ◈ IUL

## University Institute of Lisbon

IUL - School of Social Sciences
Department of Social and Organizational Psychology

# Gender, age and multiple social support:
# Impact on the well-being of socially vulnerable youths

Carina Alexandra Alegria Mendonça

Dissertation submitted as partial requirement for the conferral of Master in
Community Psychology and Child Protection

Supervisor:
PhD, Francisco Simões, Researcher,
CIS-ISCTE-IUL

September, 2017

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Abstract

The aim of this research is to understand to what extent structural factors such as gender and age, MSS coordination between sources, and the potential interaction between these factors is related to disadvantaged youths' well-being. The study was carried out in twenty-three Escolhas projects of the metropolitan area of Lisbon. Data collection occurred between April and July of 2017.

Two hundred and thirty-six adolescents aged 12 to 18 years old ($M = 14.10$; $SD = 1.78$; 60.20% boys) participated in this study. A three-class solution was retained after Latent Class Analysis (LCA) was conducted, because it guaranteed a more balanced participants' distribution and a more feasible comparison between MSS patterns.

Further analysis, using a Generalized Linear Model (GLM) showed that gender was not associated with greater quality-of-life; however, girls denoted higher social anxiety and depression rates, as hypothesized. In addition, younger participants presented higher rates of quality-of-life, but age was not related to negative well-being indicators as expected. High-attuned MSS proved to be an optimal pattern of MSS in terms of promoting greater quality-of-life, lower social anxiety, and lower depression among disadvantaged youths. The replication of this study in other contexts seems required, namely in rural settings given that in these areas resource deprivation tends to have greater impacts on disadvantaged youths' well-being and development.

**Key Words:** Social Support Attunement, Social Anxiety, Depression, Quality-of-life, Adolescents

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## Introduction

Multiple Social Support (MSS) refers to help, encouragement, and protection provided by two or more sources from the same or from different life contexts (family, friendships, and/or work, among others) (Rueger, Demeray, & Malecki, 2010; Sarason & Sarason, 2009). Multiple Social Support Attunement (MSSA) is a concept recently developed that intends to describe patterns of social support in terms of greater or lesser coordination social support provided by different support figures (Simões, Calheiros, & Alarcão, submitted). The aim of this research is to understand to what extent structural factors such as gender and age, MSS coordination between sources, and the potential interaction between these factors is related to disadvantaged youths' well-being. In this study, disadvantaged youths will designate young people with fewer opportunities than their peers to achieve goods such as education or societal positions, because of social, economic, and/or cultural reasons (Bendit & Stokes, 2003). In addition, well-being will be measured in terms of quality-of-life, social anxiety, and depression.

This study may add contributions to the existent literature in two different ways. First, it constitutes an unprecedented attempt to test the connections between patterns of MSS among disadvantaged youths' and their well-being, including its potential interactions with gender and age. This vision represents a shift of focus on the well-being literature from a comparison between the influence of each support source (in other words, a competitive view of MSS outcomes that is dominant), to a model of analysis emphasizing MSS coordination (which underlines the potential relevance of greater or lesser intended or unintended cooperation between sources), uncovering its benefits and caveats.

Second, this study is the first to focus on the role of MSSA on the well-being of different age and gender groups of disadvantaged youths. The need to understand how MSSA operates across disadvantaged youths' groups as well across gender and age subgroups is a noteworthy gap to be filled in. The literature has shown that disadvantaged youths tend to show worst well-being prospects compared to the general population whether their vulnerabilities are due to clinical conditions (Tremolada, Bonichini, Basso, & Pillon, 2016) cultural differences (Alonso-Fernández, Jiménez-Fernández, Hernández, & Palácios-Ceña,2017) or lack of social conditions and family support (Jozefiak & Sønnichsen Kayed, 2015), but these have not been related to differences in MSS patterns. In addition, MSS compensatory effects, among which

MSSA may be included, are particularly important to improve disadvantage adolescents' well-being prospect, because MSS quality is associated with more encouraging developmental perspectives at this stage (Cotterell, 2007).

**Well-being: Definition and Indicators**

Well-being refers to individual care in a healthy way and covers aspects such as awareness of the physical condition, stress reduction and self-responsibility in care (Pinto, Fumincelli, Mazzo, Caldeira, & Martins, 2016). Well-being has been approached from an *hedonic perspective* associated to happiness, pleasure, or subjective perceptions of well-being, as well as from an *eudaemonic perspective* focused on the realization of human potential in the context of the individual's life that leads to optimal functioning (Diemer, 2009).

Well-being is an umbrella concept covering several positive or negative physical, psychological, social, and/or economic dimensions. A common positive indicator of well-being is quality-of-life; it has been delimited by the World Health Organization (1997) as the individual perception about position in life, considering the cultural context personal values, as well as subjective goals, expectations, and routines. Quality-of-life measures may emphasize different attributes such as development and improvement of life, objective evaluation, empowerment, independence, dignity, achievement of goals and aspirations, capacities, or autonomy (Pinto et al., 2016).

A widely used negative indicator of well-being is anxiety, including social anxiety. Social anxiety involves a fear of being embarrassed or humiliated in social interaction or performance (Carvalho, Cunha, Cherpe, Galhardo, & Couto, 2015). Social anxiety tends to be particularly prevalent in peer relationships in adolescence; its persistence and degree of impairment may lead to a psychological disorder also known as a social anxiety disorder (American Psychological Association, 2013). Another commonly used negative indicator of well-being is depression. Depression designates a multidimensional condition involving cognitive (e.g. self-depreciating thoughts), emotional (e.g. sadness feelings), behavioral (e.g. social withdrawal), and physical (e.g. sleep problems) manifestations. The persistence of these symptoms may lead to psychopathology; its high prevalence is seen as one most serious current public health problems worldwide (American Psychiatric Association, 2013), including among late children and adolescents (Shavers, 2014).

**Gender, Age, and Well-Being Among Disadvantaged Youths**

Adolescence is a developmental period marked by great biological, cognitive, and social changes affecting personal balance and well-being (Cotterell, 2007). However, the impact of these changes is not univocal across different groups. Age and gender have been described as key sources of variation across well-being indicators, but mixed trends are evident in the literature (Rueger, Malecki, Pyun, Aycock, & Coyle, 2016).

Gender disparities have been found regarding quality-of-life, with some identifying similar rates for adolescent boys and girls (e.g. Marques, Mota, Gaspar, & Matos, 2017), a few detailing higher quality-of-life rates among boys (e.g. Chraifa & Dumitrub, 2015), and others reporting the opposite (e.g. Tremolada, Bonichini, Basso, & Pillon, 2016). These contradictions may be due to different research contexts or to different quality-of-life measures; some of them emphasize quality-of-life physical elements (e.g. Marques et al. 2017), others focus on its psychological dimensions, and others involve a multidimensional assessment. In the case of clinically vulnerable youths, girls tend to show lower quality-of-life rates (Tremolada et al., 2016), while boys tend to show a better self-image (Topolski, Patrick, Edwards, Huebner, Connell, & Mount, 2001). However, these results are limited to clinical populations; gender differences on quality-of-life measures among socially disadvantaged youths are underreported.

Gender comparisons show different trends when well-being is compared based on negative indicators such as social anxiety and depression. Adolescent girls tend to report higher levels of social anxiety than boys (Chaplin, Gillham, & Seligman, 2009), a propensity that is stronger among clinically-diagnosed samples (Cummings, Caporino, & Kendall, 2014). In general, depressive symptoms are also more prevalent among girls (Cummings et al., 2014) and can be two to three times higher when compared to boys. This trend is consistent among socially disadvantaged girls (Patwardhan, Mason, Savolainen, Chmelka, Miettunen, & Järvelin, 2017), irrespectively of ethnic origin (Moon & Ro, 2010) and are more pronounced among girls at-risk of school failure (McCarty et al., 2008). Overall, girls are more prone to develop anxiety and depression symptoms, due to greater predisposition for rumination, negative cognitive style, or corumination (excessive discussion of problems in intimate relationships) (Cummings et al., 2014).

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Age is also a determining factor of well-being outcomes. Quality-of-life is generally higher in late childhood compared to early adolescence (Dolan, Peasgood, & White, 2008; Ronen, Hamama, Rosenbaum, & Mishely-Yarlap, 2016). The transition to adolescence induces greater inclination for negative social evaluation and depression; these symptoms may overlap, but social anxiety tends to precede depressive symptoms (Dalrymple & Zimmerman, 2011). In general, these negative well-being indicators tend to be worst in early adolescence, with improvements towards late adolescence, including among more vulnerable youths (Dolan et al., 2008). This pattern is justified by developmental demands, including the diversification of social relationships, a greater centrality of peer relationships, in which social interactions and performance are more valued, the normative involvement in deviant behaviors (e.g. substance use), or biological changes which may make adolescents more prone for emotional instability and negative mood, especially in early adolescence (Cotterell, 2007).

**Multiple Social Support: Definition and Measurement Approaches**

MSS can be defined as enacted, perceived, or received social interactions involving help, protection, and encouragement made available to individuals (Sarason & Sarason, 2009) by two or more sources integrated in personal social networks. Its results may be analyzed in terms of: (a) relative influence or unique impact of each system or source of support; (b) total MSS influence of all sources; and (c) MSS intended or unintended coordination.

Most of the studies in the field of MSS analyze the influence of each source of social support on a given set of outcomes, regardless of the effects of other social support sources; these MSS effects are also known as unique effects (Rueger, Malecki, & Demaray, 2010). The second approach tests how total MSS, meaning the total amount of social support provided by all sources, affects a given outcome. Here, MSS is measured as the sum of all social providers' support rates, which can then be used as a predictor of an outcome of interest (blind, for review). The third perspective considers interindividual differences in terms of the degree of coordination perceived between MSS providers, based on each provider's social scores (Levitt, Levitt, Crooks, Hodgetts, & Milevsky, 2005). This approach, labeled MSSA, is based on the concept of attunement as a sense of unity in relationships (Erskine, 1998). This attunement definition is applied to dyadic relationships in contexts such as psychotherapy (Erskine,

1998) and mentoring (Pryce, 2012), and has recently been extended to the social support literature to describe the degree of perceived coordination between multiple supportive relationships, irrespectively of the form (perceived or received) or dimension (e.g. autonomy support) of social support (Simões & Simones, in press). The degree of perceived coordination among social support providers may take one of at least three forms: low-attuned MSS involves low levels of support from all sources; unattuned MSS occurs when the level of support is unbalanced across different providers, with ones providing higher support and others lower support; and high-attuned MSS occurs when all providers offer high levels of support (blind, for review).

**Multiple Social Support and Well-Being Among Disadvantaged Youths**

MSS structure goes through important changes during adolescence (Cotterell, 2007) which may ultimately affect the frequency, intensity and direction of well-being. Greater MSS delivered by sources such as close family members, teachers, best friends (Rueger et al., 2010) or mentors (Goldner & Mayseless, 2009; Simões & Alarcão, 2014) improves adolescents' well-being. The study of MSS impact on disadvantaged youths' well-being has not followed a MSSA approach; this means that a comparison among different MSS sources has been the most fruitful standpoint in this field of inquiry.

Quality-of-life tends to be lower among vulnerable youths (Tremolada, Bonichini, Basso, & Pillon, 2016), especially among those who present chronic physical conditions (Cassarino-Perez & Dell'Aglio, 2015). Among these youths, higher MSS, namely the one provided by family and friends tends to predict higher quality-of-life rates (Cassarino-Perez & Dell'Aglio, 2015). Less seems to be known about the effects of MSS with quality-of-life facing social, cultural and/or economical adversities, in the case of disadvantaged youths. Some studies tend to show that MSS may have a buffering effect, by reducing the impact of social hardship on quality-of-life perceptions. For instance, social support provided by mothers and partners was found to buffer the negative effect of adolescent pregnancy on low social-economic status girls' quality-of-life (Pires, Araújo-Pedrosa, & Canavarro, 2014). On the other hand, greater MSS delivered by teachers and peers mitigates the negative effect of bullying on victims' quality-of-life (Flaspohler, Elfstrom,Vanderzee, Sink, & Birchmeier, 2009).

Some studies have shown that lower MSS provided by parents, peers, and teachers overlaps with greater adolescents' social anxiety (Leeves & Banerjee, 2014;

Sahranc¸Celik, & Turan, 2017). Greater cumulative or total MSS effects have also been associated to lower adolescents' social anxiety, with parental and peer support leading to lower social anxiety rates (Cavanaugh & Buehler, 2016). However, less is known about the associations between MSS and social anxiety among disadvantaged youths. Recent research shows, however, that at-risk delinquent youths, who are usually overrepresented across lower socioeconomic ranks, reported higher social anxiety and also evidenced lower MSS provided by mother, father, and best friend (Mercer, Crocetti, Meeus, & Branje, 2017).

Lower MSS also induces depressive symptoms seemingly to social anxiety. A recent meta-analytical review (Rueger, Malecki, Pyun, Aycock, & Coyle, 2016) synthesized the effects of perceived social support on depression. Familial sources, teachers, and significant others, such as mentors, seem pivotal in preventing depressive symptoms among adolescents (Chaturvedi & Kumari, 2016; Rueger et al., 2010). Mixed trends have been found regarding the role of friends' support, with some studies finding a minimal impact in reducing depressive symptoms (Rueger et al., 2010) while others report the opposite (Kerr, Preuss, & King, 2006). Among disadvantaged youths, MSS from family and friends has a protective role by reducing the negative impact of cumulative risk on depression (Patwardhan et al., 2017). Low total MSS provided by family, friends, and significant others was also found to be associated with higher incidence of depression among adolescents from ethnic minorities (Khatib, Bhui, & Stanfeld, 2013).

**Present Study**

The literature review shows that: (a) gender disparities are contradictory regarding well-being outcomes, but girls seem more prone to develop anxiety and depression ; (b) early adolescents seem in greater risk to develop poorer well-being; (c) MSS effects on quality-of-life, social anxiety, and depression are mostly studied from the perspective of the impact of each source (the unique effects perspective); (d) greater MSS seems to improve adolescents' well-being perspectives; (e) studies relating MSS patterns and disadvantaged youths' well-being is non-existent.

Given the gaps found in the literature, the aim of this research is to understand to what extent structural factors such as gender and age, MSS coordination between sources, and the potential interaction between these factors is related to disadvantaged

youths' well-being. MSSA covers three significant relationships: closest family member, mentor, and best friend. Well-being is depicted according to a positive (quality-of-life) and two negative indicators (social anxiety in peer relationships and depression).

It was expected that worse quality-of-life, social anxiety, and depression rates could be found among girls and early adolescents. No hypothesis was formulated regarding how different MSSA conditions could affect the connections between gender and age and well-being indicators, given the exploratory nature of this research.

## Method

### Participants

Two hundred and thirty-six adolescents aged 12 to 18 years old ($M = 14.10$; $SD = 1.78$; 60.20% boys). Of the 236 youths included in the study, 122 (51.69%) identified themselves as African, 98 (41.53%) identified themselves as Portuguese, and the remaining 16 (6.77%) identified themselves with other ethnic groups. As for their level of education, 216 (88.95%) were enrolled in middle school (5th to 9th grade); and 23 (9.75%) were enrolled in secondary school (10th to 12th grade), and 3 (1.30%) were enrolled in primary education (4th grade or below).

One-hundred and seventy-three of the participants indicated their mother as the closest family member (73.31%), followed by 40 participants who indicated their father (16.95%), 11 (4.66%) who indicated their grandmother or grandfather, eight (3.39%) indicated an aunt or an uncle, and the remaining four (1.69%) indicated a brother or a sister. Regarding closest family member occupational, 147 (62.28%) were employed, 62 (26.26%) were unemployed, 18 (7.64%) were students, and nine (3.82%) were retired. As for their closest family member educational level, 73 (30.93%) were not aware of it, 66 (27.97%) reported that they had lower secondary or technical education, 51 (21.61%) completed primary education, and 39 (19.49%)completed higher education. Finally, 3.0% has not completed primary education.

## Site

The study took place in Lisbon Metropolitan Area. This region encompasses 18 municipalities of the districts of Lisbon and Setúbal, corresponding to the most populated area of Portugal (Instituto Nacional de Estatística, 2015). Lisbon Metropolitan Area represents 37% of the Portuguese Gross Domestic Product (GDP). The per capita GDP in the region is set at 22800 Euros (Instituto Nacional de Estatística, 2015). The Gini coefficient for this region is 33.90%, while the risk of poverty reached 12.40% of its population, in 2014 (Instituto Nacional de Estatística, 2017).

## Escolhas Program

Programa Escolhas (Choices Program) is a joint nation-wide initiative created in 2001 and held by the Portuguese Government, the High-Committee for Migrations, the General Bureau of Education, and the Social Welfare Institute, in partnership with local organizations, co-funded by European Union funding; its mission is to promote social inclusion, equal opportunities, and social cohesion among vulnerable children and adolescents (Site Oficial Programa Escolhas, 2017). Escolhas program is currently in its sixth edition; the program is focused in five main actions: (a) educational inclusion and non-formal education; (b) professional training and employability; (c) civic participation; (d) digital inclusion; and (e) youth entrepreneurship. Recently, the program has been acknowledged by international bodies such as the Organization for Economic Cooperation and Development (OECD) as a valuable social intervention to promote social inclusion among disadvantage children and youths (Carcillo et al., 2015).

## Measures

### Social support.

Social support was measured using the Portuguese version of the Basic Needs Satisfaction in Relationships Scale (BNSRS) (Simões & Alarcão, 2013). The questionnaire is an adaptation from the its original English version (La Guardia, Ryan, Couchman, & Deci, 2000) and encompasses 9 items rated on a five-point Likert scale that ranges from 1 (*never*) to 5 (*always*). The possible scores range from 9 to 45 points. The scale comprises nine affirmative items (e.g. When I am with him/her, I feel free to

be who I am) covering issues of relatedness, competence and autonomy support; three of the items are reversed (e.g. When I am with him/her, I often feel inadequate or incompetent). The BNSRS assesses the satisfaction of social support in any targeted relationship, with higher scores indicating greater satisfaction of social support through the satisfaction of basic psychological needs support in a particular relationship. In this study, the BNSRS was used to calculate a whole score of the adolescents' appraisals of the level of social support offered by the parent (mother, father, legal representative) with whom they live and spend more time mentors or class directors, their best friend, and the program's mentor. The option of rating relationships with class directors was given to the non-mentored students because this was their most relevant relationship with a teacher. The internal consistency of the BNSRS is adequate in both the original English version ($\alpha$ = .94) (La Guardia, Ryan, Couchman, & Deci, 2000) and the Portuguese version ($\alpha$ = .80) for the whole scale (Simões & Alarcão, 2013). In this study, internal consistency was adequate for closest family member social support ($\alpha$=.79), mentor social support ($\alpha$=.79) and best friend social support ($\alpha$=.79).

### Quality-of-life.

The KIDSCREEN-27 assesses quality-of-life in children and adolescents between 8 and 18 years of age (Ravens-Sieberer et al., 2007). The 27 items included in this instrument are organized into 5 dimensions. Physical Well-Being (5 items; sample item: "Have you felt full of energy?") explores the level of the child's/adolescent's physical activity, energy and fitness. Psychological Well-Being (7 items; sample item: Has your life been enjoyable?) includes measures of positive emotions, satisfaction with life and emotional balance. Parent Relations & Autonomy (7 items; sample item: Have you been able talk to your parent(s) when you wanted to?) examines relationships with parents, the atmosphere at home, feelings relative to age-appropriate freedom, and the degree of satisfaction with financial resources. Social Support & Peers (4 items; sample item: Have you had fun with your friends?) examines the nature of the respondents' relationships with other children/adolescents. Finally, School Environment (4 items; sample item: Have you got on well at school?) explores the child's/adolescent's perceptions of his/her cognitive capacity, learning and concentration, and feelings regarding school (Ravens-Sieberer et al. 2007). For each dimension, the respondents describe their perceptions during the previous week. Depending on their nature, the

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items are rated on a 5-point Likert scale of intensity ranging from 1 (*nothing*) to 5 (*extremely*) or on a 5-point Likert scale of frequency ranging from 1 (*never*) to 5 (*always*). The whole-scale scores range from 5 to 135 points, with higher scores denoting a more positive perception of quality of life. In this work, KIDSCREEN-27 was used as a whole scale of quality-of-life. The level of internal consistency of the KIDSCREEN-27 for the whole scale was adequate in previous studies ($\alpha$ = .89) (Simões & Alarcão, 2014) as well in this work ($\alpha$=.82).

**Depression.**

Depression was measured using the Portuguese version (Carvalho, Cunha, Galhardo, & Couto, 2015) of the Center for Epidemiological Studies Depression Scale for Children (CES-DC) (Weissman, Orvaschel, & Padian, 1980). This questionnaire assesses depression in children and adolescents aged 6 to 17 years old and encompasses 20 items (sample item: I felt low and unhappy) four of them reversed (sample item: I felt happy), covering emotional, cognitive and behavioral depressive dimensions. Items are rated in 4-point Likert scale ranging from 0 (*never*) to 3 (*frequently*). For each dimension, the respondents describe their perceptions during the previous week. Total scores range from 0 to 60 points, with higher scores indicating higher levels of depressive symptoms. The level of internal consistency of the CES-DC was adequate in previous studies for the whole scale of the original English version ($\alpha$= .90) and the Portuguese version (Carvalho et al., 2015) ($\alpha$= .90), as well in this work ($\alpha$=.86).

**Social anxiety in peer relationships.**

The Portuguese version (Pechorro, Silva, Marôco, & Gonçalves, 2014) of the Social Anxiety Scale for Adolescents (SAS-A) (La Greca & Lopez, 1998) was used to assess participants' social anxiety in peer relationships. The SAS-S includes 22 items organized in three dimensions; Fear of Negative Evaluation (eight items; sample item: I feel that people talk about me behind my back); Social Avoidance and Stress-New (six items; sample item: I am shy when I meet new people); and Social Avoidance and Stress – General (four items; sample item: I keep quiet when I am in group).  The SAS-A also includes four neutral items are neutral which are not added to scores. Items are rated in 5-point Likert scale ranging from 1 (*not at all*) to 5 (*every time*). Whole scale scores range from 18 to 90 points. Respondents higher scores indicate higher levels of

social anxiety. In this study, the SAS-A was used as a whole measure of social anxiety in peer relationships. Previous studies have shown high internal consistency for whole scale scores, for the original English version ($\alpha$=.91) (La Greca & Lopez, 1998) and for the Portuguese version ($\alpha$=.91) (Pechorro et al., 2014). In this study, internal consistency for SAS-A whole scale was adequate ($\alpha$=.90).

**Procedures**

Escolhas program board was contacted to present the study aims and methodology, as well as to obtain an agreement to contact each project. Afterwards, 47 projects from 13 municipalities of the Lisbon area were contacted for informed consent to participate, corresponding to all active projects of Escolhas program in this geographical area in 2017. Twenty-three projects agreed to participate. After parental informed consent was obtained from adolescents' legal guardians who complied with the inclusion criteria, a collective administration of the study's protocol was conducted in each project using an online survey tool. Data collection was supervised by the first author and involved an explanation of research goals, ethical principles (e.g. confidentiality norms), asking the participants for their voluntary consent to participate, and assisting in the online filling in of the protocol. The participants had 30 minutes to complete the survey. Data collection occurred between April and July of 2017.

**Data Analyses**

To categorize the participants on the basis of the degree of MSSA, latent class analysis (LCA) was employed. LCA is, originally, a clustering mixture model in which the observed variables are independent categorical variables (Celeux & Govaert, 2016). Recent developments have made it possible to perform LCA easing these assumptions. LatentGold (version 5.1) (Vermunt & Magidson, 2005) is a fully developed software to conduct rigorous LCA, with a number of advantages over other software packages: (a) modeling may include ordinal, continuous, and/or nominal variables; (b) local independence assumption between variables is not required to perform LCA in this program; and (c) exploring patterns of group membership may include all covariates at the same time, instead of a more exploratory approach available in other programs. This means that classification and class membership prediction group is simultaneously conducted in LatentGold, avoiding prediction and measurement models reestimation

which sometimes may be impractical, especially when the number of potential covariates is large (Vermunt, 2010).

In this study, LCA involved a three-step approach using the software utilities and recommendations (Vermunt & Magidson, 2005). First, a LCA model was built based on social support measures for each of the selected support relationships. Second, participants were assigned to clusters based on their posterior class membership probabilities, meaning that covariates of social support measures identified in the zero-order correlations matrix (gender and ethnicity) were included in the process of defining each participant membership probability. Fit indices that included the Bayesian information criteria (BIC), sample-size-adjusted BIC, and entropy statistics were compared to identify the model with the best fit. The validation of differences between MSSA groups was made through post-hoc mean comparisons tests between social support measures for all regarded sources. Percentiles 25, 50, and 75 were estimated for each source of support, based on the participants' original ratings for closest family member, mentor, and best friend social support, to facilitate class membership interpretation. Ratings $< P25$ indicated low social support; ratings between $P25$ indicated low social support and $P49$ indicated medium-low social support; ratings between $P50$ and $P74$ indicated medium-high social support; ratings above $P75$ showed high social support.

Finally, the association between gender or age, MSSA, and outcome variables was investigated using SPSS 23.0. A Generalized Linear Model (GLM) approach, including gender (or age), MSSA, and their interaction in the model as factors, as well as ethnicity as a covariate in the case of the quality-of-life model, was followed to test independent effects. An omnibus test of between-factors independence was calculated, as well as the model fit. A second model without the interaction term (e.g.genderXMSSA) was tested whenever interactions were not significant. Parameter estimates are reported for the models depicting independent effects for gender or age and MSSA, including covariates when necessary. Pairwise mean differences for within gender and age groups are also reported, with 95 % confidence intervals (95 % CI), based on Least Significance Difference (LSD) post-hoc tests method. This decision is based on the interest in exploring differences across gender and age subgroups, even when interactions these factors and MSSA are not significant.

## Results

### Correlational and descriptive analysis

Table 1 depicts the zero-order correlations between the study variables. Gender is significantly associated with closest family member ($p < .05$), mentor ($p < .01$), and best friend support ($p < .05$). In addition, ethnicity was significantly associated with closest family member ($p < .05$) and best friend support ($p < .01$). Age ($p < .01$) and ethnicity ($p < .05$) were significantly associated with quality-of-life as well. Percentiles were calculated to depict social support means distribution, with the following results: (a) closest family member support ($P25 = 33.00$; $P50 = 39.00$; $P75 = 41.00$); (b) mentor ($P25 = 34.00$; $P50 = 39.00$; $P75 = 43.00$); and (c) best friend ($P25 = 33.00$; $P50 = 40.00$; $P75 = 45.00$).

### Latent class analysis

According to Table 2, a four-classes model showed the best fit to the data, with a BIC of 4132.19, a sample–size-adjusted BIC of 4007.49, and an entropy score of .42. Although a four-classes solution presented a better global fit when all indicators were considered, the decision was to retain a three-classes solution, because one of the classes had a small number of members ($n < 30$). In addition, when the four classes were collapsed into gender or age subgroups, these subgroups included only a few participants ($n < 15$).

Tables 3 and 4 present main descriptive statistics for each class. Class 1 (closest family member high support) ($n = 111$; $46.61\%$) was characterized by youth reports of middle high support ($> P75$) from closest family member ($M = 38.91$; $SD = 2.92$) and middle low support ($< P50$) from mentor ($M = 38.72$; $SD = 4.43$) and best friend ($M = 38.61$; $SD = 4.61$); this class showed a greater proportion of boys ($n = 62$; $55.90\%$), early adolescents ($\leq 14$ years old) ($n = 43$; $72.90\%$) and African participants ($n = 61$; $50.00\%$). Class 2 (low-attuned MSS) ($n = 66$; $27.97\%$) was characterized by youth reports of low support ($< P25$) from closest family member ($M = 29.97$; $SD = 4.14$), mentor ($M = 32.72$; $SD = 5.35$), and best friend ($M = 32.26$ $SD = 6.15$); this class showed a greater proportion of boys ($n = 53$; $80.30\%$), early adolescents ($\leq 14$ years old) ($44$; $66.70\%$), and African participants ($n = 48$; $72.70\%$). Class 3 (high-attuned MSS) ($n = 59$; $25.00\%$) was characterized by youth reports of high support ($> P75$) from closest family member ($M = 41.57$; $SD = 1.38$) and mentor ($M = 42.75$; $SD =$

2.41), and middle high support (> *P*50) from best friend (*M* = 44.78 *SD* = .45); this class showed a greater proportion of girls (*n* = 32; 54.20%), early adolescents (≤ 14 years old) (*n* = 43; 72.90%) and Portuguese participants (*n* = 41; 69.50%). Differences between all the support variables were significant across the three classes (*p* < .001), according to Scheffe post-hoc tests.

According to Table 5, high-attuned MSS presented a higher estimate of average quality-of-life (*M* = 106.54; *SD* = 7.78), as well as lower average rates of social anxiety (*M* = 42.85; *SD* = 15.20) and depression (*M* = 13.37; *SD* = 8.71), compared to all other groups.

**General Linear Model and Multiple Mean Pairwise Comparisons**

**Gender, multiple social support attunement and well-being outcomes models.**

A GLM including quality-of-life as an outcome variable, with gender, MSSA, and their interaction entering in the model as factors, while age and ethnicity were included as covariates, revealed a significant model, Pearson $\chi 2$ (8, 228) = 106.57, *p* < .000. The omnibus test of independence between gender and MSSA, including their interaction, was also significant, *Wald χ2* (7, 229) = 75.62, *p* < .000. Only MSSA displayed a significant independent effect on quality-of-life (*p* <.001). An identical model was set without the interaction term between gender and MSSA, which was also significant, *Wald χ2* (5, 231) = 71.36, *p* < .000; according to the results for this model presented in Table 6, closest family high support was associated to greater quality-of-life (*p* <.01), contrary to low-attuned MSS (*p* <.001), in comparison to high-attuned MSS. Subsequent pairwise comparisons across categories of boys and girls, regarding their levels of MSSA, were significant, *Wald χ2* (5, 231) = 58.40, *p* < .000. According to Table 7, boys reporting closest family member high support showed significant better quality-of-life rates than those reporting low-attuned MSS (*p* <.001); in turn, boys in the low-attuned MSS class also denoted lower quality-of-life compared to those included in the high-attuned MSS class (*p* <.01). Conversely, according to Table 7, girls included in closest family member high support evidenced significantly higher quality-of-life mean rates than those included in the low-attuned MSS (*p* <.01), but also worse quality-of-life rates compared to girls included in high-attuned MSS class girls (*p* <.01) classes. In addition, girls included in the low-attuned MSS class presented significant lower

average quality-of-life rates compared to those include in the high-attuned MSS class ($p$ <.001).

A GLM including social anxiety as an outcome variable, with gender, MSSA, and their interaction entering in the model as factors, revealed a significant model, Pearson $\chi2$ (6, 230) =196.58, $p < .000$. The omnibus test of independence between gender and MSSA, including their interaction, was also significant, *Wald $\chi2$* (7, 229) = 22.90, $p < .000$. Gender ($p$ <.001) and MSSA ($p$ <.001) displayed a significant independent effect on social anxiety, contrary to their interaction. An identical model was set without the interaction term between gender and MSSA, which was also significant, Pearson $\chi2$ (4, 232) = 197.72, $p < .000$. According to the results for this model presented in Table 7, girls denoted higher social anxiety rates ($p < .001$); participants reporting low-attuned MSS also denoted significantly greater social anxiety ($p < .001$), in comparison to those reporting high-attuned MSS. Multiple mean pairwise comparisons reveal that boys reporting closest family member high support denoted lower social anxiety mean rates than boys in the low-attuned MSS class ($p$ <.05); conversely, boys reporting low-attuned MSS showed higher social anxiety compared to those included in a high-attuned MSS class ($p$ <.001). In the case of girls, only those reporting low-attuned MSS denoted significantly higher mean rates of social anxiety compared to girls reporting high-attuned MSS ($p$ <.001).

A GLM including depression as an outcome variable, with gender, MSSA, and their interaction entering in the model as factors, revealed a significant model, Pearson $\chi2$ (6, 230) =82.22, $p < .000$. The omnibus test of independence between gender and MSSA, including their interaction, was also significant, *Wald $\chi2$* (5, 231) = 41.38, $p < .000$. Gender ($p$ <.01) and MSSA ($p$ <.001) displayed a significant independent effect on depression, contrary to their interaction. An identical model was set without the interaction term between gender and MSSA, which was all significant Pearson $\chi2$ (4, 232) = 82.49, $p < .001$. According to the results for this model presented in Table 7, girls denoted higher depression estimates ($p <. 01$); participants reporting closest family member high support ($p$ <.01) and low-attuned MSS ($p$ <.001) also denoted significantly greater depression estimates ($p$ <.001), in comparison to those reporting high-attuned MSS. Pairwise mean comparisons show boys reporting closest family member high support presented lower depression mean rates compared to boys included in low-attuned MSS ($p$ <.001); the later showed

significantly higher mean rates than boys included in the high-attuned MSS class ($p$ <.001). Girls included in the closest family member high support presented significantly lower depression mean rates compared to girls in the low-attuned MSS class ($p$ <.01); the same trend was evident for girls in the low-attuned MSS group, when compared with girls in the high-attuned MSS class ($p$ <.001). Finally, girls in the closest family member class display lower depression mean rates than girls in the high-attuned MSS class ($p$ .05).

### Age, multiple social support attunement and well-being outcomes models.

A GLM including quality-of-life as an outcome variable, with age, MSSA, and their interaction entering in the model as factors, while ethnicity was included as a covariate, revealed a significant model, Pearson $\chi2$ (7, 229) = 98.86, $p$ < .000. The omnibus test of independence between age and MSSA, including their interaction, was also significant, *Wald $\chi2$* (6, 230) = 70.02, $p$ < .000. Age ($p$ <.001) and MSSA ($p$ <.001) displayed a significant independent effect on quality-of-life, contrary to their interaction. An identical model was set without the interaction term between age and MSSA, which was also significant, Pearson $\chi2$ (5, 231) = 98.06, $p$ < .000; according to the results for this model presented in Table 8, early adolescents denoted higher quality-of-life estimates; in addition, closest family high support was associated to greater quality-of-life ($p$ <.01), contrary to low-attuned MSS ($p$ <.001), in comparison to high-attuned MSS. According to Table 9, early adolescents reporting closest family member high support showed significant better quality-of-life rates than those reporting low-attuned MSS ($p$ <.001); in turn, early adolescents in the closest family member high support ($p$ <.01) and in the low-attuned MSS ($p$ <.001) classes also denoted lower quality-of-life mean rates compared to those included in the high-attuned MSS class. Conversely, older adolescents included in closest family member high support presented significantly higher quality-of-life mean rates than those included in the low-attuned MSS ($p$ <.01). In addition, older adolescents included in the low-attuned MSS class presented significantly lower average quality-of-life rates compared to those include in the high attuned MSS class ($p$ <.001).

A GLM including social anxiety as an outcome variable, with age, MSSA, and their interaction entering in the model as factors, revealed a significant model, Pearson $\chi2$ (6, 230) =201.71, $p$ < .000. The omnibus test of independence between age and

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MSSA, including their interaction, was also significant, *Wald χ2* (5, 231) = 16.82, *p* < .000. MSSA (*p* <.001) displayed a significant independent effect on social anxiety, contrary to age and the interaction between the two factors. An identical model was set without the interaction term between gender and MSSA, which was also significant, Pearson *χ2* (4, 232) = 203.32, *p* < .000. According to the results for this model presented in Table 8, early adolescents reporting low-attuned MSS also denoted significantly greater social anxiety (*p* <.01), in comparison to those reporting high-attuned MSS. Multiple mean pairwise comparisons reveal that early adolescents reporting closest family member high support showed lower social anxiety mean rates than early adolescents in the low-attuned MSS class (*p* <.001); conversely, early reporting low-attuned MSS presented higher social anxiety compared to those included in a high-attuned MSS class (*p* <.001). No significant pairwise mean comparisons were found for older adolescents.

A GLM including depression as an outcome variable, with age, MSSA, and their interaction entering in the model as factors, revealed a significant model, Pearson *χ2* (6, 230) =86.29, *p* < .000. The omnibus test of independence between age and MSSA, including their interaction, was also significant, *Wald χ2* (5, 231) = 29.99, *p* < .000. MSSA displayed a significant independent effect on depression (*p* <.001), contrary to age and age and MSSA interaction. An identical model was set without the interaction term between gender and MSSA, which was also significant Pearson *χ2* (4, 232) = 85.80, *p* < .001. According to the results for this model presented in Table 8, participants reporting closest family member high support (*p* <.05) and low-attuned MSS (*p* <.001) denoted significantly greater depression estimates, in comparison to those reporting high-attuned MSS. Pairwise mean comparisons show early adolescents reporting closest family member high support presented lower depression mean rates compared to those included in low-attuned MSS (*p* <.01), contrary to significantly higher depression mean rates when compared to high-attuned MSS (*p* <.05); in addition low-attuned MSS early adolescents showed significantly higher depression mean rates than those included in the high-attuned MSS class (*p* <.001). In turn, older adolescents in the low-attuned MSS group showed higher depression rates, when compared with older adolescents in the high-attuned MSS class (*p* <.001).

**Discussion**

The aim of this research is to understand to what extent structural factors such as gender and age, MSS coordination between sources, and the potential interaction between these factors is related to disadvantaged youths' well-being. It was expected that worse quality-of-life, social anxiety, and depression rates could be found among girls and early adolescents. No hypotheses were formulated regarding MSSA links with the selected well-being indicators, given that research on the association between MSS patterns and well-being among disadvantaged youths is novel. Five key findings support, in part, the hypothesis and shed some light on the influence of MSSA on disadvantaged youths' well-being.

LCA revealed that a four-classes solution presented a better global fit when all indicators were considered; however, a very small number of participants was included in one of the classes. Thus, the decision was to retain a three-classes solution, in order to obtain an interpretable solution which would also allow unbiased comparisons between patterns of MSSA. According to a three-classes solution, one of the classes denoted high closest family member support; a second class was marked by a pattern of low-attuned MSS; finally, a third class showed a pattern of high-attuned MSS. These results are sustained by previous findings in studies with general groups of early adolescents, showing that balanced and unbalanced patterns of MSS are evident during this developmental period (Levitt et al., 2005). It is also remarkable that the most common MSSA pattern in this study was the one demonstrating closest family member support; this may be due to the fact that the research protocol did not focus on a specific family support source, enabling participants to choose other significant familial relationships (e.g. older siblings or uncle/aunt) in a time when parental support becomes less central or may become a source of conflict (Cotterell, 2007).

Contrary to what was expected, gender was not associated with greater quality-of-life; however, girls denoted higher social anxiety and depression rates, as hypothesized. Previous findings show mixed trends regarding gender differences on quality-of-life outcomes (Chraifa & Dumitrub, 2015; Matos et al., 2017; Tremolada et al., 2016), but most of these findings were obtained with cross-sectional or clinically vulnerable groups of adolescents. This means that gender trends among disadvantaged youths are less known. Nonetheless, disadvantaged boys' and girls' greater exposure to risks such as involvement with deviant peers, substance use, or lower levels of physical activity

may attenuate gender differences, especially when quality-of-life measures are multidimensional, as it is the case with Kidscreen questionnaires. In turn, greater social anxiety and depression rates among girls are more consistent with general gender comparisons (Chaplin et al., 2009) as well as with recent studies focused on disadvantaged youth groups (e.g. Patwardhan et al., 2017). Altogether, the literature, as well as this study, show girls' greater vulnerability to anxiety and depression.

Third, younger participants presented higher rates of quality-of-life, but age was not related to negative well-being indicators as expected. In general, early adolescence involves an increment of social anxiety and depression, which tends to be attenuated during adolescence (Dalrymple & Zimmerman, 2011). This contradictory finding may be justified by contextual reasons: disadvantaged early adolescents may have been less exposed to enduring social, economic hardships and to concurrent social development risks, which are more often present among socially vulnerable groups, leaving more room for improved quality-of-life. It is also feasible that sampling procedures biased these results, in the sense that more deviant and potentially more ill-being older adolescents may have hot adhered to Escolhas program and ultimately to this study. In any case, the unbalanced numbers of younger and older adolescents recommends careful consideration of age relationships with well-being, in this study.

Fourth, high-attuned MSS proved to be an optimal pattern of MSS in terms of promoting greater quality-of-life, lower social anxiety, and lower depression among disadvantaged youths. This result extends on at least one study by Levitt et al. (2005) showing that greater MSS coordination contributes to improved adjustment. However, Levitt et al. (2005) study analyzed the transition between later childhood and early adolescence and did not focus on vulnerable groups. This result also reproduces recent findings showing that greater social support coordination between significant adults (parents, teachers, and mentors) is related to improvements in social development prospects, showing greater and more generalized impact than the quantity of support (Simões, Calheiros, & Alarcão, submitted). In this case, MSS coordination between adults and peers is also relevant in producing better well-being prospects. More importantly, the connections between high-attuned MSS and well-being indicators were more generalized, systematic, and greater than the ones found between gender or age and the selected well-being indicators. Thus, this result stresses the importance of greater MSS coordination among disadvantaged youths pointed by a significant body of

studies (Chaturvedi & Kumari, 2016; Mercer, Crocetti, Meeus, & Branje, 2017; Rueger et al., 2010), adding the to the literature the relevance of share/coordinated patterns of MSS for well-being in socially disadvantaged groups.

Finally, interactions between age or gender and MSSA were not significant, meaning that these factors show independent paths in their associations with quality-of-life, social anxiety, and depression. However, exploratory pairwise-mean comparisons of the interactions between gender or age and MSSA patterns led to some additional findings. While patterns of results for boys and girls across MSSA were similar, early adolescents in closest family member or high-attuned MSS categories tended to display better quality-of-life perspectives, as well as lower social anxiety and depression rates, compared to early adolescents reporting low-attuned MSS. Although exploratory, these results indicate the importance of family support or greater MSS coordination in the transition to adolescence, in socially deprived environments.

**Implications and Limitations**

This study suggests that MSSA patterns play a significant role in the production of well-being. From a practical standpoint, community, educational, or social skills training programs seem to benefit from better integrating its assessment, as well as activities to improve MSS coordination. Assessment may be improved from screening stages by using social networks maps or other tools to identify youths' most significant relationships and by investigating social support provided by different sources, through interviews and questionnaires. Screening procedures may also have to take into account greater well-being risks showed by girls. From an intervention standpoint, it may also be important to invest in cross-generational activities, which help support sources form different generations to build ties based on mutual knowledge and trust, which can ultimately be translated in greater MSS coordination.

From a research standpoint, longitudinal studies to clarify gender, age and MSSA connections and potential interactions, as well as their influence in well-being may be particularly informative. The replication of this study in other contexts seems required, namely in rural settings given that in these areas resource deprivation tends to have greater impacts on disadvantaged youths' well-being and development. Comparisons between clinical groups and disadvantaged groups regarding their MSS

patterns and its consequences to general well-being also seem to be required to clarify how different vulnerabilities affect well-being.

This study has limitations which need to be mentioned. The access to youths was mediated by the program. Although a protocol for contact and obtaining informed consent was made available, contacts may have not followed the same procedure across each of the projects that take part in the program. Age distribution is unbalanced across MSSA classes. In addition, it was not possible to divide in groups in more consensual fashion, according to social development literature suggestions (early, intermediate, and late adolescence). Multi-informants are also required in future studies.

## Conclusion

This study demonstrates that MSSA has connections with disadvantaged youths' quality-of-life, social anxiety, and depression which are independent from age and gender. These associations are more generalized and systematic than the links between gender or age and the selected well-being indicators. High-attuned MSS is the optimal MSSA, regarding these youths' better well-being prospects. Exploration of interactions between gender, age, and MSSA through pairwise comparisons show that high-attuned MSS is more systematically associated with improved well-being among early adolescents.

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Table 1. *Zero-order correlations between study variables*

| Variables | 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10. | 11. | 12. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Gender | --- | | | | | | | | | | | |
| 2. Age | -.11 | --- | | | | | | | | | | |
| 3. Ethnicity | .15** | .11 | --- | | | | | | | | | |
| 4. Educational level | .06 | -.23** | .09 | --- | | | | | | | | |
| 5. Closest family member occupational status | -.03 | -.05 | .02 | .16* | ---- | | | | | | | |
| 6. Closest family member social support | -.14* | -.09 | -.16* | .03 | .05 | --- | | | | | | |
| 7. Mentor social support | -.28** | .05 | -.05 | -.05 | -.08 | 53** | --- | | | | | |
| 8. Best friend social support | -.16* | .08 | -.15** | -.09 | -.03 | -.39** | .46** | --- | | | | |
| 9. Multiple social support attunement | -.04 | -.11 | -.10 | -.21** | .06 | .18** | .28** | .27** | --- | | | |
| 10. Quality-of-life | -.02 | -.28** | -.16* | .04 | .10 | .50** | .32** | .21** | .42** | --- | | |
| 11. Social Anxiety | -.10 | -.06 | .03 | .07 | .05 | .18** | -.15** | -.12 | -.20* | .07 | --- | |
| 12. Depression | -.08 | .02 | .01 | .03 | .02 | -.32** | -.25** | -.29** | -.26** | -.22** | .55** | --- |

*p <.05 ** p <.01

Table 2. *Fit indices for one-, two-, three- and four-latent class solutions for latent class analysis*

| Fit indices | One-cluster solution | Two-clusters solution | Three-clusters solution | Four-clusters solution |
|---|---|---|---|---|
| BIC | 4520.71 | 4232.93 | 4178.48 | 4132.19 |
| Sample-size adjusted BIC | 4499.39 | 4177.52 | 4088.42 | 4007.49 |
| Entropy | | .17 | .46 | .42 |

*Note:* BIC – Bayesian Information Criteria

Table 3. *Means (and standardized errors) for social support variables for the four-clusters latent class analysis solution*

| Supports | High closest | Low-attuned | High-attuned | Clusters differences $F$ (3, 233) |
|---|---|---|---|---|
| | Family member support | MSS | MSS | |
| | ($n = 111$) | ($n = 66$) | ($n = 59$) | |
| Closest family member | 38.91 (*2.92*) | 29.97 (*4.14*) | 41.57 (*1.38*) | 264.17*** |
| Mentor | 38.72 (*4.43*) | 32.72 (*5.35*) | 42.75 (*2.41*) | 86.29*** |
| Best friend | 38.87 (*4.61*) | 33.26 (*6.15*) | 44.78 (*.45*) | 99.95*** |

*** $p < .001$

*Note:* All paired mean comparisons showed significant differences on the basis of post-hoc Scheffé tests

Table 4. *Descriptive information for each cluster of multiple social support attunement*

| Variables | High closest Family member support ($n = 111$) | Low-attuned MSS ($n = 66$) | High-attuned MSS ($n = 59$) | Clusters differences $F$ (3, 233) |
|---|---|---|---|---|
| Gender | | | | $\chi2$ (2,234) = 17.14*** |
| Girls | 49 (44.10%) | 13 (19.70%) | 32 (54.20%) | |
| Boys | 62 (55.90%) | 53 (80.30%) | 27 (45.80%) | |
| Age | | | | |
| ≤ 14 years old | 67 (60.40%) | 44 (66.70%) | 43 (72.90%) | $\chi2$ (2,234) = 2.74 |
| ≥ 15 years old | 44 (39.60%) | 22 (33.30%) | 16 (27.10%) | |
| Ethnic group | | | | $\chi2$ (4, 232) = 35.55*** |
| Portuguese | 40 (36.00%) | 17 (25.80%) | 41 (69.50%) | |
| African | 61 (50.00%) | 48 (72.70%) | 5 (22.00%) | |
| Other | 10 (9.00%) | 1 (6.30%) | 5 (8.80%) | |

** $p <.01$; *** $p <.001$

Table 5. *Means and standard deviations for each cluster of multiple social support attunement*

| Outcome variable | High closest Family member support | Low-attuned MSS | High-attuned MSS |
|---|---|---|---|
| | M (*SD*) | M (*SD*) | M (*SD*) |
| Quality-of-Life | 100.21 (*9.33*) | 93.14 (*13.44*) | 106.54 (*7.78*) |
| Social anxiety | 43.52 (*12.66*) | 50.52 (*15.82*) | 42.85 (*15.20*) |
| Depression | 17.05 (*8.36*) | 22.42 (*10.97*) | 13.37 (*8.71*) |

Table 6. *Multiple regressions testing independent effects of gender and multiple social support attunement with age and ethnic group as covariates*

| Factors | Quality-of-life B | S.E. | 95% C. I. | Social anxiety B | S.E. | 95% C. I. | Depression B | S.E. | 95% C. I. |
|---|---|---|---|---|---|---|---|---|---|
| 1. Gender[a] | -1.67 | 1.36 | (-4.35, 1.01) | 5.25** | 1.93 | (1.48, 9.03) | 3.83** | 1.24 | (1.40, 6.28) |
| 2. MSSA/closest family member high support[b] | -5.39** | 1.62 | (-8.57, -2.20) | 1.21 | 2.25 | (-3.31, 5.62) | 4.06** | 1.46 | (1.21, 6.91) |
| 3. MSSA/low-attuned MSS[b] | -13.21*** | 1.84 | (-16.83, -9.59) | 9.48** | 2.58 | (4.42, 14.55) | 10.38*** | 1.67 | (7.11, 13.65) |
| 5.Age | -5.98*** | 1.36 | (-8.65, -3.31) | --- | --- | --- | --- | --- | --- |
| 6. Ethnic group[d] | -1.26 | 1.09 | (-3.41, .90) | --- | --- | --- | --- | --- | --- |

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

*Note:* reference categories: a. Boys; b. High-attuned MSS; c. African participants.

Table 7. *Post-hoc comparisons between interaction categories of GenderXMSS attunement levels for each of the outcome variables*

|  | Quality-of-life | Social anxiety | Depression |
|---|---|---|---|
| 1. | 12.97*** (7.04, 18.90) | -9.02* ( -17.48, -.56) | -10.36*** (-15.83, -4.89) |
| 2. | -3.56 (-7.95, .83) | -2.83 (-9.00, 3.33) | -3.41 (.58, 7.40) |
| 3. | -16.53*** (-22.79, -10.27) | 17.04*** (7.88, 26.20) | 13.77*** (8.00, 19.54) |
| 4. | 5.84** (2.28, 9.39) | 4.68 (-.70, 10.06) | -4.90** (-8.18, -1.62) |
| 5. | -6.96** (-11.40, -2.51) | -4.34 (-12.74, 4.06) | 4.52* (.48, 8.57) |
| 6. | -12.79*** (-17.35, -8.24) | 12.70*** (6.28, 19.11) | 5.87** (1.94, 9.80) |

1.Boys/Closest family member supportXBoys low-attuned MSS; 2. Boys/Closest family member supportXBoys/high-attuned MSS; 3. Boys/low-attuned MSSXBoys/high-attuned MSS; 4.Girls/Closest family member supportXGirls low-attuned MSS; 5. Girls/Closest family member supportXGirls/high-attuned MSS; 6. Girls/low-attuned MSSXGirls/high-attuned MSS.

Table 8. *Multiple regressions testing independent effects of age and multiple social support attunement with ethnic group as covariate*

| | Quality-of-life | | | Social anxiety | | | Depression | | |
|---|---|---|---|---|---|---|---|---|---|
| Factors | B | S.E. | 95% C. I. | B | S.E. | 95% C. I. | B | S.E. | 95% C. I. |
| 1. Age[a] | 6.21*** | 1.35 | (3.55, 8.85) | 1.68 | 1.94 | (-2.13, 5.49) | -.28 | 1.26 | (-2.75, 2.20) |
| 2. MSSA/closest family member high support | -5.24** | 1.63 | (-8.43, -2.06) | .88 | 2.29 | (-3.60, 5.938) | 3.63* | 1.49 | (.72, 6.55) |
| 3. MSSA/low-attuned MSS | -12.12*** | 1.80 | (-16.21, -9.15) | 7.77** | 2.53 | (2.80, 12.74) | 9.03* | 1.65 | (5.81, 12.26) |
| 4. Ethnic group[d] | -.93 | 1.10 | (-3.08, 1.23) | --- | --- | --- | --- | --- | --- |

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

*Note:* reference categories: a. Participants aged ≥ 15 years old; b. High-attuned MSS; c. African participants.

Table 9. *Post-hoc comparisons between interaction categories of ageXMSS attunement levels for each of the outcome variables*

|  | Quality-of-life | Social anxiety | Depression |
|---|---|---|---|
| 1. | 7.08*** (3.36, 10.81) | -10.04*** (-15.37, -4.71) | -5.69** (-9.18, -2.20) |
| 2. | -5.60** (-9.42, -1.78) | .12 (-5.25, 5.49) | 4.22* (.71, 7.74) |
| 3. | -12.68*** (-16.88, -8.49) | 10.55** (2.53, 18.57) | 9.91*** (6.06, 13.77) |
| 4. | 8.05** (3.03, 13.06) | -1.11 (-8.29, 6.06) | -4.77 (-9.47, .08) |
| 5. | -4.52 (-10.16, 1.12) | 1.64 (-6.38, 9.66) | 2.15 (-3.09, 7.40) |
| 6. | -12.57*** (-18.91, -6.23) | 2.76 (-6.27, 11.78) | 6.93* (1.02, 12.83) |

1. Participants aged ≤ 14 years old/Closest family member supportX Participants aged ≤ 14 years old/low-attuned MSS; 2. Participants aged ≤ 14 years old//Closest family member supportX Participants aged ≤ 14 years old//high-attuned MSS; 3. Participants aged ≤ 14 years old//low-attuned MSSX Participants aged ≤ 14 years old//high-attuned MSS.; 4. Participants aged ≥ 15 years old/Closest family member supportX Participants aged ≥ 15 years old/low-attuned MSS; 5. Participants aged ≥ 15 years old//Closest family member supportX Participants aged ≥ 15 years old//high-attuned MSS; 6. Participants aged ≥ 15 years old//low-attuned MSSX Participants aged ≥ 15 years old//high-attuned MSS.

# Appendix

**ISCTE ◉ IUL**
**Instituto Universitário de Lisboa**

**Apresentação do Estudo**

Exmo. (a) Senhor(a)

O meu nome é Carina Mendonça e sou aluna do Mestrado de Psicologia Comunitária e Proteção de Menores no ISCTE – Instituto Universitário de Lisboa. Estou de momento a realizar a minha dissertação para a conclusão do curso, sob orientação de Francisco Simões, investigador do Centro de Investigação e Intervenção Social, do ISCTE-IUL.

O presente estudo tem por tema *A importância do Suporte Social Integrado na ansiedade, depressão e bem-estar de adolescentes*. O suporte social integrado é um conceito global em desenvolvimento no ISCTE-IUL que pretende descrever o impacto da maior ou menor coordenação do apoio social disponibilizado por diferentes figuras de apoio. Este estudo em particular tem por objetivo geral compreender em que medida uma melhor coordenação do suporte social disponibilizado por diferentes figuras adultas de referência poderá contribuir para o desenvolvimento em indicadores de bem-estar negativo e positivo em jovens com idades compreendidas entre os 12 e os 18 anos. São objetivos específicos desta pesquisa: (a) comparar os efeitos de uma maior integração de apoio social, nos indicadores referidos, entre jovens pré-adolescentes (12-14 anos), na adolescência intermédia (15-16 anos) e na adolescência tardia; (b) comparar os efeitos de uma maior integração de apoio social, nos indicadores referidos, entre jovens com diferentes tempos de frequência do projeto (6 ou menos meses, 6 a 11 meses e mais de 12 meses, inclusivé); (c) avaliar o tempo necessário para que o programa promova a coordenação do apoio social, no caso dos jovens com 6 ou menos meses de frequência. Este estudo integra-se numa linha de investigação mais vasta a ser desenvolvida no ISCTE-IUL acerca do suporte social integrado.

Pretende dirigir-se o convite à participação no estudo a todos os projetos dos 4 concelhos da zona de Lisboa com maior número de projetos Escolhas em funcionamento (Lisboa, Sintra, Loures e Amadora) perfazendo um total de 26 projetos. Caso todos estes projetos se encontrem no ativo e aceitem o convite, pretenderíamos recolher os dados nos mesmos.

A recolha será feita com recurso a questionários preenchidos pelos jovens online, sendo, por isso, necessária a utilização das salas de TIC dos projetos. Este estudo envolverá dois

momentos de resposta aos questionários, sendo que o primeiro a realizar nos meses de Março e Abril (consoante disponibilidade dos respetivos projetos) e o segundo momento se prevê ser nos meses de Julho/Agosto (apenas com os jovens que frequentam o programa há menos de 6 meses).
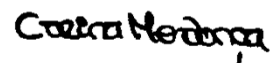
O procedimento terá uma duração aproximada de 45/60 minutos e contará com a presença da responsável pelo estudo que irá explicar aos jovens em que consiste o estudo, preparar os questionários online para preenchimento, assim como acompanhar a sua aplicação, num momento a designar que coincida com atividades do projeto Escolhas. Da parte dos responsáveis dos projetos, será pedido, apenas, que garantam o envio e recolha das autorizações dos encarregados de educação ou representantes legais dos jovens, bem como a colaboração com o estudo na calendarização da recolha de dados.

Os dados recolhidos necessitarão da devida autorização dos representantes legais dos jovens, são confidenciais e serão utilizados, apenas, no contexto deste estudo. É, também, garantida toda a confidencialidade dos dados fornecidos em qualquer comunicação, relatório ou publicação que venha a resultar deste trabalho. Do mesmo modo, é assegurada a divulgação da parceria com o programa Escolhas no estudo em causa, em todas as publicações e apresentações que poderão vir a ser geradas a partir deste trabalho.
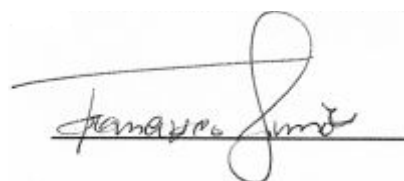
Por fim, e numa ótica de disseminação do conhecimento, pretende-se que as conclusões deste estudo sejam partilhadas quer com o programa Escolhas, ao seu nível executivo, bem como cada projeto aderente, através de workshops cujo formato e duração poderá, posteriormente, ser acordado entre as partes.

Com os melhores cumprimentos,

Carina Mendonça (Responsável pelo estudo)

Francisco Simões (Orientador do projeto de Investigação)

## Appendix B



<div align="right">

Exmo. (a) Senhor(a)

Encarregado de Educação

</div>

**Assunto:** Autorização para participação em projeto de investigação

Chamo-me Carina Mendonça. Sou estudante do Mestrado de Psicologia Comunitária e Proteção de Menores do ISCTE-IUL. Neste momento, estou a desenvolver um estudo para a minha dissertação de Mestrado sobre o tema *A importância do Suporte Social Integrado na ansiedade, depressão e bem-estar de adolescentes,* que tem por objetivo compreender em que medida uma melhor coordenação do suporte social disponibilizado por diferentes adultos importantes poderá contribuir para o desenvolvimento de indicadores de saúde e bem-estar de adolescentes com idades compreendidas entre os 12 e os 18 anos.

Venho, por este meio, pedir a colaboração do(a) seu/sua educando(a) neste estudo, autorizando-o(a) a preencher alguns questionários online, durante uma atividade no âmbito do programa Escolhas. Este estudo irá envolver um momento de resposta aos questionários, sendo que deverá realizar-se em Abril/Julho.

O procedimento terá uma duração de cerca de 30 minutos.

Os dados recolhidos serão confidenciais e utilizados apenas no contexto deste estudo.

Para qualquer dúvida, poderá abordar-me através dos seguintes contactos:

Telemóvel: X/ e-mail: X

Grata pela sua colaboração, despeço-me com os mais cordiais cumprimentos.

Lisboa,     de Abril de 2017

<div align="center">

*Carina Mendonça*

(Carina Mendonça)

</div>

---

<div align="center">

(DEVOLVER, POR FAVOR, A FOLHA COMPLETA)

</div>

Tomei conhecimento das condições do projeto de investigação e autorizo o meu educando (colocar o nome)_____ a participar no estudo, autorizando, ainda, a respetiva equipa a utilizar os dados que aqui forneço no âmbito deste projeto.

Assinatura: _____          Data ___/___/____

**ISCTE ⊗ IUL**
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No âmbito deste projeto de investigação, gostaríamos que preenchesses o questionário que se segue de acordo com as instruções apresentadas.

**É muito importante que respondas a todas as perguntas.** No fim, confirma que respondeste a tudo.

Cada parte do questionário tem instruções sobre como deves responder.

**Isto não é um teste.** Ao responderes, pedimos-te que sejas o mais honesto/ a possível. O importante é a tua perspetiva, as tuas experiências, comportamentos e sentimentos. **Não existem respostas certas ou erradas**. Estamos apenas interessados na tua opinião.

As tuas respostas são **confidenciais**. Quer dizer que ninguém que tu conheças saberá a tua opinião. Por isso, não deves escrever o teu nome em qualquer uma das páginas deste questionário.

Agradecemos mais uma vez o teu importante contributo neste trabalho, sem a tua colaboração tal não seria possível. Irás ter o tempo suficiente para responderes.

Obrigado!

CÓD:

1. Sexo?

   F      □
   M     □

2. Que idade tens? _____

3. Que ano de escolaridade frequentas? _____

4. Em que localidade vives?

_____

5. Agregado Familiar (Com quem vives)?

_____

6. Grupo Étnico:

   ◯ Luso

   ◯ Brasileiro

   ◯ Africano

   ◯ Cigano

   Outro?_____

7. Responde, por favor, a algumas questões relacionadas com a figura parental adulta (pai, mãe ou outra) com quem vives e passas mais tempo. Diz-nos primeiro em quem te vais basear para responder a estas questões:

Figura parental adulta com quem vivo e passo mais tempo:

Pai □
Mãe□
Outro □ _____

Situação Profissional (Da Figura Parental)?

Estudante □
Empregado/a □
Desempregado/a □
No fundo de desemprego □
Reformado/a □

Se empregado, qual a sua profissão? <u>Responde apenas se a pessoa se encontra a trabalhar.</u>

_____

Nível de Escolaridade?

Ensino universitário ou equivalente □
Ensino médio ou técnico superior (Técnicos e peritos) □
Ensino médio ou técnico inferior (Cursos de liceu, industrial ou comercial, militares de baixa patente ou sem academia) □
Ensino primário completo □
Ensino Primário incompleto ou nulo □
Não sei □

Agora voltamos a focar-nos em ti e gostaríamos de saber mais sobre este projeto que frequentas...

8. Há quanto tempo participas neste projeto?

_____

9. Quantas horas por semana passas no projeto durante o tempo de aulas?

_____ Horas

10. E durante as férias letivas, quantas horas frequentas o projeto?

_____ Horas

Como estás? É isso que queríamos que tu nos contasses. Por favor lê todas as questões cuidadosamente. Que resposta vem à tua cabeça primeiro? Escolhe e assinala a resposta mais adequada ao teu caso.

## 1. Saúde e Atividade Física

1. Em geral, como descreves a tua saúde?

☐ Exelente
☐ Muito boa
☐ Boa
☐ Má
☐ Muito má

Pense na última semana…

|  | Nada | Pouco | Moderadamente | Muito | Extremamente |
|---|---|---|---|---|---|
| 2. Sentiste-te bem e em forma? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Estiveste fisicamente activo (ex: correr, escalada, andar de bicicleta)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Foste capaz de correr bem? | ☐ | ☐ | ☐ | ☐ | ☐ |

Pensa na última semana…

|  | Nunca | Raramente | Algumas vezes | Frequentemente | Sempre |
|---|---|---|---|---|---|
| 5. Sentiste-te cheio (a) de energia? | ☐ | ☐ | ☐ | ☐ | ☐ |

## 2. Estado de humor geral e sentimentos sobre si próprio

Pense na última semana…

| | Nada | Pouco | Moderada mente | Muito | Extremame nte |
|---|---|---|---|---|---|
| 1. A tua vida tem sido agradável? | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Nunca | Raramente | Algumas vezes | Frequente mente | Sempre |
|---|---|---|---|---|---|
| 2. Tiveste bom humor? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Divertiste-te? | ☐ | ☐ | ☐ | ☐ | ☐ |

Pense na última semana….

| | Nunca | Raramente | Algumas vezes | Frequente mente | Sempre |
|---|---|---|---|---|---|
| 4. Sentiste-te triste? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Sentiste-te tão mal que não quiseste fazer nada? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Sentiste-te sozinho (a)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Sentiste-te feliz com a tua maneira de ser? | ☐ | ☐ | ☐ | ☐ | ☐ |

## 3. Família e tempo livre

Pense na última semana…

| | Nunca | Raramente | Algumas vezes | Frequente mente | Sempre |
|---|---|---|---|---|---|
| 1. Tiveste tempo suficiente para ti próprio? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Foste capaz de fazer atividades que gostas de fazer no teu tempo livre? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Os teus pais tiveram tempo suficiente para ti? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Os teus pais trataram-te com justiça? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Foste capaz de conversar com os teus pais quando quiseste? | ☐ | ☐ | ☐ | ☐ | ☐ |

| | 6. Tiveste dinheiro suficiente para fazeres as mesmas atividades que os teus amigos(as)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| --- | --- | --- | --- | --- | --- | --- |
| 7. Tiveste dinheiro suficiente para as tuas despesas? | ☐ | ☐ | ☐ | ☐ | ☐ |

## 4. Amigos

Pense na última semana…

| | Nunca | Raramente | Algumas vezes | Frequente mente | Sempre |
| --- | --- | --- | --- | --- | --- |
| 1. Passaste tempo com os teus amigos(as)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Divertiste-te com os teus amigos(as)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Tu e os teus/tuas amigos(as) ajudaram-se uns aos outros? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Sentiste que podes confiar nos(as) teus/tuas amigos(as)? | ☐ | ☐ | ☐ | ☐ | ☐ |

## 5. Ambiente escolar e aprendizagem

Pense na última semana…

| | Nada | Pouco | Moderada mente | Muito | Extremame nte |
| --- | --- | --- | --- | --- | --- |
| 1. Sentiste-te feliz na escola? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Foste bom aluno (a) na escola? | ☐ | ☐ | ☐ | ☐ | ☐ |

Pense na última semana…

| | Nunca | Raramente | Algumas vezes | Frequente mente | Sempre |
| --- | --- | --- | --- | --- | --- |
| 1. Sentiste-te capaz de prestar atenção? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Tiveste uma boa relação com os teus professores? | ☐ | ☐ | ☐ | ☐ | ☐ |

Por favor, lê cuidadosamente as afirmações que se seguem. De que forma se relacionam com a tua vida? E de que forma achas que são verdadeiras na relação com as pessoas indicadas no quadro (figura parental adulta [pai, mãe ou outra] com quem vives e passas mais tempo, o teu mentor no programa e o teu melhor amigo)?

Classifica cada frase de um (nunca) a cinco (sempre) de acordo com a escala abaixo.

1= Nunca; 2 = Poucas vezes; 3=Às vezes; 4= Muitas vezes; 5 = Sempre.

| | Figura parental com quem passas mais tempo _____ | Mentor do programa | Melhor Amigo |
|---|---|---|---|
| 1. Quando estou com ele/ela, sinto que posso ser eu próprio/a. | | | |
| 2. Quando estou com ele/ela, sinto-me capaz de fazer as coisas bem. | | | |
| 3. Quando estou com ele/ela, sinto muita proximidade/confiança. | | | |
| 4. Quando estou com ele/ela, sinto que posso dizer o que penso. | | | |
| 5. Quando estou com ele/ela, sinto que sou capaz de fazer as coisas depressa e bem. | | | |
| 6. Quando estou com ele/ela, sinto que se interessa e que gosta de mim. | | | |
| 7. Quando estou com ele/ela, sinto-me incapaz. | | | |
| 8. Quando estou com ele/ela, sinto um grande afastamento entre nós. | | | |
| 9. Quando estou com ele/ela, sinto-me obrigado a ser de uma maneira que não sou. | | | |

Isto não é um teste, por isso não há respostas certas ou erradas. Por favor responde a cada item o mais sinceramente possível.
De acordo com a escala abaixo apresentada, seleciona quanto é que achas que cada afirmação tem a ver contigo.

**1 =De forma nenhuma**
**2 =Dificilmente tem a ver comigo**
**3 =Algumas vezes**
**4 =A maioria das vezes**
**5 =Todas as vezes**

|  | De forma nenhuma (1) | Dificilmente tem a ver comigo (2) | Algumas Vezes (3) | A maioria das vezes (4) | Todas as Vezes (5) |
|---|---|---|---|---|---|
| 1. Fico nervoso quando tenho de fazer coisas novas em frente a outras pessoas. |  |  |  |  |  |
| 3. Preocupa-me que as outras pessoas me gozem. |  |  |  |  |  |
| 4. Sou tímido quando estou com pessoas que não conheço. |  |  |  |  |  |
| 5. Só falo com pessoas que conheço muito bem. |  |  |  |  |  |
| 6. Sinto que as pessoas falam de mim nas minhas costas. |  |  |  |  |  |
| 8. Preocupo-me com o que as outras pessoas pensam de mim. |  |  |  |  |  |
| 9. Tenho medo que as outras pessoas não gostem de mim. |  |  |  |  |  |
| 10. Fico nervoso quando falo com pessoas que não conheço bem. |  |  |  |  |  |
| 12. Preocupo-me com o que as |  |  |  |  |  |

| | | | | | |
|---|---|---|---|---|---|
| outras pessoas dizem de mim. | | | | | |
| 13. Fico nervoso quando conheço pessoas novas. | | | | | |
| 14. Preocupa-me que as outras pessoas não gostem de mim. | | | | | |
| 15. Fico calado quando estou num grupo de pessoas. | | | | | |
| 17. Sinto que as outras pessoas gozam comigo | | | | | |
| 18. Preocupa-me que as pessoas não gostem de mim se eu discutir com elas. | | | | | |
| 19. Tenho medo de convidar outras pessoas para fazerem coisas comigo porque elas podem dizer que não. | | | | | |
| 20. Fico nervoso quando estou perto de certas pessoas. | | | | | |
| 21. Sou tímido mesmo com pessoas que conheço bem. | | | | | |
| 22. É-me difícil pedir às outras pessoas para fazerem coisas comigo. | | | | | |

De seguida, são apresentadas algumas frases que descrevem sentimentos. Pensa como te sentiste na última semana e seleciona com um X a opção que consideras mais adequada e que corresponde melhor à forma como te sentiste.

Responde tendo em consideração a seguinte escala: 0=Nunca; 1=Poucas Vezes; 2=Algumas Vezes e 3=Muitas Vezes.

| | Nunca (0) | Poucas Vezes (1) | Algumas Vezes (2) | Muitas vezes (3) |
|---|---|---|---|---|
| 1. Senti-me aborrecido(a)/incomodado(a) com coisas que normalmente não me aborrecem ou incomodam | | | | |
| 2. Não tive vontade de comer, não tive muita fome | | | | |
| 3. Não consegui sentir-me feliz, mesmo quando a minha família ou amigos tentaram "animar-me" | | | | |
| 4. Senti que era tao bom (boa) quanto os (as) outros (as) colegas | | | | |
| 5. Senti que não conseguia prestar atenção ao que estava a fazer | | | | |
| 6. Senti-me "em baixo" e infeliz | | | | |
| 7. Senti-me muito cansado(a) para fazer as minhas coisas | | | | |
| 8. Senti que alguma coisa boa estava para acontecer | | | | |
| 9. Senti que as coisas que eu fiz no passado falharam | | | | |
| 10. Senti-me com medo | | | | |
| 11. Não dormi tao bem como costumo dormir | | | | |
| 12. Senti-me feliz | | | | |
| 13. Estive mais parado(a) do que o habitual | | | | |
| 14. Senti-me sozinho(a), como se não tivesse nenhum amigo | | | | |
| 15. Senti que os meus colegas não eram meus amigos ou que não queriam estar comigo | | | | |
| 16. Diverti-me | | | | |
| 17. Tive vontade de chorar | | | | |
| 18. Senti-me triste | | | | |
| 19. Senti que as pessoas não gostavam de mim | | | | |
| 20. Foi difícil começar a fazer as coisas | | | | |

**F I M**
**Obrigado por teres respondido a este questionário!**