# Social support as a moderator of associations between youth's perceptions of their social images and self-representations in residential care


## Abstract

This study explored the associations between the perceptions that youth in residential care have about their social images (i.e., their perceptions of how other people in general perceive them) and their self-representations, and the moderating role of social support from residential caregivers and friends in those associations. A sample of 926 youths in residential care, aged between 12 and 25 years old, filled out self-report questionnaires tapping their perceptions of their social images, self-representations, and perceived social support. Results indicated that positive youths' perceptions of their social images were associated to youth's positive self-representations, and that negative youths' perceptions of their social images dimensions were associated to youth's negative self-representation dimensions. Results also indicated that support from the main residential caregiver and friends moderated associations between youth's perceptions of their social images and self-representations, functioning as a protective factor. These findings underline the importance of youth's perceptions of their social images and the support from residential caregivers and friends both for youth in residential care.


*Keywords*: social images; self-representations; social support; youth in residential care

## Introduction

According to the Symbolic Interactionist Theory, self-representations develop through social interactions with other individuals (e.g., Major & O'Brien, 2005). Grounding on this premise, Mead (1934) highlighted the influence of other people in general, of the 'generalized other', arguing that it is by reference to the content available and transmitted in the social context that individuals define themselves. According to Kinch (1963), the impact of others' representations (i.e., social images) on self-representations is mediated by individuals' perceptions of others' representations of them, that is, what the individual considers that others think about him.

Following this approach, many classic perspectives assumed that individuals in stigmatized groups internalize the negative view of them held by society (Crocker & Quinn, 2000; Turner & Whitehead, 2008). Therefore, individuals may develop negative self-representations, especially when their group is socially devalued (Major & O'Brien, 2005). Looking specifically at youth in care, some authors stressed that they may face additional challenges in their development, such as adopting a negative self-identity as a result of the stigmatization of being a youth in care (Lopes, Calheiros, Garrido, & Patrício, 2017; Simkiss, 2013). Indeed, studies with youths in residential care have shown that they feel labelled and a target of negative attitudes by society because of their looked-after status (Montserrat, Casas, & Malo, 2013; Simkiss, 2013). They feel different in part because they have experiences of name-calling and differential treatment outside the care setting, which is often a consequence of the stigma associated to residential care (Mullan, McAlister, Rollock, & Fitzsimons, 2007). The few studies addressing the social images of children and youth in RC indicate that they are often associated with negative attributes (e.g., aggressive, sad, rebellious, deprived, lonely) (Garrido, Patrício, Calheiros, & Lopes, 2016; Ibrahim & Howe, 2011). Moreover,

these images are conveyed by different sources such as laypeople, welfare workers, legislators, and policy makers (Calheiros, Garrido, Lopes, & Patrício, 2015).

Also, there is a lack of research with youth in residential care focused on exploring the influence of generalized others on youth's self-representation construction process. Therefore, in this study we will analyze the role of youth's perceptions of their social images (PSI; i.e., youth's perceptions of how others in general describe them) on their Self-representations (SR) in the context of residential care. Moreover, we will analyze the moderating role of social support received from caregivers and friends, since it may buffer the effect of negative PSI on SR, and potentiate the effect of positive PSI on SR.

**Social support in the context of residential youth care**

Social support networks of adolescents in care play an important role in their lives (Del Valle, Bravo, & López, 2010; Pinchover & Attar-Schwartz, 2018). A recent systematic review has identified the positive role of significant others in the context of residential care, positive relationships with residential caregivers and friends, and educational support as significant factors that may foster resilience of young people in care (Lou, Taylor & Di Folco, 2018). Furthermore, findings of studies with adolescents in residential care have shown that peer relationships are meaningful sources of support (e.g., these friends empathize with their own experiences in care) together with residential caregivers (Del Valle et al., 2010; Pinchover & Attar-Schwartz, 2018).

Social support positively impacts mental health, through direct (i.e., social support positively affects health and well-being regardless of stress) (Attar-Schwartz & Fridman-Teutsch, 2018) or buffer effects (i.e., social support acts as a buffer, being a protective factor as it lessens the negative consequences of stressful events) (e. g., Cohen, 2004). Particularly, literature on young people in residential care also emphasizes this protective role of social support, namely regarding emotional and behavioral problems (Erol, Simsek, & Münir, 2010;

Magalhães & Calheiros, 2017). Adolescents reporting higher support from professionals and positive peer support show better adjustment outcomes (Brausch & Decker, 2014). Social support has also been shown to moderate the link between perceived discrimination and health (Pascoe & Richman, 2009). The availability of friends to talk to after experiences of discrimination may help to rebuild an individual's feelings of self-worth, potentially preventing the development of depressive symptoms (e.g., Pascoe & Richman, 2009).

Furthermore, considering the significant social and psychological vulnerability of young people in residential care, supportive relationships in residential care are essential for helping these youth overcome previous adverse experiences and fostering their healthy development (Dell Valle et al., 2010; Magalhães & Calheiros, 2017). These young people have to deal not only with stigma and discrimination but also with different separations, (re)integrations as well as with adaptation challenges to the residential facilities (Dell Valle et al., 2010). In addition, in Portugal (where this study was conducted), there are young people with a long-lasting placement in care, with no prospect of family reunification, and for whom the quality of relationships in the context of residential care is even more critical and protective. Considering the theoretical benefits of social support, the residential care setting plays a vital role in providing social and supportive resources that enable young people to acquire coping strategies in the face of their negative life events. Moreover, the residential care setting should offer a stable, supportive, and secure environment that provides feelings of security and protection, as well as the opportunity for young people to identify themselves with positive models, thus leading to a positive idea about the self.

However, studies focused on the role of social support in residential care are mainly descriptive (Dell Vale et al., 2010) or have only tested direct effects of support on mental health (Attar-Schwartz, 2013). Few exceptions testing the moderating role of supportive relationships in care have not included youth's perceived support from residential caregivers

in the model (Attar-Schwartz & Huri, 2019) nor evaluated its effect on the self. However, considering the significant role of residential caregivers in the daily routines of youth in residential care as well as their main role as caregivers, the support from them should be evaluated and tested as an important protective factor.

### Current study

Based on this theoretical background, in this study we will test the following hypothesis: a) Youths' perceptions of their social images (PSI) are associated to their self-representations (SR); and b) social support buffers associations between negative PSI and SR, and amplifies associations between positive PSI and SR. Considering that SR varies with age, length of placement and gender (Salley, Vannatta, Gerhard, & Noll, 2010), these variables will be controlled in the analyses as covariates.

## Method

### Research Context

In Portugal, the full implementation of a protection system focused on the family potential has not yet been established (Rodrigues, Barbosa-Ducharne, & Del Valle, 2013). Thus, residential care is still the primary form of out-of-home care for children and youth in Portugal. The residential care system is supervised by the Ministry of Welfare and is divided into the following services: emergency shelters, temporary care centers, and children and youth residential care centers (standard or specialized). Residential care centers are used as long-term out-of-home response enforced by the child care protection system in order to ensure the safety, well-being, and development of children and youth at risk (e.g., orphaned, abandoned, deprived of adequate family environment, subject to abuse and/or neglect). Recent data from the Portuguese context indicates that 88% of young people in out-of-home care are living in long-term out-of-home, standard residential care settings, and 9% are living in specialized or therapeutic residential care settings. These data show the insufficient

investment in prevention and the promotion of family foster care or therapeutic residential care as an alternative to standard residential care (foster care represents merely about 3% of out-of-home care) (Instituto da Segurança Social, 2017).

In the current study, we are referring to standard residential care units (that do not include autonomy residences, emergency, therapeutic, or correctional care; see Whittaker et al., 2016). Recent official reports (Instituto da Segurança Social, 2017) indicate that children up to 11 years old are predominantly placed in Temporary Care Centers (68%), while standard Residential Care Centers host children or youth older than 12 years (82%). Overall, gender is relatively balanced (52% of males and 48% females) and the length of placement is usually high, with 34% of the children and youth living in residential care for over 4 years or more. Behavioral problems have been identified in 27% of this population with particular incidence in youth aged between 15 and 17 years. As for clinically diagnosed mental health problems, these have been identified in approximately 8% of this population, mostly (and similarly) among 10 to 20-year-old (Instituto da Segurança Social, 2017).

**Participants**

The sample was composed by 926 young people (45.5% females) from 71 residential care institutions, with ages between 11.90 and 25.36 years old (M = 16.26, SD = 2.22). The majority were Portuguese (84.9%) and the remaining were mostly from African countries (5.5%, Angola, Cape Verde, Sao Tome, Guinea), but also from other countries. Most participants were placed in the current care institution for 0.08 to 20.84 years (M = 3.74, SD = 3.71) and 37.6% had previous out-of-home placements. These youths were placed in care due to neglect (49.5%), exposure to harmful behaviors (45.2%), physical and psychological abuse (33.8%), anti-social behaviors (27.2%), abandonment (10.5%) and/or sexual abuse (4.6%). The residential care institutions hosted between 3 and 53 youth (*M* = 18.05, *SD* = 10.44). The mean ratio was of 3.26 children/youth per caregiver (SD = 5.23, Min = 1, Max =

41). These were mainly long-term residential care units (60.6%), from urban areas (67.6%), 33.8% were mixed, 35.2% for female youth, and 31% for male youth.

## Instruments

**Self-representations (SR).** The Self-representations Questionnaire for Youth in Residential Care (SRQYRC; Patrício, Calheiros, & Martins, 2016) is composed by 23 attributes, organized in 6 dimensions: Social (nice, friend, helpful, funny); Competence (intelligent, hard-working, committed and competent); Relational (cherished, protected, loved); Behavioral (aggressive, recalcitrant, misbehaved, conflicting, problematic, stubborn); Emotional (depressed, traumatized, sad, lonely); and Misfit (misfit, neglected). These factors, in turn, compose 2 second order factors: Global positive self-representations (Social, Competence and Relational) and Global negative self-representations (Behavioral, Emotional and Misfit), which reflect youth' self-representations, respectively, on positive social, competence and relational attributes, and on negative behavioral, emotional, and misfit attributes. Youths were asked to rate each attribute on a 5-point scale, indicating how descriptive each attribute was of themselves (1= I am definitely not like that; 5= I am totally like that). This measure showed an adequate model fit ($\chi^2/df$ = 2.031, CFI = .927, TLI = .916, RMSEA = .050), adequate reliability except on the Misfit dimension (Social α = .81, Competence α = .75, Relational α = .72, Global positive self-representations α = .84, Behavioral α = .80, Emotional α = .75, Misfit α = .55, Global negative self-representations α = .81), and adequate construct validity (related to mental health dimensions) (Patrício, Calheiros, & Martins, 2016).

**Youths' perceptions of their social images (PSI).** The questionnaire used to measure youth's perceptions of their social images (i.e., their perceptions of others' representations of them) included a set of 19 attributes, organized in 4 dimensions: Social (nice, friend, helpful), Resilience (courageous, fighter, protected), Behavioral (recalcitrant,

stubborn, misbehaved, aggressive, conflicting, angry), and Emotional (depressed, lonely, traumatized, sad, neglected, low self-esteem, abandoned). These dimensions, in turn, are organized in 2 second order factors: Global positive (Social and Resilience) and Global negative (Behavioral and emotional), which respectively reflect whether youth think people in general perceive them as sociable and resilient, or as behaviorally and emotionally problematic. Youths were asked to rate each attribute on a 5-point scale, indicating how descriptive each attribute was of the way people in general think about them (1= People in general think I am definitely not like that; 5= People in general think I am totally like that). This measure showed an adequate model fit ($\chi^2/df$ = 2.17, CFI = .936, TLI = .924, RMSEA = .059) and adequate reliability (Social α = .870, Resilience α = .697, Global Positive α = .816, Behavioral α = .837, Emotional α = .831, Global Negative α = .864).

**Social support.** Perceptions of social support were evaluated through the Network of Relationships Inventory–Relationship Quality Version (NRI-RQV; Furman & Buhrmester, 1985; Buhrmester & Furman, 2008), which describes supportive and discordant qualities of relationships among children, adolescents, and adults. We asked the youths to evaluate their relationship with their main caregiver (previously selected by the researcher based on the time they spend with the youth) and a friend (also selected by the youth) in a 5-point scale (1= Little or None to 5 = The Most; or 1=Never to 5=Always). In this study we used four positive dimensions of the NRI-RQV, specifically: companionship (e.g., How often do you and this person go places and do things together?), intimate disclosure (e.g., How often do you share secrets and private feelings with this person?), satisfaction (e.g., How good is your relationship with this person?), and emotional support (e.g., How often do you turn to this person for support with personal problems?), which are organized in a second-order factor of social support In this sample, this measure showed an adequate model fit for the two relationships evaluated (Caregiver: $\chi^2/df$ = 4.90, CFI = .928, TLI = .916, RMSEA = .072;

Friend: $\chi^2/df$ = 3.43, CFI = .931, TLI = .920, RMSEA = .057), and adequate reliability (α = .640 to α = . 927).

**Individual characteristics.** Youth's individual characteristics were collected through a questionnaire filled out by each youth's respective case manager. In this questionnaire, professionals gave information regarding the youth birthday and placement date, gender, along with other information.

## Procedure

The present study is part of a national broader research project focused on youths' self-representations. Following approval by the Ethics Commission of ISCTE-University Institute of Lisbon, formal contacts with the residential care units were conducted to obtain the necessary authorizations to collect the data. All the residential care units (381) registered in a social services' online database were invited to participate in this study. From these, 39.9% residential care units replied, of which 93 (61%) accepted to participate in the project and 59 (39%) declined (38 justified that they did not have young people 12 or older; 17 justified that they were overloaded with work and had no time to participate; one was closed; and three gave no reason to decline). From the 93 institutions that accepted to participate in this study, four later quit their participation due to the amount of data that was necessary to collect, 17 institutions were not available to conduct the study until after the project data collection term, and one was excluded after the data collection because the questionnaires were not properly filled. Thus, a set of 71 long-term (for placements longer than 6 month) or temporary (for placements shorter than six month), standard (i.e., not including emergency, therapeutic, or correctional care; see Whittaker et al., 2016), residential care units were included in the study, representing 17 of the 18 districts of Portugal (94.4%).

All youths placed in these units for more than 1 month, aged 12 or more years old, were invited to participate, except if they presented major cognitive difficulties (information

given by the residential unit director). Consent for youth's participation was first obtained from their respective residential unit director, since he/she is youth's representatives in the context of residential care and responsible for accompanying and pronouncing him or herself regarding youth's formal decisions while they are in residential care. All youths who met the inclusion criteria and were authorized to participate by the residential unit director were included in the study, except those who declined to participate. Overall, youth's consent and participation ranged from 13.3% to 100% ($M$ = 68.84, $SD$ = 24.11) across participating institutions. Data collection with youths was conducted by the researchers, in groups of 3 to 20 participants (a mean of 10 youth per group and a ratio of at least 1 researcher to 10 youths). To ensure youth that their participations in the study was independent from their case management within the residential unit, no residential care staff was present in youth's data collection session. The goals of the study and instructions for filling out the data protocol were explained at the beginning of the data collection session, and the researcher was always present to answer any questions and provide youths with any help or assistance whenever necessary. Information regarding anonymity and confidentiality was also given at the beginning and the youth signed an informed consent form prior to their participation.

Youth with reading and comprehension difficulties were previously identified by their case managers and were individually interviewed by one of the researchers, following the assessment protocol (195 individual interviews conducted, 21%). At the end of each data collection session, participating youth put their questionnaires in a box, which was then sealed and taken by the research team, to ensure them that their answers would not be seen by the residential care professionals. Finally, the case managers filled out a form to collect young people's additional demographic information (e.g., sex, age, length of placement, prior placements). Case managers were also given information regarding the aims of the research, anonymity, and confidentiality of the data, and signed an informed consent prior to their

participation. To ensure anonymity of the data, a code-system was created for allowing the research team to merge the data from youth's questionnaires with that of their corresponding case manager. All youths were assigned a Youth-ID, all case managers were assigned a Case-manager-ID, and residential units were assigned a Setting-ID. Then, for each residential unit, a masterfile was created, with personal identifiers (i.e., name of the youth, case managers, and residential unit) and with the correspondence between the IDs at the three levels (i.e., youth, case manager, and residential unit). These masterfiles were password-protected, could only be accessed by the research team, and were only used prior to data collection to prepare the study materials. Such preparation involved writing participants' unique IDs in the questionnaire to be handed to each participant. The form filled out by the case managers contained both Youth- and Case-manager- IDs to allow the research team to merge youth's and respective case managers' questionnaire without having to consult the masterfiles. Once the materials were prepared, the masterfiles could only be accessed the project lead researcher and were destroyed once data collection was completed. All research staff were psychologists with solid experience in collecting research data, particularly with youth in residential care. Prior to the data collection, they received training and supervision in administering this study's specific measures by the project lead researcher. All the research staff were proficient in entering, verifying, and cleaning data. This process was carefully monitored by the project lead researcher, and data entry in the database was double-checked by two members of the research team to assure that all data was correctly entered.

**Data analyses**

We used SPSS (Version 20) to analyze the data. Initial analyses included descriptive statistics and bivariate correlations of the predictor, criterion, and moderator variables. Next, multiple regression analyses were conducted to estimate the association between youth's perceptions of their social images (PSI) and youth's self-representations (SR). The effect of

the second order PSI factors (Global positive and Global negative) and of the first order PSI dimensions (Social, Resilience, Behavioral and Emotional) were tested on separated models because of multicollinearity assumptions. To examine the moderation effects, the hypothesized moderating variables (i.e., quality of support from the main caregiver and quality of support from a friend) and the interaction terms were added to these models. Variables were standardized and multiplied to create the interaction terms (Aiken & West, 1991). Age, placement length and gender were controlled for in these subsequent analyses.

## Results

### Descriptive Statistics and Bivariate Relations

Descriptive statistics (*M, SD*) and bivariate correlations are presented in Table 1. Overall, positive PSI dimensions (Social, Resilience, Global Positive) were positively related to positive SR dimensions (Social, Competence, Relational, Global Positive), and negatively related to negative SR dimensions (Behavioral, Emotional, Misfit, Global Negative); while negative PSI dimensions (Behavioral, Emotional, Global Negative) were negatively related to positive SR dimensions, and positively related to negative SR dimensions. Only Behavioral SR was not significantly related to Resilience and Global Positive PSI. Regarding the moderating variables, as shown in Table 1, in general the positive PSI and SR dimensions were positively related to the quality of support from residential caregivers and friends, while negative PSI and SR dimensions were negatively related to the quality of support. However, Behavioral PSI and SR were not significantly related to quality of support from friends, and Emotional PSI and SR were not significantly related to quality of support from caregiver. Regarding the caregiver support, 45.8% of the youth indicated that the pre-selected caregiver was their favorite caregiver. Regarding the friend support, the friend selected by the youth when filling the questionnaire was not from the residential care unit in 56.3% of the cases. As for the control variables, age was positively related to Competence and Global positive SR,

and negatively related to quality of support from caregiver. Length of placement was positively related to Competence SR, Global, positive SR, and quality of support from friends; and negatively related to Behavioral PSI, Behavioral SR, and Global negative SR.

[INSERT TABLE 1]

Regarding gender differences, as can be seen in Table 2, female youth reported higher levels of Behavioral, Emotional, and Global negative PSI, as well as higher levels of Behavioral, Emotional, and Global negative SR than male youth. Female youth also had significantly higher levels of quality of support from friends. Finally, females were significantly older than males.

[INSERT TABLE 2]

**Associations between youth's perceptions of their social images and self-representations**

Results of the multiple regression analyses are shown in Table 3. Linearity and normality assumptions were poor. Nevertheless, residual plots, tolerance and VIF values suggest no serious violation of the normality and homoscedasticity assumptions. As can be seen in Table 3, both in the first models (i.e., with the second order PSI factors as predictors – Global positive and Global) and the second models (i.e., with the first order PSI dimensions as predictors – Social, Resilience, Behavioral and Emotional), the SR dimensions with the higher explained variance were Global positive SR, Global negative SR and Behavioral SR, and the dimension with the lower explained variance was the Misfit SR.

[INSERT TABLE 3]

Coefficients of the multiple regression analyses are shown in Table 4. Only significant coefficients are presented. Results showed that the positive PSI dimensions (i.e., Global positive, Social, Resilience) were associated with the positive SR dimensions (i.e., Social, Competence, Relational, Global positive). That is, the more youth think that others in general perceive them as more resilient and sociable (i.e., Global positive PSI), the more they

present positive Social, Competence, Relational and Global positive SR. Similarly, the more youth think that others in general perceive them as having more behavioral and emotional problems (Global negative PSI), the more they present negative self-representations. However, the effects of the negative PSI dimensions differed across different SR dimensions. Specifically, only Emotional PSI (and not Behavioral PSI) had a significant and positive association with Emotional and Misfit SR – that is, the more youth think that others in general perceive them as having more emotional problems, the more they present emotional problematic and misfit self-representations. Additionally, Behavioral and Emotional PSI both had a significant and positive effect on Behavioral SR – that is, the more youth think that others in general perceive them as having more behavioral problems and less emotional problems, the more they present behavioral problematic self-representations.

Results also showed some associations between positive and negative dimensions of both measures. Specifically, the more youth think that others in general perceive them as more sociable, the less they present misfit self-representations; and the more youth think that others in general perceive them as having more behavioral problems, the less they present competence self-representations. In addition, although small, a positive association between Global positive PSI and Behavioral SR was also observed.

[INSERT TABLE 4]

**Associations between youths' perceptions of their social images and self-representations moderated by social support**

Results of the multiple regression analyses with the moderating variables (i.e., the quality of social support) are shown in Table 5. Again, in both the first models (i.e., with the second order PSI factors as predictors) and the second models (i.e., with the first order PSI factors as predictors), the SR dimensions with the higher explained variance were Global positive SR, Global negative SR, Social SR and Behavioral SR, while Misfit SR was the

dimension with the lower explained variance. Significant moderation effects are presented in Table 6.

[INSERT TABLE 5]

[INSERT TABLE 6]

**Caregiver support.** Specifically, significant interaction effects were found between Global negative, Social and Emotional PSI dimensions and quality of caregiver's support on Social and Global positive SR. As shown in Figure 1, the association between Global negative PSI and Social SR was buffered by the quality of caregiver's support, wherein higher levels of Global negative PSI were associated with lower levels of social SR, particularly when youth have lower levels of support from caregiver, and not when they have higher levels of support. The effect of Global negative and Emotional PSI on Global positive SR was also buffered in the same direction (figures not shown). Higher levels of Global negative and Emotional PSI were associated with lower levels of Global positive SR, particularly when youth have lower levels of support quality from their main caregiver, as compared to when they have higher levels of support quality.

[INSERT FIGURE 1]

As shown in Figure 2, the association between Social PSI and Social SR was amplified by the quality of caregiver's support. In this case, higher levels of Social PSI were associated with higher levels of Social SR, particularly when youth have higher levels support quality from the caregiver. The association between Social PSI and Global positive SR was also intensified in the same direction (figure not shown), wherein higher levels of Social PSI were associated with higher levels of Global positive SR, particularly when youth have higher levels of support quality.

[INSERT FIGURE 2]

**Friend support.** Significant interaction effects were found between Global negative PSI and quality of support from a friend on Relational SR. As shown in Figure 3, the association between Global negative PSI and Relational SR was not buffered by the quality of support from a friend, wherein higher Global negative PSI was associated with less Relational SR for youth with higher levels of support quality from a friend, but not for youth with lower levels of support quality. However, when the Global negative PSI are low, youth with higher levels of friend support quality show better Relational SR (i.e., friend support is positive for youth only when there is no perceived threat in the form of negative PSI).

[INSERT FIGURE 3]

Similarly, as shown in Figure 4, the association between Behavioral PSI and Emotional SR was not buffered by quality of support from a friend, wherein higher levels of Behavioral PSI was associated with higher levels of Emotional SR for youth with higher levels of support quality from a friend, but not for youth with lower levels of such support quality. However, similar to the association previously described, when Behavioral PSI are low, youth with more support quality from a friend show lower levels of Emotional SR (i.e., friend support is positive for youth when there is no threat).

[INSERT FIGURE 4]

## Discussion

In this study we analyzed the effects of youth's perceptions of others' representations of them on youth's self-representations, testing the moderating role of social support, in a sample of youth in residential care. Findings supported the first hypothesis of this study. Indeed, youth's perceptions of their social images were related to their self-representations. The positive dimensions of youth's perceptions of their social images had a positive effect on the positive self-representation dimensions: that is, the more youth perceive that others in general identify them as resilient and sociable, the more they present positive social,

competence, relational and globally positive self-representations. Moreover, some positive dimensions of youth's perceptions of their social images had a negative effect on negative self-representation dimensions. For example, youth that thought that others in general perceive them as more sociable presented lower levels of misfit self-representations.

Likewise, the negative dimensions of youth's perceptions of their social images had a positive effect on the negative self-representation dimensions, although some of these effects differed according to the SR dimension measured. The more youth thought that others in general perceive them as having more emotional problems, the more they presented emotional problematic and misfit self-representations; and the more youth think that others in general perceive them as having more behavioral problems and less emotional problems, the more they present behavioral problematic self-representations. Moreover, some negative PSI dimensions also had a negative effect on positive SR dimensions, namely the youth thinking that others in general perceive them as having more behavioral problems have less competence self-representations. Thus, associations between PSI and SR is stronger when the same domain is evaluated (i.e., within-domain effects) (e.g., Emotional PSI and Emotional SR) but several PSI dimensions are also associated to self-representations in other domains (i.e., cross-domain effects).

These results are consistent with the symbolic interactionism theory and the reflected appraisals models (Cooley, 1902/1964; Mead, 1934; Serpe & Stryker, 2011) suggesting that people learn about themselves by interacting with others, internalizing their opinions into their self-views (Baumeister & Twenge, 2003; Pfeifer et al., 2009; Wallace & Tice, 2012). Indeed, the results are consistent with other studies that found that self-concept is highly related with reflected appraisals and that adolescents define themselves in part through internalized perceptions of reflected self-appraisals (Markowitz, Angell, & Greenberg, 2011). However, since this is a cross-sectional study we cannot conclude about the causal links

between these variables. Indeed, the SR may be influenced by the PSI but some authors suggest that self-perception precedes the meta-perceptions, i.e. that people form impressions of each other by simple observation of their behavior and hence infer how they are perceived by others (Kenny & DePaulo, 1993).

We also found support for the second hypothesis of this study. However, only the support from the caregiver had a consistent positive effect on the relation between PSI and SR. Concretely, the quality of support from the caregiver had a buffer effect, since the negative effect of PSI on SR was reduced or not verified when the youth had higher levels of support from the caregiver and the positive effect of PSI on SR was pronounced when the youth had higher levels of support from the caregiver. This result is consistent with previous studies about the importance of the youth-caregiver relationship and about its protective role. Actually, some studies show that higher levels of non-parental adult social support are related to higher levels of self-esteem and more positive self-concept, but also to decreased levels of negative outcomes, such as behavior and emotional problems among youth (Sterrett, Jones, McKee, & Kincaid, 2011). Higher support from staff and a sense of security in placement are associated with better adjustment (Moore, McArthurb, Deathc, Tilburyd, & Roche, 2018). Additionally, some studies also indicate that the quality of the relationship to significant figures of affection has a positive effect on well-being of young people in residential care and that this relation is partially mediated by resilience (Mota & Matos, 2015).

On the other hand, the support from friends adds an effect contrary to what was hypothesized, since the negative association of PSI with SR was stronger for the youth with higher levels of support from friends. This was true for the impact of global negative PSI on Relational SR, and for the impact of Behavioral and Emotional PSI on Emotional SR. However, we also verified that when the negative PSI is low having more support from friends is positive for the youth SR, i.e., when there is no threat having high support is

protective, but when there is higher risk having more friends support was not protective. This result may indicate that the youth more dependent from friends' support may be especially vulnerable to the negative PSI due to their placement situation. Indeed, the availability of friends to talk to after experiences of discrimination may help to rebuild an individual's feelings of self-worth, potentially preventing depressive symptoms from developing (e.g., Pascoe & Richman, 2009). Prior studies about relational victimization and risk for depressive symptoms in adolescence have also shown that emotional support from friends had a vulnerability-enhancing role instead of a protective role (Desjardins & Leadbeater, 2011). These authors suggest that this may be related to a higher co-rumination (i.e., excessive and repeated discussion and speculation about problems that focus on negative feelings) when friends support is higher (Desjardins & Leadbeater, 2011). In future studies it would be important to analyze differences in function of the specific support source chosen by the youth (e.g. father, mother or other; friend from inside or outside the residential institution) and to control the frequency and availability of these support sources, in order to explore the purposed justification for the results.

An important limitation of this study is that the study design does not allow inferences to be made about the causality of these effects. Although the hypothesized direction of effects is based on a solid theoretical and empirical background, since this is a cross-sectional study we cannot conclude about causality. Therefore, one could argue that youth's self-perceptions may both be explained by, as well as explain, their perceptions of their social images (Kenny, Albright, Malloy, Kashy, 1994). Indeed, even though recent research has confirmed people's ability to recognize how most others view (e.g., Carlson & Furr, 2009), as subjective variables, youth's perceptions of their social images could hardly be immune to their own perspective and be only informed by the actual images that other in general hold towards youth in residential care. When evaluating their social images, people also inevitably use

private information that others do not have, thus playing an active role in shaping the reflected appraisal process (Chambers, Chambers, Epley, Savitsky, & Windschitl, 2008; Vazire & Carlson, 2011). Therefore, future research on this topic include longitudinal design studies with autoregressive controls to provide stronger empirical support of the theoretical assumption that youth's perceptions of their social images influence their self-representations. Another limitation worth mentioning is that only youth's perceived support from residential caregivers and from friends were analysed in this study. Despite the relevance of youth's relationships with their main residential caregiver and with their peer for their self-representation construction process in the context of residential care (e.g., Marshal et al., 2020; McMurray et al., 2011), their perceptions of support from their parents (or their caregivers in their original home environment) could further shed light on the role of social support quality as a moderator of the effects of youth's perceptions of their social images on how they perceive themselves.

Notwithstanding these limitations, this study adds to the literature in this field by providing empirical evidence supporting the hypothesis that the awareness that youth in residential care have about their social images (i.e., others' perceptions of them) are related to their self-representations, and that caregiver's support moderates those associations (either by buffering associations between negative social images and self-representations or by enhancing the associations between positive social images and self-representations). This suggests that the removal of children/youth from highly adverse family environments and their placement in residential care may provide them the opportunity to develop other supportive relations, namely with the residential caregivers, that can scaffold the development of a positive self-image and protect them from stigmatizing social images (Ashford & LeCroy, 2010). Results of this study have, thus, relevant implications for practice. Specifically, interventions aimed at fostering the construction of positive self-

representations in youth in residential care should include residential caregivers as key agents. Such interventions should focus on training caregivers to give youth positive feedback contingent on their behavior on different domains (e.g., social, behavioral, competence) in order to provide them with behavioral evidence that can challenge stigmatizing social images and stimulate positive reflected appraisals. This would, in turn, facilitate the construction of positive as well as realistic self-representations, contingent on tangible behavior (O'Mara, Marsh, Craven, & Debus, 2006). No less important, caregivers should also be trained in providing constructive feedback regarding youth's negative attributes and related behavior, stimulating youth's motivation to self-improve thus paving the way for the construction of positive future self-representations.

In addition, based on the evidence regarding the moderating role of youth-caregiver relationship quality, policy makers should instigate that the training of RC staff places special emphasis on capacitating professional caregivers to establish supportive relationships with the youth in care (Pinchover & Attar-Schwartz, 2018). Since findings of this study suggest that caregivers' support is an important protective factor against the deleterious effects of negative social images, training of residential caregivers should also target the improvement of the quality of such support. To that end, caregivers should be trained in how to foster companionship, reinforce youth's intimate disclosure through active and empathic listening, provide emotional support, and promote youth's satisfaction with their relationship with their main residential caregiver. To stimulate caregivers' ability to provide high quality support, policy makers should also place efforts on improving employment conditions of these professionals in order to avert the high turnover rates of residential youth care staff (Colton & Roberts, 2007). Specifically, preventing heavy workload, improving supervision could significantly contribute to increase professionals' satisfaction with work and promote staff stability.

## Conclusion

In sum, we can conclude that, in residential care, youths' perceptions of their social images are associated to their self-representations and that social support from the caregiver is essential to buffer the negative effect of stigmatizing social images on youth's self-representations.

## References

Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions*. Thousand Oaks, CA, US: Sage Publications, Inc.

Ashford, J. & LeCroy, C. (2010). The social dimension for assessing social functioning. In J. Ashford & C. LeCroy (Eds.), *Human behavior in the social environment: A multidimensional perspective* (4th ed.). Belmont, CA: Wadsworth, Cengage Learning.

Attar-Schwartz, S. & Fridman-Teutsch, A. (2018). Father support and adjustment difficulties among youth in residential care: The moderating role of peer victimization and gender. *American Journal of Orthopsychiatry, 88*(6), 701–712. https://doi.org/10.1037/ort0000287

Attar-Schwartz, S. (2013). Runaway behavior among adolescents in residential care: The role of personal characteristics, victimization experiences while in care, social climate, and institutional factors. *Children and Youth Services Review, 35*(2), 258–267. https://doi.org/10.1016/j.childyouth.2012.11.005

Attar-Schwartz, S., & Huri, Y. (2019). Grandparental support and life satisfaction among adolescents in residential care. *Children and Youth Services Review, 96,* 70–78. https://doi.org/10.1016/j.childyouth.2018.11.033

Baumeister, R. F., & Twenge, J. M. (2003). The social self. In T. Millon, M. Lerner & B. Weiner (Eds.), *Handbook of Psychology, Personality and Social Psychology* (pp. 327–352). New Jersey: John Willey & Sons. https://doi.org/10.1002/0471264385.wei0514

Brausch, A. M. & Decker, K. M. (2014). Self-esteem and social support as moderators of depression, body image, and disordered eating for suicidal ideation in adolescents. *Journal of Abnormal Child Psychology, 42*(5), 779–789. https://doi.org/10.1007/s10802-013-9822-0

Buhrmester, D. & Furman, W. (2008). *The Network of Relationships Inventory: Relationship Qualities Version*. Unpublished measure, available from the authors, University of Texas at Dallas.

Calheiros, M. M., Garrido, V. M., Lopes, D., & Patrício, J.N. (2015). Social images of residential care: how do children, youth and residential care institutions are portrayed? *Children and Youth Services Review, 55*, 159–169. https://doi.org/10.1016/j.childyouth.2015.06.004

Carlson, E. N., & Furr, R. M. (2009). Evidence of differential meta-accuracy: People understand the different impressions they make. *Psychological Science, 20*(8), 1033–1039. https://doi.org/10.1111/j.1467-9280.2009.02409.x

Chambers, J. R., Epley, N., Savitsky, K., & Windschitl, P. D. (2008). Knowing too much: Using private knowledge to predict how one is viewed by others. *Psychological Science, 19*(6), 542–548. https://doi.org/10.1111/j.1467-9280.2008.02121.x

Cohen S. (2004). Social relationships and health. *The American psychologist, 59*(8), 676–684. https://doi.org/10.1037/0003-066X.59.8.676

Cooley, C. H. (1902). *Human Nature and social order* (1964 ed.). New York: Schribner's.

Crocker, J., & Quinn, D. M. (2000). *Social stigma and the self: Meanings, situations, and self-esteem.* In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 153–183). Guilford Press. https://psycnet.apa.org/record/2000-05051-006

Del Valle, J. F., Bravo, A., López, M. (2010). Parents and peers as providers of support in adolescents' social network. A developmental perspective. *Journal of Community Psychology, 38*(1), 16–27. https://doi.org/10.1002/jcop.20348

Desjardins, T. L., & Leadbeater, B. J. (2011). Relational victimization and depressive symptoms in adolescence: Moderating effects of mother, father, and peer emotional support. *Journal of Youth and Adolescence, 40*(5), 531–544. https://doi.org/10.1007/s10964-010-9562-1

Emond, R. (2014). Longing to belong: Children in residential care and their experiences of peer relationships at school and in the children's home. *Child and Family Social Work*, 19(2), 194–202. https://doi.org/10.1111/j.1365-2206.2012.00893.x

Erol, N., Simsek, Z., & Münir, K. (2010). Mental health of adolescents reared in institutional care in Turkey: Challenges and hope in the twenty-first century. *European Child & Adolescent Psychiatry, 19*(2), 113–124. https://doi.org/10.1007/s00787-009-0047-2

Furman, W. & Buhrmester, D. (1985). Children's perceptions of the personal relationships in their social networks. *Developmental Psychology, 21*(6), 1016–1024. https://doi.org/10.1037/0012-1649.21.6.1016

Garrido, V. M., Patrício, J., Calheiros, M. M., & Lopes D., (2016). Comparing the social images of youth in and out of residential care. *Journal of Community & Applied Social Psychology, 26*, 439–455. https://doi.org/10.1002/casp.2273

Ibrahim, R. W. & Howe, D. (2011). The experience of jordanian care leavers making the transition from residential care to adulthood: The influence of patriarchal and collectivist culture. *Children and Youth Services Review, 33*(12), 2469–2474. https://doi.org/10.1016/j.childyouth.2011.08.019

Instituto da Segurança Social. (2017). *CASA 2017: Caracterização anual da situação de acolhimento das crianças e jovens*. Retrieved from http://www.seg-

social.pt/documents/10152/16000247/Relatorio_CASA_2017/537a3a78-6992-4f9d-b7a7-5b71eb6c41d9

Kenny, D. A., Albright, L., Malloy, T. E., & Kashy, D. A. (1994). Consensus in interpersonal perception: Acquaintance and the big five. *Psychological Bulletin, 116*(2), 245–258. https://doi.org/10.1037/0033-2909.116.2.245

Kenny, D. A., & DePaulo, B. M. (1993). Do people know how others view them? An empirical and theoretical account. *Psychological Bulletin, 114*(1), 145–161. https://doi.org/10.1037/0033-2909.114.1.145

Kinch, J. W. (1963). A formalized theory of the self-concept. *American Journal of Sociology, 68*(4), 481–486. https://www.jstor.org/stable/2774427

Lopes, D., Calheiros, M. M., Patrício, J. N., & Garrido, M. V. (2017). Development and validation of a Social Images Evaluation Questionnaire for youth in residential care. *PloS one*, *12*(6), e0179890. https://doi.org/10.1371/journal.pone.0179890

Lou, Y., Taylor, E. P., & Di Folco, S. (2018). Resilience and resilience factors in children in residential care: A systematic review. *Children and Youth Services Review, 89*, 83–92. https://doi.org/10.1016/j.childyouth.2018.04.010

Magalhães, E., & Calheiros, M., M. (2017). A dual-factor model of mental health and social support: evidence with adolescents in residential care. *Children and Youth Services Review. 79*, 442–449. https://doi.org/10.1016/j.childyouth.2017.06.041

Major, B. & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*, 393–421. doi.org/10.1146/annurev.psych.56.091103.070137

Markowitz, F. E., Angell, B., & Greenberg, J. S. (2011). Stigma, reflected appraisals, and recovery outcomes in mental illness. *Social Psychology Quarterly, 74*(2), 144–165. https://doi.org/10.1177/0190272511407620

Mead, G. H. (1934). *Mind, self and society*. University of Chicago Press: Chicago.

Mead, G.H. (1934). *Mind, Self, and Society from the Standpoint of a Social Behaviorist*. Chicago: University of Chicago Press.

Montserrat, C., Casas, F., & Malo, S. (2013). Delayed educational pathways and risk of social exclusion: The case of young people from public care in Spain. *European Journal of Social Work, 16*(1), 6–21. https://doi.org/10.1080/13691457.2012.722981

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2018). Sticking with us through it all: The importance of trustworthy relationships for children and young people in residential care. *Children and Youth Services Review, 84*, 68–75. https://doi.org/10.1016/j.childyouth.2017.10.043

Mota, C. P., & Matos, P. M. (2015). Adolescents in Institutional Care: Significant Adults, Resilience and Well-Being. *Child & Youth Care Forum, 44*, 209–224. https://doi.org/10.1007/s10566-014-9278-6

Mullan, C., McAlister, S., Rollock, F., & Fitzsimons, L. (2007). Care just changes your life: Factors impacting upon the mental health of children and young people with experiences of care in northern Ireland. *Child Care in Practice, 13*(4), 417–434. https://doi.org/10.1080/13575270701488865

O'Mara, A. J., Marsh, H. W., Craven, R. G., & Debus, R. L. (2006). Do self-concept interventions make a difference? A synergistic blend of construct validation and meta-analysis. *Educational Psychologist, 41*(3), 181–206. https://doi.org/10.1207/s15326985ep4103_4

Pascoe, E. A. & Richman, L.S. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi.org/10.1037/a0016059

Patrício, J., Calheiros, M. M., & Martins, A.C. (2016). Self-representation questionnaire for youths in residential care. *Children and Youth Services Review, 61*, 317–326. https://doi.org/10.1016/j.childyouth.2016.01.007

Pfeifer, J. H., Masten, C. L., Borofsky, L. A., Dapretto, M., Fuligni, A. J., & Lieberman, M. D. (2009). Neural correlates of direct and reflected self-appraisals in adolescents and adults: When social perspective-taking informs self-perception. *Child Development, 80*(4), 1016–1038. https://doi.org/10.1111/j.1467-8624.2009.01314.x

Pinchover, S. & Attar-Schwartz, S. (2018). Is someone there for you? Social support of youth in educational residential care from family, peers and staff. *The British Journal of Social Work, 48*(8), 2195–2214. https://doi.org/10.1093/bjsw/bcx164

Rodrigues, S., Barbosa-Ducharne, M., & Del Valle, J. F. (2013). The quality of residential child care in Portugal and the example of its development in Spain. *Papeles del Psicólogo, 34*(1), 11–22. https://www.redalyc.org/articulo.oa?id=77825706002

Salley, C. G., Vannatta, K., Gerhardt, C.A., & Noll, R.B. (2010). Social self-perception accuracy: Variations as a function of child age and gender. *Self and Identity, 9*, 209–223. https://doi.org/10.1080/15298860902979224

Serpe, R. T., & Stryker, S. (2011). The symbolic interactionist perspective on identity theory. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 225–248). New York, NY: Springer.

Simkiss, D. (2013). Children and society policy review: Health policy affecting children and young people. *Children & Society, 27*(3), 233–239. https://doi.org/10.1111/chso.12021

Sterrett, E. M., Jones, D. J., McKee, L. G., & Kincaid, C. (2011). Supportive non-parental adults and adolescent psychosocial functioning: Using social support as a theoretical framework. *American Journal of Community Psychology, 48*(3-4), 284–295. https://doi.org/10.1007/s10464-011-9429-y

Turner, R., & Whitehead, C. (2008). How collective Representations can change the Structure of the Brain. *Journal of Consciousness Studies, 15*(10-11), 43–57. https://www.ingentaconnect.com/content/imp/jcs/2008/00000015/f0020010/art00001

Vazire, S., & Carlson, E. N. (2011). Others sometimes know us better than we know ourselves. *Current Directions in Psychological Science*, *20*(2), 104–108. https://doi.org/10.1177/0963721411402478

Wallace, H. M., & Tice, D. M. (2012). Reflected appraisal through a 21st-century looking glass. In M. R. Leary & J. P. Tangney (Eds.), *Handbook of self and identity* (2nd ed., pp. 124–140). New York, NY: Guilford.

Whittaker, J. K., Holmes, L., Del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., . . . Zeira, A. (2016). Therapeutic residential care for children and youth: A consensus statement of the International Work Group on Therapeutic Residential Care. *Residential Treatment for Children & Youth, 33*, 89–106. https://doi.org/10.1080/0886571X.2016.1215755

Table 1

*Descriptive statistics (M, SD) and bivariate correlations*

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. PSI_Soc | – | | | | | | | | | | | | | | | | | |
| 2. PSI_Res | 0.50** | – | | | | | | | | | | | | | | | | |
| 3. PSI_Pos | 0.86** | 0.87** | – | | | | | | | | | | | | | | | |
| 4. PSI_Beh | -0.18** | -0.03 | -0.11** | – | | | | | | | | | | | | | | |
| 5. PSI_Emo | -0.31** | -0.23** | -0.31** | 0.44** | – | | | | | | | | | | | | | |
| 6. PSI_Neg | -0.29** | -0.15** | -0.25** | 0.86** | 0.83** | – | | | | | | | | | | | | |
| 7. SR_Soc | 0.53** | 0.47** | 0.57** | -0.10** | -0.24** | -0.20** | – | | | | | | | | | | | |
| 8. SR_Com | 0.36** | 0.43** | 0.45** | -0.12** | -0.12** | -0.14** | 0.48** | – | | | | | | | | | | |
| 9. SR_Rel | 0.40** | 0.51** | 0.52** | -0.08* | -0.19** | -0.16** | 0.47** | 0.38* | – | | | | | | | | | |
| 1. SR_Pos | 0.54** | 0.59** | 0.65** | -0.13** | -0.23** | -0.21** | 0.81** | 0.81** | 0.76** | – | | | | | | | | |
| 11. SR_Beh | -0.13** | 0.00 | -0.07 | 0.71** | 0.26** | 0.58** | -0.10** | -0.17** | -0.02 | -0.12** | – | | | | | | | |
| 12. SR_Emo | -0.13** | -0.09* | -0.12** | 0.25** | 0.52** | 0.44** | -0.17** | -0.08* | -0.15** | -0.16** | 0.32** | – | | | | | | |
| 13. SR_Mis | -0.27** | -0.15** | -0.24** | 0.16** | 0.39** | 0.32** | -0.20** | -0.10** | -0.19** | -0.22** | 0.22** | 0.35** | – | | | | | |
| 14. SR_Neg | -0.20** | -0.07* | -0.15** | 0.62** | 0.49** | 0.65** | -0.19** | -0.17** | -0.12** | -0.20** | 0.84** | 0.74** | 0.52** | – | | | | |
| 15. Sup_caregiver | 0.17** | 0.15** | 0.18** | -0.12** | -0.01 | -0.08* | 0.13** | 0.10** | 0.19** | 0.17** | -0.12** | -0.06 | -0.11** | -0.13** | – | | | |
| 16. Sup_friend | 0.30** | 0.33** | 0.36** | -0.03 | -0.25** | -0.16** | 0.28** | 0.23** | 0.27** | 0.33** | 0.01 | -0.11** | -0.12** | -0.07* | 0.15** | – | | |
| 17. Pl_Lenght | 0.05 | -0.01 | 0.02 | -0.10* | -0.02 | -0.07 | 0.06 | 0.11** | 0.02 | 0.08* | -0.11** | -0.04 | -0.01 | -0.10** | 0.05 | 0.09* | – | |
| 18. Age | 0.01 | -0.01 | 0.00 | -0.07 | 0.04 | -0.02 | 0.03 | 0.20** | -0.02 | 0.09** | -0.07 | 0.06 | 0.02 | -0.01 | -0.09* | -0.05 | 0.38** | – |
| *M* | 40.12 | 30.83 | 30.98 | 20.45 | 10.82 | 20.11 | 40.17 | 30.68 | 30.84 | 30.90 | 20.53 | 20.25 | 10.78 | 20.32 | 30.17 | 40.08 | 30.74 | 160.26 |
| *SD* | 0.77 | 0.82 | 0.69 | 0.89 | 0.70 | 0.67 | 0.64 | 0.72 | 0.84 | 0.57 | 0.79 | 0.84 | 0.82 | 0.61 | 0.93 | 0.70 | 30.71 | 20.22 |

*Note*. PSI = Perceptions of social images; SR = Self-representations; PSI_Soc = Social PSI; PSI_Res = Resilience PSI; PSI_Pos = Global positive PSI; PSI_Beh = Behavioral PSI; PSI_Emo = Emotional PSI; PSI_Neg = Global negative PSI; SR_Soc = Social SR; SR_Com = Competence SR; SR_Rel = Relational SR; SR_Pos = Globally positive SR; SR_Beh = Behavioral SR; SR_Emo = Emotional SR; SR_Mis = Misfit SR; SR_Neg = Globally negative SR; Sup_caregiver = Support from caregiver; Sup_friend = Support from friend; Pl_Lenght = Placement Length.
* $p < 0.05$ ** $p < 0.01$

Table 2
*Significant gender differences in study variables*

| | Sex | *M* | *t* (738) | *p*-value |
|---|---|---|---|---|
| Behavioral PSI | Female | 2.56 | 3.55 | < .001 |
| | Male | 2.33 | | |
| Emotional PSI | Female | 1.89 | 2.677 | .008 |
| | Male | 1.75 | | |
| Global negative PSI | Female | 2.20 | 3.605 | < .001 |
| | Male | 2.02 | | |
| Behavioral SR | Female | 2.63 | 3.111 | .002 |
| | Male | 2.46 | | |
| Emotional SR | Female | 2.48 | 7.130 | < .001 |
| | Male | 2.06 | | |
| Global negative SR | Female | 2.44 | 5.206 | < .001 |
| | Male | 2.22 | | |
| Friends support | Female | 4.18 | 3.780 | < .001 |
| | Male | 3.98 | | |
| Age | Female | 16.47 | 2.575 | .010 |
| | Male | 16.08 | | |

*Note*. PSI = Perceptions of social images; SR = Self-representations.

Table 3

*Multiple regression models of PSI on SR*

| | Adjusted $R^2$ | *F* | *df* 1 | *df* 2 | *p*-value |
|---|---|---|---|---|---|
| PSI Global | | | | | |
| Social SR | 0.330 | 1870.585 | 2 | 756 | < 0.001 |
| Competence SR | 0.205 | 990.061 | 2 | 757 | < 0.001 |
| Relational SR | 0.265 | 1370.484 | 2 | 757 | < 0.001 |
| Globally Positive SR | 0.423 | 2790.492 | 2 | 757 | < 0.001 |
| Behavioral SR | 0.343 | 1990.418 | 2 | 757 | < 0.001 |
| Emotional SR | 0.193 | 910.393 | 2 | 756 | < 0.001 |
| Misfit SR | 0.124 | 540.019 | 2 | 747 | < 0.001 |
| Globally Negative SR | 0.426 | 2830.085 | 2 | 757 | < 0.001 |
| PSI Dimensions | | | | | |
| Social SR | 0.337 | 960.732 | 4 | 749 | < 0.001 |
| Competence SR | 0.219 | 530.828 | 4 | 750 | < 0.001 |
| Relational SR | 0.276 | 720.804 | 4 | 750 | < 0.001 |
| Globally Positive SR | 0.431 | 1430.645 | 4 | 750 | < 0.001 |
| Behavioral SR | 0.512 | 1980.846 | 4 | 750 | < 0.001 |
| Emotional SR | 0.263 | 680.221 | 4 | 749 | < 0.001 |
| Misfit SR | 0.170 | 390.080 | 4 | 740 | < 0.001 |
| Globally Negative SR | 0.440 | 1490.195 | 4 | 750 | < 0.001 |

*Note*. PSI = Perceptions of social images; SR = Self-representations.

Table 4
*Multiple regression coefficients of PSI on SR*

| | *B* | *SE* | *β* | *T* | *p*-value |
|---|---|---|---|---|---|
| Social SR | | | | | |
| Positive PSI | 0.492 | 0.027 | 0.558 | 180.180 | < 0.001 |
| Social PSI | 0.302 | 0.028 | 0.382 | 10.747 | < 0.001 |
| Resilience PSI | 0.197 | 0.026 | 0.265 | 70.640 | < 0.001 |
| Competence SR | | | | | |
| Positive PSI | 0.454 | 0.034 | 0.447 | 130.390 | < 0.001 |
| Social PSI | 0.164 | 0.035 | 0.180 | 40.673 | < 0.001 |
| Resilience PSI | 0.304 | 0.032 | 0.356 | 90.464 | < 0.001 |
| Behavioral PSI | -0.080 | 0.028 | -0.102 | -20.825 | 0.005 |
| Relational SR | | | | | |
| Global positive PSI | 0.597 | 0.038 | 0.508 | 150.808 | < 0.001 |
| Social PSI | 0.201 | 0.039 | 0.189 | 50.111 | < 0.001 |
| Resilience PSI | 0.392 | 0.036 | 0.395 | 10.895 | < 0.001 |
| Globally Positive SR | | | | | |
| Global positive PSI | 0.508 | 0.023 | 0.638 | 220.427 | < 0.001 |
| Social PSI | 0.229 | 0.024 | 0.319 | 90.720 | < 0.001 |
| Resilience PSI | 0.287 | 0.022 | 0.428 | 130.305 | < 0.001 |
| Behavioral SR | | | | | |
| Global positive PSI | 0.088 | 0.034 | 0.078 | 20.563 | 0.011 |
| Negative PSI | 0.704 | 0.035 | 0.602 | 190.829 | < 0.001 |
| Behavioral PSI | 0.650 | 0.025 | 0.739 | 250.954 | < 0.001 |
| Emotional PSI | -0.076 | 0.033 | -0.069 | -20.318 | 0.021 |
| Emotional SR | | | | | |
| Global negative PSI | 0.536 | 0.041 | 0.437 | 120.980 | < 0.001 |
| Emotional PSI | 0.606 | 0.043 | 0.517 | 140.195 | < 0.001 |
| Misfit SR | | | | | |
| Global positive PSI | -0.185 | 0.039 | -0.167 | -40.729 | < 0.001 |
| Global negative PSI | 0.319 | 0.041 | 0.276 | 70.810 | < 0.001 |
| Social PSI | -0.166 | 0.040 | -0.166 | -40.161 | < 0.001 |
| Emotional PSI | 0.382 | 0.043 | 0.346 | 80.952 | < 0.001 |
| Globally Negative SR | | | | | |
| Negative PSI | 0.589 | 0.025 | 0.657 | 230.153 | < 0.001 |
| Behavioral PSI | 0.333 | 0.021 | 0.494 | 160.192 | < 0.001 |
| Emotional PSI | 0.230 | 0.027 | 0.269 | 80.499 | < 0.001 |

*Note*. PSI = Perceptions of social images; SR = Self-representations.

Table 5

*Multiple regression models of PSI on SR with the moderators*

| | Adjusted $R^2$ | *F* | *df* 1 | *df* 2 | *p*-value |
|---|---|---|---|---|---|
| MT Global | | | | | |
| Social SR | 0.362 | 250.192 | 14 | 597 | < 0.001 |
| Competence SR | 0.277 | 170.363 | 14 | 598 | < 0.001 |
| Relational SR | 0.298 | 190.115 | 14 | 598 | < 0.001 |
| Globally Positive SR | 0.473 | 390.342 | 14 | 598 | < 0.001 |
| Behavioral SR | 0.365 | 250.527 | 14 | 598 | < 0.001 |
| Emotional SR | 0.242 | 140.614 | 14 | 598 | < 0.001 |
| Misfit SR | 0.112 | 60.375 | 14 | 594 | < 0.001 |
| Globally Negative SR | 0.446 | 350.354 | 14 | 598 | < 0.001 |
| MT Dimensions | | | | | |
| Social SR | 0.383 | 170.771 | 22 | 594 | < 0.001 |
| Competence SR | 0.294 | 120.239 | 22 | 595 | < 0.001 |
| Relational SR | 0.307 | 120.980 | 22 | 595 | < 0.001 |
| Globally Positive SR | 0.481 | 260.049 | 22 | 595 | < 0.001 |
| Behavioral SR | 0.536 | 30.095 | 22 | 595 | < 0.001 |
| Emotional SR | 0.315 | 130.428 | 22 | 595 | < 0.001 |
| Misfit SR | 0.149 | 50.721 | 22 | 591 | < 0.001 |
| Globally Negative SR | 0.460 | 240.068 | 22 | 595 | < 0.001 |

*Note.* MT = Maltreatment; SR = Self-representations.

Table 6
*Multiple regression coefficients of interaction terms*

| | *B* | *SE* | *β* | *t* | *p*-value |
|---|---|---|---|---|---|
| Social SR | | | | | |
| Negative PSI x Caregiver support caregiver | 0.048 | 0.021 | 0.079 | 20.277 | 0.023 |
| Social PSI x Caregiver support | 0.058 | 0.026 | 0.092 | 20.205 | 0.028 |
| Relational SR | | | | | |
| Negative PSI x Friend support | -0.069 | 0.027 | -0.095 | -20.608 | 0.009 |
| Globally Positive SR | | | | | |
| Negative PSI x Caregiver support | 0.036 | 0.017 | 0.067 | 20.111 | 0.035 |
| Social PSI x Support caregiver | 0.049 | 0.022 | 0.085 | 20.221 | 0.027 |
| Emotional PSI x Caregiver support | 0.045 | 0.020 | 0.078 | 20.257 | 0.024 |
| Emotional SR | | | | | |
| Behavioral PSI x Friend support | 0.073 | 0.034 | 0.096 | 20.162 | 0.031 |

*Note*. PSI = Perceptions of social images; SR = Self-representations.

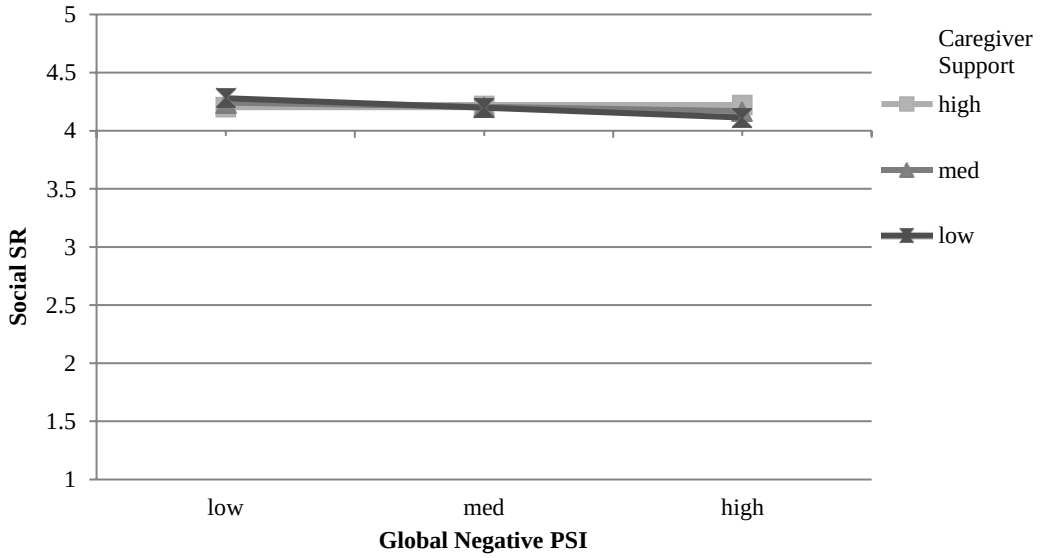


*Figure 1*. Global negative PSI effect on Social SR moderated by caregiver support

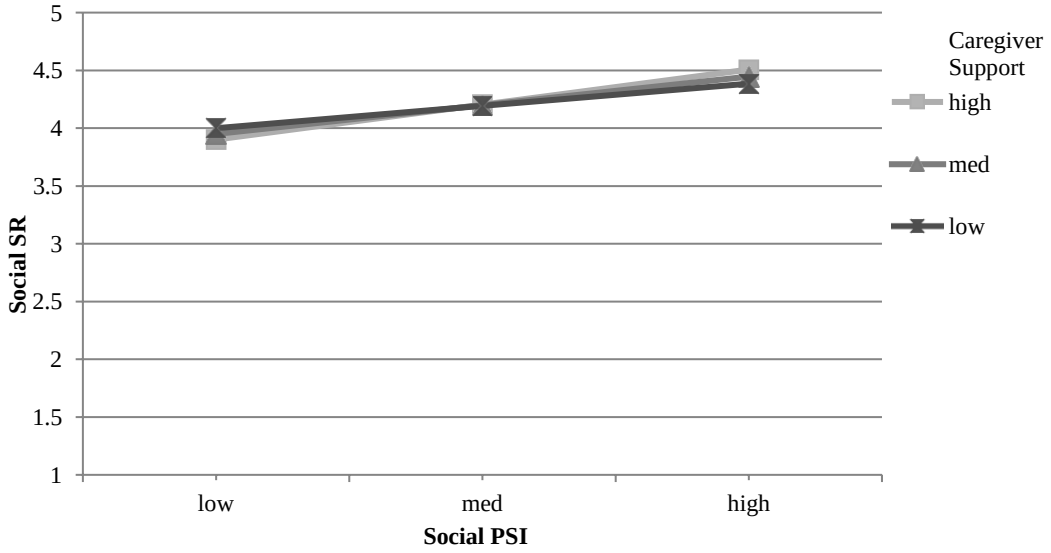


*Figure 2*. Social PSI effect on Social SR moderated by caregiver support

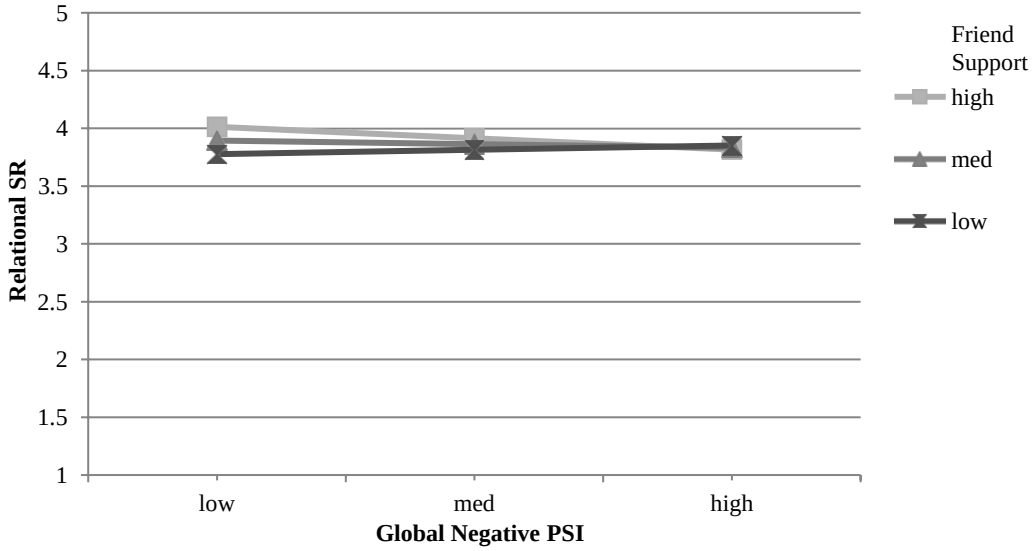


*Figure 3.* Global negative PSI effect on Relational SR moderated by friend support

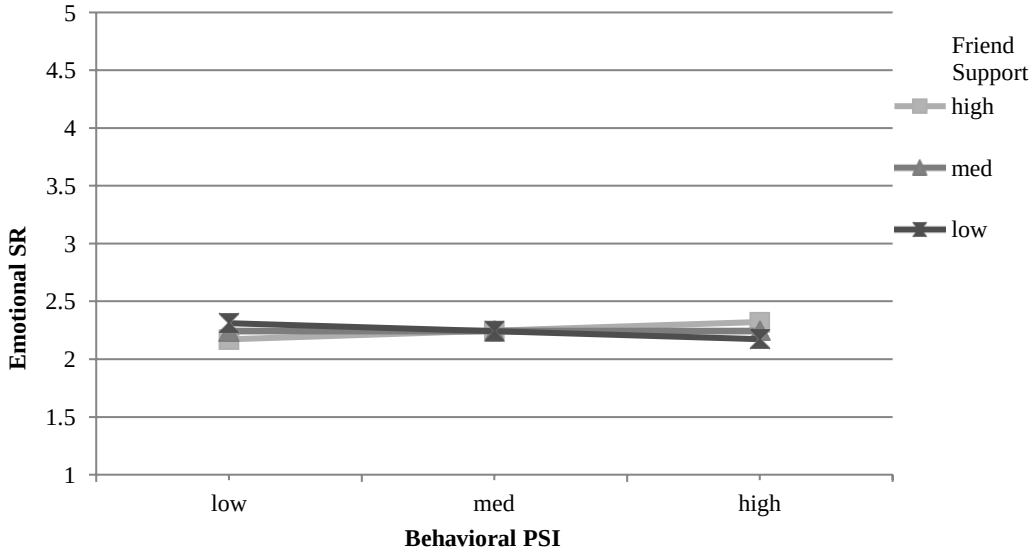


*Figure 4.* Behavioral PSI effect on Emotional SR moderated by friend support