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Psychological Adjustment of Adolescents in Residential Care: A Multi-Informant Analysis of Youth and Caregiver Reports

Ana Simão * and Cristina Nunes

University Research Center in Psychology (CUIP), Universidade do Algarve, Campus de Gambelas, 8005-135 Faro, Portugal; csnunes@ualg.pt
* Correspondence: a21331@ualg.pt

Abstract

Scientific evidence shows that perception of adolescents' psychological adjustment in residential care varies depending on the informant. This study examined discrepancies between adolescents' self-reports and caregiver reports of psychological adjustment in 46 residential care institutions across Portugal. Data were collected from a sample of 511 adolescents (aged 12–24) and their institutional caregivers using the Strengths and Difficulties Questionnaire and the Socially Desirable Response Set-5. Descriptive statistics and paired-samples *t*-tests were conducted to compare mean scores between informants. Intraclass correlation coefficients and Cohen's Kappa were calculated to assess agreement. Results revealed significant differences across all subscales and the total difficulties score, with adolescents consistently reporting more emotional, behavioral, and peer-related problems than caregivers, regardless of sex or age. Agreement ranged from poor to moderate, with the lowest concordance for internalizing symptoms. These discrepancies underscore the role of developmental factors in shaping self- and caregiver perceptions and highlight the importance of multi-informant, developmentally sensitive assessments in residential care. Practical implications include incorporating adolescents' perspectives into evaluation and intervention, enhancing caregiver training to recognize internalizing issues, and implementing age- and gender-tailored mental health programs.

Keywords: adolescents; multiple informants; psychological adjustment; residential care

1. Introduction

Adolescence involves important biological, psychological, and social changes, making this stage vulnerable to psychological adjustment difficulties [1–3]. Mid-adolescence sees a notable increase in anxiety and depression symptoms, particularly among girls, who are more prone to internalizing problems.

According to the Report on the Transition from Institutional Care to Community-Based Services in 27 EU Member States [4], institutionalization remains the predominant care model for children without parental care or exposed to psychosocial risk across several EU countries. In Portugal, reliance on institutional care within the child welfare system persists. In 2023, over 6400 youths were separated from their families; more than 80% were placed in institutions, nearly 70% of whom were aged 12 to 20 [5].

Residential care in Portugal aims to safeguard children's rights and welfare under the Law for the Protection of Children and Young People in Danger [6]. The purpose is to support individualized life projects through tailored interventions addressing developmental stages and personal needs. Residential care settings (RCS) must maximize well-being,

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ensure equal opportunities, foster autonomy, and support children's rights regardless of age or religion.

Despite legal frameworks and protective services, children in RCS face higher risk of emotional, behavioral, and social challenges than peers in other care forms [7,8]. Daily interactions within care environments, particularly relationships with residential caregivers, play a vital role in fostering security and well-being. These relationships support positive, stable attachments that can compensate for disrupted bonds [9,10]. Thus, residential care institutions must consistently prioritize children's and adolescents' best interests [11].

Psychological adjustment during adolescence refers to individuals' effective use of emotional, cognitive, and social resources to adapt to their environment [12]. It is often measured via internalizing and externalizing difficulties, which commonly co-occur [13,14]. Poor adjustment may appear as emotional distress, somatic symptoms, or behavioral problems [15,16]. Institutionalization may affect adjustment, due to new social dynamics and caregivers [17].

Personal adaptation manifests through emotions, behaviors, and cognitions; insufficient adjustment can lead to low self-esteem, anxiety, sadness, somatic complaints, or guilt, hindering compliance with social norms and residential care rules [18,19]. Multiple factors influence psychological adjustment among residential care adolescents, many of whom experience developmental difficulties across various domains [20].

Comprehensive assessment of psychological adjustment requires information from multiple informants covering diverse dimensions and contexts. Institutional staff are primary caregivers in RCS and well-positioned to assess youth mental health and behavior. Combining reports from adolescents and caregivers offers complementary perspectives. Adolescents tend to underreport externalizing behaviors yet report higher internalizing symptoms compared to other informants [21]. Differences in informant agreement may reflect age, gender, social desirability, or attachment patterns [21,22].

Current Study

In this study, both adolescents and their caregivers completed the questionnaire, reflecting evidence that perceptions of youth psychological adjustment in residential care often differ between the adolescents and their adult caregivers [23]. Previous research has noted discrepancies in agreement between these informants when assessing internalizing and externalizing difficulties [21,24]. Additionally, adopting a multi-informant approach helps reduce potential biases related to social desirability common in self-report measures [25], and offers a more comprehensive understanding of adjustment difficulties [26].

The objectives of the present study are fourfold: (1) To examine whether differences exist between the reports of caregivers and adolescents regarding psychological adjustment, considering sex and age group; (2) To compare the perceptions of youths and caregivers across the various subscales of the Strengths and Difficulties Questionnaire; (3) To assess the level of agreement between the two informants and investigate whether disagreement varies according to the severity of reported problems; and (4) To explore whether a systematic pattern of discrepancy exists between adolescent and caregiver reports.

Based on existing literature, we formulated the following hypotheses: (H1) There will be significant differences between adolescents' and caregivers' reports of psychological adjustment: (H1a) differences will vary according to adolescent's sex, (H1b) differences will vary according to adolescent's age group; (H2) Adolescents and caregivers will differ in their perceptions across the SDQ subscales: (H2a) adolescents will report more emotional problems and higher levels of prosocial behaviors, (H2b) caregivers will report higher levels of behavioral problems, hyperactivity difficulties and peer relationship problems; (H3) A systematic pattern of discrepancy will be present, whereby adolescents report higher levels of internalizing symptoms while caregivers report more externalizing behaviors; (H4) The agreement between adolescents and caregivers will vary according to the severity of the reported problems, with greater disagreement at higher levels of difficulties; (H5) The discrepancy between informants will be greater in the subscales most sensitive to social desirability.

2. Materials and Methods

2.1. Participants

The study sample included 511 adolescents (232 males, 45%; 279 females, 55%) aged 12 to 24 years (*M* = 15.87, *SD* = 2.25), all residing in 46 RCS across Portugal. The age groups were relatively evenly distributed: 226 participants were between 12 and 15 years old, 227 were aged 16 to 18, and 58 were between 19 and 24 years. On average, adolescents had been living in their current facility for 41 months (*SD* = 43). Various factors contributed to their placement, with neglect and abuse reported by 38%, school absenteeism by 33%, financial hardship by 28%, and exposure to domestic violence by 26%. Furthermore, 10% of the participants had lost at least one parent, and 10% reported no contact with their biological family. Although 93% had siblings, only 32% resided in the same residential institution.

2.2. Measures

2.2.1. Socially Desirable Response Set-5 (SDRS-5 [10,27])

The Socially Desirable Response Set-5 [10] is a 5-item self-report measure designed to assess the degree to which self-report responses may be influenced by social desirability, i.e., the tendency to give socially desirable responses. Responses are given in a five-point Likert scale (1 = "Totally true" to 5 = "Totally not true"). In the original study, the internal consistency reliability ranged from 0.66 to 0.68 [19], while the Portuguese version reported Cronbach's alphas between 0.70 and 0.73 [27]. In the present study, the internal consistency was 0.56.

Only adolescents completed this questionnaire.

2.2.2. Strengths and Difficulties Questionnaire (SDQ, [28,29])

The SDQ is a 25-item self-report measure to evaluate socio-emotional issues through a three-point Likert scale (0 = "Not true", 1 = "Somewhat true", 2 = "Certainly true"). Items are organized into five subscales relating to emotional problems (e.g., "I am nervous in new situations. I easily lose confidence."), behavioral problems (e.g., "I get very angry and often lose my temper."), hyperactivity/inattention difficulties (e.g., "I am easily distracted, I find it difficult to concentrate."), peer relationship problems (e.g., "I am usually on my own. I generally play alone or keep to myself."), and prosocial behaviors (e.g., "I am helpful if someone is hurt, upset or feeling ill.") and a total difficulties score assesses the overall child's mental health [9]. The Portuguese adaptation showed Cronbach's alphas between 0.43 and 0.61 [29]. For the present study, the reliability coefficients (Cronbach's alpha) obtained for the adolescent sample were as follows: emotional problems $\alpha = 0.68$, behavioral problems $\alpha = 0.57$, hyperactivity/inattention difficulties $\alpha = 0.66$, peer relationship problems $\alpha = 0.51$, prosocial behaviors $\alpha = 0.78$, and total scale $\alpha = 0.78$. For the caregiver sample, the reliability coefficients were: emotional problems $\alpha = 0.74$, behavioral problems $\alpha = 0.76$, hyperactivity/inattention difficulties $\alpha = 0.77$, peer relationship problems $\alpha = 0.58$, prosocial behaviors $\alpha = 0.86$, and total scale $\alpha = 0.82$.

2.3. Procedures

2.3.1. Data Collection

Ethical approval for this study was obtained from the Ethics Committee of the University of Algarve (CEUAlg No. 110/2023). All study procedures adhered to the ethical principles outlined in the 1964 Declaration of Helsinki and its later amendments. Authorization to use the Portuguese version of the scales was secured from the original authors.

Participants were recruited using a convenience sampling method. A total of 46 RCS facilities from mainland Portugal and the archipelagos of the Azores and Madeira were invited to participate via telephone and email. Each institution received detailed information about the study's aims and procedures and agreed to participate voluntarily. Whenever possible, data collection was conducted in person by the first author. In cases where in-person administration was not feasible due to geographic limitations, questionnaires were sent by email and completed under the supervision of a designated staff member at the institution. Clear written guidelines were provided both at the time of approval and again upon delivery of the questionnaires. The first author was available throughout the process to address any questions from staff or participants.

Eligibility criteria included being 12 years or older, proficiency in Portuguese, and absence of medical conditions that could hinder participation. Adolescents identified by institutional staff as having cognitive impairments were excluded. All eligible participants received detailed information about the study objectives and their voluntary involvement, including the right to withdraw at any time without any consequences. Written informed consent was obtained from participants aged 16 or older. For those under 16, consent was provided in writing by a legal guardian or, alternatively, by the institution's technical director, in line with ethical standards.

Data were collected using anonymous, structured self-report questionnaires administered within the residential care institutions. Each adolescent completed the self-report version of the SDQ, while a caregiver simultaneously completed the parents' version for the same adolescent. Questionnaires were coded by caregivers using matching numbers to enable pairing while preserving participants' anonymity. Additionally, caregivers completed anonymous questionnaires providing organizational and religious affiliation information about their institutions. Participants with incomplete responses were excluded from the final sample.

2.3.2. Analysis Plan

Statistical analyses were conducted using IBM SPSS Statistics version 30.0 [30].

Data were entered into SPSS such that each case (dyad) included paired responses: the adolescent's self-report on the SDQ and the corresponding caregiver's report on the adolescent's behavior.

The analysis began by examining differences between informants across SDQ subscales and total score with respect to sex and age group, presenting descriptive statistics for adolescent self-reports and caregiver reports.

To examine agreement between youth and caregiver ratings across the five SDQ subscales and the total difficulties score, paired-samples *t*-tests were first conducted to identify systematic differences in mean scores between informants.

Subsequently, intraclass correlation coefficients (ICCs) were calculated to assess absolute agreement between adolescent and caregiver ratings for each subscale and the total score. The analysis employed a two-way mixed-effects model with single measures and absolute agreement definitions, as recommended [31]. This model assumes fixed raters and evaluates whether scores from the two informants can be used interchangeably.

ICC values were interpreted following guidelines [31]: values below 0.50 indicate poor agreement, between 0.50 and 0.75 moderate, between 0.75 and 0.90 good, and above 0.90 excellent agreement. Ninety-five percent confidence intervals were reported for all ICC estimates to indicate the precision of the agreement.

To strengthen the robustness of our findings, we have additionally conducted agreement analyses using weighted Cohen's kappa coefficients with jamovi software (version 2.6) [32–36].

3. Results

The sample average of answers in SDRS-5 was 14, which shows a tendency for participants to take a neutral attitude toward the questions instead of answering in a socially desirable way. Although the level of internal consistency of the scale was unsatisfactory, we conducted the statistical analysis assuming the veracity of the participants' answers because the data still provided valuable insights into the research questions and allowed for exploratory analyses that could inform future studies.

The analysis began with an examination of differences between informants across the five Strengths and Difficulties Questionnaire (SDQ) subscales and the total score, stratified by sex and age group. Table 1 presents descriptive statistics of SDQ scores reported by adolescents and caregivers, disaggregated by sex and age group.

Table 1. Means and standard deviations of SDQ dimensions from adolescents' self-reports and caregiver's reports, by sex and age group (N = 511).

	SDQ Domains	**Males (*n* = 232)**	**Females (*n* = 279)**	**12–15 Y (*n* = 226)**	**16–18 Y (*n* = 227)**	**19–24 Y (*n* = 58)**	**Total (*n* = 511)**
		M **±** ***SD***	***M*** **±** ***SD***	***M*** **±** ***SD***	***M*** **±** ***SD***	***M*** **±** ***SD***	***M*** **±** ***SD***
Self-report	Emotional	3.80 ± 2.20	5.29 ± 2.39	4.73 ± 2.53	4.58 ± 2.31	4.28 ± 2.41	4.61 ± 2.42
	Behavior	3.08 ± 2.04	2.79 ± 2.01	3.35 ± 2.19	2.82 ± 1.88	1.67 ± 1.21	2.92 ± 2.03
	Hyperactivity	4.37 ± 2.19	4.94 ± 2.50	5.09 ± 2.36	4.59 ± 2.26	3.43 ± 2.46	4.68 ± 2.38
	Peer	3.34 ± 2.05	3.34 ± 2.04	3.34 ± 2.10	3.47 ± 2.02	2.81 ± 1.88	3.34 ± 2.04
	Prosocial	6.87 ± 2.42	7.79 ± 2.13	6.93 ± 2.32	7.56 ± 2.23	8.33 ± 2.24	7.37 ± 2.31
	SDQ Total	14.59 ± 5.82	16.35 ± 6.46	16.50 ± 6.47	15.46 ± 6.87	12.19 ± 5.58	15.55 ± 6.24
Caregiver-report	Emotional	2.57 ± 2.11	3.65 ± 2.38	2.94 ± 2.18	3.38 ± 2.40	3.14 ± 2.52	3.16 ± 2.33
	Behavior	2.66 ± 2.40	2.57 ± 2.26	2.73 ± 2.36	2.84 ± 2.35	1.26 ± 1.55	2.61 ± 2.32
	Hyperactivity	4.02 ± 2.70	4.00 ± 2.36	4.42 ± 2.53	3.90 ± 2.42	2.81 ± 2.45	4.01 ± 2.52
	Peer	2.88 ± 2.05	3.14 ± 2.11	2.98 ± 2.12	3.08 ± 2.04	2.97 ± 2.16	3.02 ± 2.09
	Prosocial	6.33 ± 2.55	6.46 ± 2.65	6.08 ± 2.65	6.47 ± 2.53	7.38 ± 2.49	6.40 ± 2.61
	SDQ Total	12.13 ± 6.40	13.36 ± 6.35	13.07 ± 6.37	13.20 ± 6.33	10.21 ± 6.27	12.80 ± 6.40

Note. Emotional = Emotional problems; Behavior = Behavior problems; Hyperactivity = Hyperactivity/Inattention difficulties; Peer = Peer relationship problems; Prosocial = Prosocial behaviors; SDQ Total = SDQ Total score; Y = Years (age group); *M* = Mean; *SD* = Standard Deviation.

Analysis of Table 1 revealed notable differences between adolescent self-reports and caregiver assessments across all subscales and the total difficulties score. Overall, adolescents reported higher levels of emotional symptoms, behavioral problems, hyperactivity, peer difficulties, and total difficulties compared to caregivers. This pattern was consistent across sexes and age groups.

Female adolescents reported greater emotional problems, hyperactivity difficulties and prosocial skills than males, while males reported slightly higher behavioral difficulties. Caregivers also perceived more emotional difficulties in females than males, but these differences were less pronounced than in adolescent reports. Regarding age groups, younger adolescents (12–15 years) exhibited higher self-reported difficulties across most subscales relative to older groups, with the oldest group (19–24 years) reporting the lowest scores. Caregivers similarly perceived fewer difficulties among the oldest group.

Notably, prosocial behavior scores were consistently higher in adolescent self-reports than caregiver ratings. The discrepancies between adolescent and caregiver reports were most evident in emotional symptoms and total difficulties, particularly among females and younger adolescents.

To examine agreement between youth and caregiver ratings across the five SDQ subscales and the total difficulties score, paired-samples *t*-tests were conducted and differences in mean scores between informants are presented in Table 2.

Table 2. Descriptives and comparison of adolescent and caregiver ratings on the Strengths and Difficulties Questionnaire (N = 511).

Subscales	**Adolescents**		**Caregivers**		***t*(df)**	***p***	**Cohens *d***	**95% CI**
	M	***SD***	***M***	***SD***				
Emotional	4.61	2.42	3.16	2.33	11.85(510)	<0.001	0.52	0.43–0.62
Behavior	2.92	2.03	2.61	2.32	3.04(510)	0.001	0.14	0.05–0.22
Hyperactivity	4.68	2.38	4.01	2.52	5.77(510)	<0.001	0.26	0.17–0.34
Peer	3.34	2.04	3.02	2.09	2.78(510)	0.003	0.12	0.04–0.21
Prosocial	7.37	2.31	6.40	2.61	7.47(510)	<0.001	0.33	0.24–0.42
SDQ total	15.55	6.24	12.80	6.40	9.21(510)	<0.001	0.41	0.32–0.50

Note. Emotional = Emotional problems; Behavior = Behavior problems; Hyperactivity = Hyperactivity/Inattention difficulties; Peer = Peer relationship problems; Prosocial = Prosocial behaviors; SDQ Total = SDQ Total score; *M* = Mean; *SD* = Standard Deviation.

Analysis of Table 2 reveals significant differences between adolescent self-reports and caregiver assessments across all SDQ subscales and the total difficulties score (all $p < 0.01$), indicating that, on average, adolescents and caregivers do not report the same level of difficulties or behaviors. Adolescents scored higher than caregivers on all subscales, showing that youth perceive themselves as more symptomatic than caregivers report. The total SDQ score also showed a significant difference, with adolescents reporting more overall difficulties than caregivers, corresponding to a moderate effect size ($d = 0.41$). Simultaneously, adolescents rated themselves as more prosocial than caregivers perceived them to be. Clinically meaningful differences were observed particularly in the emotional problems subscale ($d = 0.52$) and the total scale ($d = 0.41$). For the remaining domains, effect sizes ranged from small to moderate.

Finally, to assess the extent to which the different informants provided similar ratings, intraclass correlation coefficients (ICCs) and Cohen's Kappa coefficients were calculated (Table 3).

Table 3. Agreement between adolescents' and caregivers' reports on SDQ subscales and total score, as assessed by ICC calculation and Cohen's kappa coefficients (N = 511).

Subscales	**ICC**	**95% IC**	**F Test with True Value 0**				**K**	***p***
			Value	***df1***	***df2***	***Sig***		
Emotional	0.27	0.12–0.39	1.936	510	510	<0.001	−0.001	0.960
Behavioral	0.44	0.37–0.51	2.599	510	510	<0.001	0.07	<0.001
Hyperactvity	0.41	0.32–0.48	2.463	510	510	<0.001	0.03	0.057
Peer	0.23	0.15–0.31	1.601	510	510	<0.001	0.06	<0.001
Prosocial	0.27	0.17–0.36	1.812	510	510	<0.001	0.04	0.036
SDQ total	0.39	0.27–0.50	2.507	510	510	<0.001	0.03	<0.001

Note. Emotional = Emotional problems; Behavior = Behavior problems; Hyperactivity = Hyperactivity/Inattention difficulties; Peer = Peer relationship problems; Prosocial = Prosocial behaviors; SDQ Total = SDQ Total score; ICC = Intraclass Correlation Coefficients; K = Cohen's Kappa.

ICC values for all five SDQ subscales and total SDQ represent a poor to moderate level of agreement according to guidelines (<0.50) [31].

Adolescents and caregivers show low concordance in ratings of emotional symptoms, peer problems and prosocial behaviors, although the ICC is statistically significant, indicating that agreement exists but is weak. Adolescents tend to rate themselves higher prosocially than caregivers perceive them.

On behavioral problems and hyperactivity difficulties, ICC values indicate moderate agreement level suggesting a moderate consistency between adolescent and caregiver reports.

For the SDQ total difficulties score, ICC value falls just below the moderate threshold, indicating poor to moderate overall agreement between adolescents and caregivers.

To strengthen the robustness of the findings from ICC values, we have additionally conducted agreement analyses using weighted Cohen's kappa (see Table 3). Kappa values reflect the level of agreement beyond chance for categorical classifications, with higher values indicating stronger agreement between informants. The results were broadly consistent with those obtained using ICCs. Agreement between adolescents and caregivers across SDQ subscales was consistently low. Cohen's kappa coefficients indicated negligible agreement for most domains, with values ranging from $\kappa = -0.001$ to $\kappa = 0.07$. No agreement beyond chance was observed for emotional problems or hyperactivity/inattention difficulties. Although statistically significant, agreement for behavioral problems, peer relationship problems, prosocial behaviors, and the SDQ total score remained negligible in magnitude. Overall, these findings indicate minimal agreement between adolescent self-reports and caregiver reports across all domains.

4. Discussion

In Portugal, a substantial number of adolescents aged 12 to 17 reside in RCS [5]. Empirically based assessments of mental health symptomatology are essential, as they inform the development of targeted clinical interventions for this population [37]. Behavior rating scales are particularly valuable in child welfare contexts due to their efficiency and cost-effectiveness. Most can be administered by professionals with minimal assessment training, allowing for early screening and multi-informant data collection, including input from individuals under 18. The Strengths and Difficulties Questionnaire, in particular, offers a brief, low-cost format for identifying behavioral and emotional concerns across multiple informants.

Reports from both adolescents and caregivers provide complementary perspectives on youth adjustment challenges. This study aimed to examine potential discrepancies between caregiver and adolescents reports on psychological adjustment among youth in residential care, with attention to adolescents' sex and age group.

We explored the possibility that adolescents' responses might reflect social desirability; however, scores on the SDRS-5 were generally neutral. This may be due to the broad age range of participants—where younger adolescents may have shown response fatigue—or to the presence of institutional staff during questionnaire completion. Some authors noted that social desirability is influenced both by respondent characteristics and item properties, as some items are more prone to elicit socially desirable responses [27].

The sample mean on the SDRS-5 was 14, indicating a neutral response tendency rather than a bias toward favorable self-presentation. Moreover, the significant findings in areas such as emotional and behavioral problems align with theoretical expectations, suggesting that social desirability likely did not distort the results. Although the SDRS-5 showed low internal consistency, which limits strong conclusions about the extent of socially desirable responding, the observed differences across informants, and by adolescents' sex and age, are consistent with prior research and support the validity of adolescents' self-reports in this study.

Significant discrepancies emerged between adolescents' and caregivers' reports of psychological adjustment across all SDQ subscales and the total difficulties score. These findings partially support our first hypothesis and align with prior research highlighting informant discrepancies and the importance of using multi-informant approaches in residential care contexts [23,38,39]. Regarding adolescent's sex and age group we also observed scores differences, supporting the first hypothesis.

Regarding sex differences, self-reported total difficulties (SDQ Total) were higher among girls than boys, suggesting that girls perceive greater emotional and overall adjustment challenges—consistent with previous findings [25,40]. This aligns with existing literature indicating that girls tend to report more emotional difficulties, whereas boys are more often associated with behavioral problems [41–43].

Similar patterns were observed for age, with younger adolescents reporting more difficulties than older ones [19,41]. The greater discrepancies in reports among girls may reflect higher emotional-awareness or the possibility that caregivers underestimate internalizing symptoms. Moreover, the pubertal transition is a critical period for internalizing problems, particularly in girls, and may be exacerbated by trauma histories such as sexual abuse [44].

The decrease in difficulties reported with age—particularly among those aged 19–24—may indicate better psychosocial adjustment, potentially due to prolonged staff support [7], developmental changes in self-perception, more stable interpersonal relationships [19] or length of placement [45]. Future studies should explore whether these improvements are more strongly associated with age at institutional entry or length of institutionalization, as suggested in previous research [7].

Caregivers consistently reported fewer difficulties than adolescents across all SDQ domains, partially supporting our second hypothesis, although this diverges from some existing literature. While some authors [46] also found that adolescents tend to report more problems than caregivers, other studies indicate that adolescents may underreport externalizing behaviors and overreport internalizing symptoms [47].

Caregivers' reports of greater emotional, behavior, peer relationship problems, and overall difficulties in adolescents aged 16–18 may reflect both developmental transitions and the impact of institutionalization on previously formed social bonds. Research indicates that conflict with close friends tends to decrease with age, while peer support increases in early adolescence but declines in mid to late adolescence [48,49].

Lower levels of support and companionship in close friend have been linked to negative psychosocial outcomes [23,50]. Additionally, prior research found that while close relationships offer opportunities to share problems, they may also contribute to maintaining depressive symptoms by reinforcing negative affect [51]. These findings suggest that negative qualities in peer relationships may be more predictive of mental health outcomes than the presence of positive ones.

The discrepancy pattern was stable across all subscales and the total score, lending partial support to our third hypothesis. However, caregivers reported lower levels of difficulties across all SDQ dimensions.

Intraclass correlation coefficients for behavioral problems and hyperactivity suggested moderate agreement, supporting our fourth hypothesis. This moderate consistency reinforces the importance of multi-informant assessment in RCS, where behavioral and peer-related issues can impact the group dynamic in these collectivist environments.

Regarding the potential influence of social desirability on agreement, our results showed that although adolescents self-reported more emotional and behavioral difficulties, they also reported higher levels of prosocial behaviors compared to caregivers. This pattern, consistent with previous studies [23], supports our fifth hypothesis.

Despite significant mean differences, ICCs indicated poor to moderate agreement between adolescents and caregivers. According to guidelines [31], the ICC values suggest weak to moderate agreement; however, lower bounds below 0.50 indicate that assessments may not be equivalent across the full range of symptom severity. This suggest that agreement may vary depending on the level of symptomatology rather than being uniformly distributed. Nonetheless, the statistically significant correlations and kappa coefficients suggest that the observed agreement is not merely due to chance.

The total difficulties score indicates limited to moderate agreement, reinforcing that adolescents and caregivers often do not fully concur on the severity or presence of difficulties. These findings underscore the importance of caution when substituting one informant for another and highlight the value of multi-informant assessments [52].

While these results are consistent with prior research showing low caregiver-youth agreement for externalizing behaviors and related constructs [53], they also offer insight into the relational dynamics within RCS. The interaction between informants must be considered, as discrepancies may be informative but are not, on their own, sufficient to confirm the presence of adjustment difficulties or psychopathology. Differences in reports may reflect varying access to information—caregivers, for instance, typically rely on observable behaviors—and may depend on the specific construct being assessed [53]. Therefore, although this study clearly demonstrates the existence of informant discrepancies across SDQ subscales and the total score, caution is warranted in interpreting these results as definitive indicators of adolescents' psychological adjustment. Misinterpretation could lead to inaccurate conclusions, reinforcing the need for integrative assessment approaches that consider both informant perspectives and construct-specific factors [52].

The literature shows that studies reporting discrepancies between informants often yield inconsistent results, making it difficult to estimate parameters or the prevalence of mental health problems in this specific population [54].

Research indicates that when multiple informants independently report on the same psychological constructs, substantial discrepancies often emerge, with significant implications for understanding adolescent development and psychopathology [37,53]. These differences highlight the importance of interpreting informant discrepancies not merely as measurement error, but as potentially meaningful variations linked to the nature of the construct being assessed. Such discrepancies may be context-specific, influenced by informant characteristics, or even predictive of external indicators of psychosocial functioning [22,53].

Various factors have been associated with cross-informant disagreement, including demographic variables, time spent in care [21], the quality of interpersonal relationships, and caregiver-related factors such as depressive symptoms [55]. In institutional settings, it is also plausible that a high child-to-caregiver ratio may hinder the development of close relationships and limit caregivers' ability to acquire deep, individualized knowledge of each adolescent.

Limitations and Implications for Practice

Although these findings contribute meaningfully to the literature in this filed, several limitations should be acknowledged. The cross-sectional design limits causal inferences, the SDRS-5 and some SDQ subscales present low internal consistency values, and adolescents' self-reports—often completed within institutional settings and sometimes in the presence of staff—may have been influenced by social desirability. The exclusive reliance on questionnaire-based measures can also be a limitation since they may not fully capture the complexity of adolescents' emotional experiences. Additionally, self-report measures are also subject to difficulties in emotional awareness. Caregivers may be more attuned to observable and externalizing behaviors, while having reduced sensitivity to less visible internalizing symptoms. As a result, questionnaire reports provided by caregivers may underestimate adolescents' internal distress, contributing to the discrepancies observed between informants. Taken together, these limitations highlight the importance of complementing questionnaire-based assessments with other methods, such as clinical interviews or observational approaches, in order to obtain a more comprehensive and ecologically valid understanding of adolescents' psychological functioning in RCS.

Nevertheless, the study has several notable strengths, including the use of a nationally representative sample, the integration of adolescents' own perspectives on key developmental issues, and a high response rate within a typically hard-to-reach population. While the national scope of the data is a clear strength, variations in child protection systems and residential care practices across countries may constrain the generalizability of the findings. Still, given that as residential care remains a common arrangement for children without parental care across many European countries, these results are consistent with prior research and may offer insights beyond the Portuguese context.

From a practical standpoint, the modest—and at times poor—agreement between adolescents and caregivers underscores the limitations of relying on a single informant when assessing psychological adjustment. First, practitioners should routinely integrate both self-reports and caregiver reports to obtain a more comprehensive understanding of adolescents' psychological functioning.

Secondly, the findings underscore the relevance of the age of entry into residential care and the duration of institutionalization as influential factors in youths' adjustment. A substantial number of adolescents enter residential care during late adolescence—a period in which they reported significantly more emotional, behavioral, and social difficulties than those perceived by caregivers. This gap reinforces the clinical importance of taking adolescents' self-reports seriously to avoid under-identifying internalizing symptoms that may go unnoticed by caregivers.

The observed discrepancies between adolescents' self-reports and caregivers' reports of internalizing symptoms suggest that relying solely on caregiver perspectives may lead to an underestimation or misinterpretation of youths' emotional distress. Therefore, assessment procedures in RCS should systematically incorporate adolescents' self-reports as a central component of psychological evaluation and ongoing monitoring. At an organizational level, these results highlight the need for structured opportunities for individual expression, as well as enhanced training for caregivers to better recognize less observable forms of distress, such as anxiety and depressive symptoms.

The absence of agreement observed in some domains further underscores the extent of discrepancies between adolescent and caregiver reports. The fact that agreement did not differ from chance levels suggests that caregivers' perceptions may not reliably reflect adolescents' self-reported difficulties, reinforcing concerns about the exclusive reliance on informant-based reports in RCS.

In this context, enhancing caregiver training to better recognize emotional and internalizing difficulties could improve observational accuracy and reduce future informant discrepancies. The observed tendency for caregivers to underestimate adolescents' internalizing symptoms suggests that staff may benefit from additional guidance in recognizing less visible forms of psychological distress. In this sense, targeted training programs focused on the identification and interpretation of internalizing symptoms could enhance caregivers' sensitivity to adolescents' emotional needs.

Furthermore, the results support the implementation of tailored interventions based on age and sex, as different groups reported distinct patterns of difficulties. Intervention strategies should therefore be developmentally appropriate and gender-sensitive to more effectively address the needs and experiences of youth in care. Additionally, the findings support the implementation of multidisciplinary approaches that integrate diverse sources of information in care planning.

Differences between adolescents' and caregivers' reports, particularly in relation to internalizing symptoms may have meaningful implications for the identification and treatment of emotional difficulties. The under-detection of such symptoms may delay access to appropriate psychological support and intervention, thus these findings underscore the clinical importance of adopting multi-informant assessment strategies and ensuring that adolescents' subjective experiences are systematically considered in both diagnostic and intervention processes, particularly in residential care contexts where vulnerability may be heightened.

Moreover, these implications should be considered within the broader context of caregiving conditions in RCS, which are often characterized by high workloads, time constraints, and complex group dynamics. Such structural factors may limit opportunities for individualized attention and reduce caregivers' capacity to detect more nuanced emotional difficulties. Therefore, beyond individual training, organizational support mechanisms—such as adequate staffing ratios, regular supervision, and multidisciplinary collaboration—are likely to play a crucial role in improving the quality of assessment and care [56]. Taken together, these findings highlight the need for both enhanced professional training and systemic investment in residential care environments to better support the mental health of adolescents.

From a policy perspective, the results underscore the importance of establishing guidelines that promote multi-informant assessment as standard practice, alongside ensuring adequate staff ratios and investment in specialized mental health resources within RCS. Such measures may contribute to more accurate identification of needs and more effective, youth-centered interventions.

Overall, the findings emphasize the need for comprehensive, developmentally informed, and multi-informant assessment practices in RCS. Such approach can enhance the quality of psychological support and inform the design of preventive and mental health promotion programs tailored to this vulnerable population.

5. Conclusions

This study contributes to a growing body of research highlighting the complexity of assessing psychological adjustment in adolescents living in residential care. The total score reported by caregivers was lower than adolescents' self-reports for both sexes, with higher overall scores observed among younger participants. Discrepancies were more pronounced in the subscales related to emotional and behavioral symptoms, particularly among girls and younger adolescents. Additionally, in the prosocial subscale, adolescents rated themselves higher than caregivers did, suggesting that adolescents tend to perceive themselves as more socially skilled.

The observed discrepancies between adolescent and caregiver reports reinforce the importance of using multi-informant approaches, particularly in institutional settings where caregivers may have limited access to the internal experiences of youth. Although caregiver reports remain valuable, adolescents' self-reports offer essential insights—especially regarding emotional and internalizing difficulties that may otherwise go unnoticed.

Developmental and contextual factors—such as age, sex, and timing of entry into care—appear to influence psychological outcomes and should be considered in intervention planning. Although differences were observed in this study, results should be interpreted with caution, as some scores may reflect normative developmental changes during adolescence.

Tailored interventions that account for these variables are essential for effectively supporting adolescents' mental health in residential settings. The findings underscore the need for developmentally sensitive, gender-responsive, and preventive mental health programs. Enhancing assessment practices and intervention strategies can ultimately lead to more accurate identification of needs and improved psychological support for youth in care.

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Abbreviations

The following abbreviations are used in this manuscript:

ICC	Intraclass Correlation Coefficients
RCS	Residential care settings
SDQ	Strengths and Difficulties Questionnaire
SDRS-5	Socially Desirable Response Set-5

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