Longitudinal Effects of Negative Ethnic-Racial Identity Affect on Internalizing Symptoms in Youth of Latiné Background Exposed to Interpersonal Trauma

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Abstract

Objectives: Latiné youth in the US are at elevated risk for trauma exposure, but factors that contribute to their symptoms are not well studied. We examined the effects of interpersonal trauma (IPT) burden and negative affect about ethnic-racial identity (NERI-A) on internalizing symptoms following trauma exposure.

Method: Participants were 1,006 US-born youth of Latiné background (mean age 15.4 years, 60% female at birth, and 70% identified as White) from the Childhood Trauma Research Network, a research consortium examining long-term outcomes of childhood trauma in Texas. Participants were enrolled between October 2020 and February 2024. Analyses controlled for sex, age, race, non-interpersonal trauma, whether parents were of the immigrant generation, and mental health treatment received.

Results: Greater IPT burden and higher baseline NERI-A were associated with greater baseline anxiety ($P < .001$, $P = .026$) and depressive ($P < .001$, $P = .040$) symptoms. The effect of baseline IPT burden on direction and magnitude of longitudinal change in anxiety (0.038) and depression (0.002) differed for those with high NERI-A vs low NERI-A. In the context of low NERI-A, IPT burden showed steady or decreasing associations with symptoms over time. In contrast, for those reporting high NERI-A, IPT burden showed strengthening associations with both anxiety and depression over time.

Conclusion: Our study highlights the vulnerability of youth who experience IPT and report NERI-A. Further research is needed to determine how NERI-A develops, changes, and is moderated in the diverse groups of individuals of Latiné descent.

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Although traumatization and trauma-related disorders are substantial in children and adolescents from minoritized backgrounds in the US,[1] these youth are frequently underrepresented in research.[2] The current study is a sample of 1,006 youth of Latiné background drawn from the Texas Childhood Trauma Research Network, a cohort designed to examine long-term outcomes of childhood trauma in racially and culturally diverse youth. We examined whether in the context of interpersonal trauma (IPT), Latiné youth's psychological relationship to their culture of origin, specifically their negative affect about their ethnic-racial identity (NERI-A), influenced change in anxiety and depressive symptoms from baseline to 1 and 6 months later.

Individuals of Latiné background are the fastest growing ethnic group and make up almost 20% of the population in the US.[3] Latiné youth are more likely to experience potentially traumatic events[4] and are at greater risk for the development of posttraumatic stress disorder (PTSD) following trauma exposure[5] compared with their non-Latiné White counterparts. The chronic and acute trauma experiences that accompany harmful social determinants of health are associated with physical and mental disparities.[6] Cultural pride promotes close community connections and activates the protective factor of social integration.[7] Thus, while systems of inequity create risks for Latiné individuals, their culture offers resources for recovery and resilience.

Editor's Note

We encourage authors to submit papers for consideration as a part of our Focus on Childhood and Adolescent Mental Health section. Please contact Karen D. Wagner, MD, PhD, at psychiatrist.com/contact/wagner

Clinical Points

- Negative affect about one's own ethnic-racial identity (NERI-A) has been proposed as an important risk factor for psychopathology in minoritized youth, but its effect on symptoms of anxiety and depression following trauma has not been previously investigated.
- In a large group of Latiné youth who had experienced trauma, we found that NERI-A not only is associated with worse internalizing symptoms but also increases the negative effects of interpersonal trauma (IPT) burden over time.
- Our study highlights the vulnerability of youth who experience IPT and report NERI-A. Treatments that enhance family and community connection for these youth are recommended.

Interpersonal vs Non-Interpersonal Trauma

Traumatic events can be classified as either *interpersonal* trauma (IPT, eg, physical attacks or sexual assaults) or *non-interpersonal* trauma (NIPT, eg, natural disasters or accidents). IPTs are more strongly associated with negative physical[8] and psychological[9–11] health, compared to NIPTs. IPTs have been associated with a range of internalizing and externalizing behaviors in young people[9,12–17] and adults.[11,18–21] The pernicious effects of IPT have been attributed to interactions with neurobiological vulnerabilities,[22] and cognitive, affective, and interpersonal processes.[10,18,19,23]

IPT is reported to be higher in Latiné than in White populations.[24] The evidence is strong for negative effects of childhood traumas among Latiné individuals on several health outcomes.[25] A recent review of the literature on trauma and mental health needs of Latiné youth[26] reported inconsistent findings and methodological limitations including small samples, inadequate accounting for types and number of traumatic events, and a primary focus on PTSD with studies needed on transdiagnostic risk.

Negative Affect About Ethnic-Racial Identity

The construction of identity, or the individual's sense of who they are, including their beliefs, values, and their self-concept, accelerates during adolescence.[27] A stable and positive identity is associated with higher self-esteem, resilience, and adaptive coping strategies.[28–30] Affect about ethnic-racial identity (ERI), reflecting feelings, thoughts, and attitudes about membership in an ethnic or racial group, is a salient component of the identity of individuals from minoritized backgrounds. It is complicated by encounter with pervasive inequities of resource distribution, structural racism, implicit and explicit messages of bias, and being defined by others based on ethnic and racial membership. ERI also offers potential resources of cultural heritage, values, beliefs, and community.[31]

Positive affect about one's group membership (PERI-A), also referred to as *affirmation, private regard*, and *cultural pride*, has been proposed to be a buffer against negative experiences resulting from ongoing marginalization.[32] Although the literature has been driven by an interest in affirmation or PERI-A, many studies have assumed that PERI-A and NERI-A are opposite ends of the same dimension. For example, one widely used instrument, the Ethnic Identity Scale,[33] measures affirmation by reverse coded items that express NERI-A. Recent empirical enquiry has challenged this construction.[34] Current conceptualization is that PERI-A and NERI-A are separate dimensions,[35] with the former enhancing positive aspects of well-being and the latter having greater negative effects on psychopathology.

Although there have been many studies of ERI in minoritized[36,37] and specifically in Latiné youth,[38–41] we are not aware of any in those with trauma. NERI-A has been proposed to drain psychological resources,[35] which might mediate its effect on symptoms. In addition, we anticipated that NERI-A might also moderate the effect of IPT burden on anxiety and depression symptoms. Our rationale was based on the literature that social support is an important predictor of symptom management following trauma. For example, a recent meta-analysis[42] has documented the importance of social support in mitigating the development of PTSD particularly when the trauma events are combat/war and interpersonal violence (types of IPT). NERI-A might present a barrier against seeking and utilizing family and community support, and its presence could complicate the trajectory of recovery. The need for more longitudinal studies of the effects of affect about ethnic-racial identity has been emphasized.[35]

The Current Study

Noting shortcomings in the literature, the current study uses a large sample, a longitudinal and prospective design, and accounts for types and multiple exposures to trauma and treatment as potential influences on the transdiagnostic symptoms of anxiety and depression. We excluded participants born outside the US to acknowledge the importance of disaggregating data from US born and immigrant Latiné samples.[43] We controlled for parental place of birth (US vs foreign born) as acculturative stress is greatest for new immigrants.

Our aims were to examine (*a*) prediction by NERI-A to change over 6 months in the outcomes of depressive and anxiety symptoms in youth of Latiné background who have experienced IPT and (*b*) given that NERI-A might interfere with seeking family and community support, we investigated whether NERI-A moderated the influence of IPT burden on outcomes. In all analyses, we controlled parental place of birth, race, NIPT burden, and participation in any treatment.

METHOD

Procedure

The Texas Childhood Trauma Research Network (TX-CTRN) is a statewide study of youth who have experienced lifetime trauma, established in 2020. Assessments are conducted by trained raters at 6 waves over 24 months. Raters are trained to read the items for youth younger than 12 years old and to make adaptations to item wording based on developmental and culture factors. See Shahidullah et al[44] for more details about the registry and procedures to ensure consistency across sites. The data reported here from this ongoing study were collected between October 2020 and February 2024 and represent findings at baseline and 1- and 6-month follow-ups. All visits were conducted in person or virtually via HIPAA-compliant telehealth software. The study was approved by the University of Texas Southwestern Institutional Review Board.

Participants

Recruitment for TX-CTRN occurred at 12 academic medical centers in Texas, across a variety of academic, medical, psychiatric, and community settings.[44]

Inclusion criteria for participation in the larger study were (1) a history of trauma exposure that fulfills *DSM-5* Criterion A for PTSD and/or have experienced bullying; (2) between 8 and 20 years of age; (3) able to provide consent for 18–20 year olds or assent for those under 18 years with parental consent; (4) able to speak and read English or Spanish; and (5) level of function that allows accurate completion of the assessment instruments. Exclusion criteria included either the child or the consenting parent exhibiting cognitive or behavioral impairment precluding valid completion of assessments.

The current report includes youth (n = 1,006) from 8 to 20 years of age who were US born, and they or their parent endorsed a Hispanic background (terminology used in the survey). Parental education and family income were only available for participants under 18 years whose parents also completed the demographic questionnaires. At baseline, 343 of 588 (58.3%) reported family income less than $50,000.00 USD; 213 of 625 (34.1%) reported a high school education or less.

Measures

Predictors measured at baseline. Traumatic Events Screening Inventory for Children (TESI-C)[45] is a clinician-administered interview that assesses a child's experience of a broad range of potentially traumatic events, widely used with individuals aged 6 to 18 years.[46] We added 2 bullying items (repeated in-person or online attempts at social or physician intimidation). Consistent with prior work in this sample,[47] we created 2 scores that represented total trauma burden as reflected by number of events reported meeting *DSM-5* PTSD A1 criteria: interpersonal trauma (TESI-IP, eg actual or threats of experienced interpersonal physical violence, sexual abuse, and bullying) and other trauma (TESI-NIP, eg, accidents, natural disasters, and witnessed violence).

Ethnic Identity Scale (EIS-B)[33] is a 9-item measure of NERI-A validated among youth. Items are rated on a scale from 1 (doesn't describe me well) to 4 (describes me well). We used the Affirmation scale, which consists of the following items: I feel negatively about my ethnicity; I wish I were of a different ethnicity; I dislike my ethnicity. These items are consistent with negative feelings concerning one's own ethnicity (NERI-A). For some younger participants, the term "ethnicity" required explanation; reference to heritage, geographical origins, language, and culture were used to illustrate its meaning. Cronbach α was acceptable (0.73). The distribution was highly positively skewed (3.6) and kurtotic (18.6), with 83% of the sample having total scores at the minimum possible score of 3. Hence, we reduced the total score to a binary value of no (0) vs some NERI-A (1) for use in the analyses.

Outcomes measured at baseline and 1- and 6-month follow-ups. Screen for Child Anxiety Related Disorders (SCARED)[48] is a 41-item self-report scale for anxiety symptoms rated from 0 (not true) to 2 (very true), validated in children 8 years and older. The total score was used. Cronbach αs were excellent (≥0.95) at each wave. The average SCARED score was significantly higher among those who screened positive in the MINI-KID[49] interview for any anxiety disorder at each wave, *P*'s < .001, and the lower limit of the 95% confidence interval (CI) for SCARED total for those with positive MINI-KID anxiety screens was higher than the cut-off value of 30 for this instrument.

Patient Health Questionnaire for Adolescents (PHQ-A)[50] is a 9-item self-report scale for depressive symptoms, rated from 0 (not at all) to 3 (nearly every day), validated in youth 12 years and older. We used the total score. Cronbach αs were excellent at each wave (≥0.88). The PHQ-A score was significantly higher among those who screened positive in the MINI-KID interview for any depressive episode/disorder at each wave, *P*'s < .001, and the lower limit of the 95% CI was consistent with at least mild to moderate depressive symptoms. These associations reduced concerns that the scale has not been validated in youth below 12 years. Furthermore, the inferences in the results were unchanged when those under 12 years were excluded from the analyses.

Analytic Plan

Because the primary outcome measures were continuous and normally distributed, we relied on mixed linear regressions with random person intercepts to examine outcomes at baseline, 1-month, and 6-month follow-ups, with time coded categorically. These analytic methods use all data at all time points and thus

Table 1.

Descriptive Statistics for All Measures

Study variables	Frequency (%)	Mean	SD	n
Female sex at birth	612 (60.8)			1,006
Age (y)		15.4	3.4	1,006
Race				1,006
White	728 (72.4)			
Black	32 (3.2)			
Other	246 (24.5)			
Immigrant parents[a]	423 (46.5)			910
Treatment[b]	619 (65.0)			952
TESI				1,006
TESI-IP		1.7	1.5	
TESI-NIP		3.0	1.9	
NERI-A	165 (16.5)			1,006
SCARED				
Baseline		29.8	18.3	996
1 month		25.6	18.4	798
6 months		23.6	18.1	527
PHQ-A				
Baseline		8.2	6.4	996
1 month		6.9	6.28	798
6 months		6.0	6.02	527

[a]Most (74%) immigrant parents indicated that they were born in Mexico.
[b]Participating in any behavioral/ psychiatric treatment delivered by a licensed mental health professional.
Abbreviations: NERI-A = negative affect about ethnic-racial identity (measured by Brief Ethnic Identity Scale-Affirmation Scale); , PHQ-A = Patient Health Questionnaire-Adolescent, SCARED = Screen for Child Anxiety Related Disorders, TESI-IP = Traumatic Event Screening Inventory-Interpersonal Trauma Burden, TESI-NIP = Traumatic Event Screening Inventory-Noninterpersonal Trauma Burden.

Table 2.

Mixed Linear Regressions for Prediction of Symptoms of Anxiety and Depression From the Full Model[a]

	Anxiety[b]		Depression[c]	
	Coeff (SE)	P value	Coeff (SE)	P value
Model terms				
Female sex at birth[d]	**10.89 (1.05)**	**<.001**	**1.95 (0.34)**	**<.001**
Age at baseline	**0.47 (0.16)**	**.003**	**0.31 (0.05)**	**<.001**
Race[e]				
Black	**−5.96 (2.78)**	**.032**	−1.29 (0.92)	.156
Other mixed	−1.42 (1.16)	.221	0.41 (0.38)	.298
Immigrant parents[f]	−0.52 (1.02)	.610	−0.38 (0.33)	.388
Treatment[g]	1.08 (0.84)	.201	1.81 (0.35)	**<.001**
Time[h] **× treatment**				
1 mo	1.12 (1.0)	.262	−0.37 (0.44)	.400
6 mo	−0.41 (1.14)	.717	**−1.66 (0.50)**	**.001**
TESI-IP[i]	**2.68 (0.43)**	**<.001**	**0.89 (0.15)**	**<.001**
TESI-NIP[i]	**0.78 (0.28)**	**.005**	0.09 (0.09)	.330
NERI-A[j]	**4.77 (2.15)**	**.026**	**1.52 (0.74)**	**.040**
Time × TESI-IP				
1 mo	**−0.65 (0.31)**	**.040**	−0.04 (0.14)	.767
6 mo	**−0.93 (0.37)**	**.012**	−0.01 (0.16)	.955
Time × NERI-A				
1 mo	−1.73 (1.71)	.312	1.28 (0.76)	.091
6 mo	−3.77 (1.97)	.055	−0.89 (0.86)	.301
TESI-IP × NERI-A	0.34 (0.88)	.697	−0.39 (0.31)	.207
Time × TESI-IP × NERI-A				
1 mo	0.70 (0.70)	.312	0.13 (0.31)	.664
6 mo	**1.60 (0.77)**	**.038**	**1.04 (0.34)**	**.002**

[a]Boldface indicates statistical significance.
[b]As measured by the Screen for Child Anxiety Related Disorders.
[c]As measured by the Patient Health Questionnaire-Adolescent.
[d]Centered on males.
[e]Centered on white.
[f]Centered on nonimmigrant parents.
[g]Participating in any behavioral/psychiatric treatment delivered by a licensed mental health professional.
[h]Time is centered on 0, or baseline.
[i]TESI-IP and TESI-NIP were centered at the sample median of 1 and 3, respectively.
[j]As measured by the Brief Ethnic Identity Scale-Affirmation Scale.
Abbreviations: Coeff (SE) = fixed effect coefficients from the mixed linear model and associated SEs, NERI-A = negative affect about ethnic-racial identity (measured by Brief Ethnic Identity Scale-Affirmation Scale), TESI-IP = Traumatic Event Screening Inventory-Interpersonal Trauma Burden, TESI-NIP = Traumatic Event Screening Inventory-Noninterpersonal Trauma Burden.
Symbol: × = product (indicating interaction term).

minimize bias in estimates from relying on complete data. We examined a covariates-only model first and subsequently examined whether effects concerning ethnic identity improved the fit of the models. The first covariates-only model included sex assigned at birth (centered on males), child age, child race (self-reported White, Black or Other, centered on White), immigrant parents (binary, centered on nonimmigrant), baseline levels of TESI-IP and TESI-NIP, participating in any behavioral/psychiatric treatment from baseline through 6 months (binary), and treatment's interaction with time indicators. We refer to this model as the covariates-only model hereafter. In the second step, NERI-A main effect and all of the 2-way interactions subsumed under the 3-way interaction (NERI-A × TESI-IP × time) were included. If the nested log-likelihood tests between the full and covariates-only model were significant, we proceeded with the interpretation of the full model.

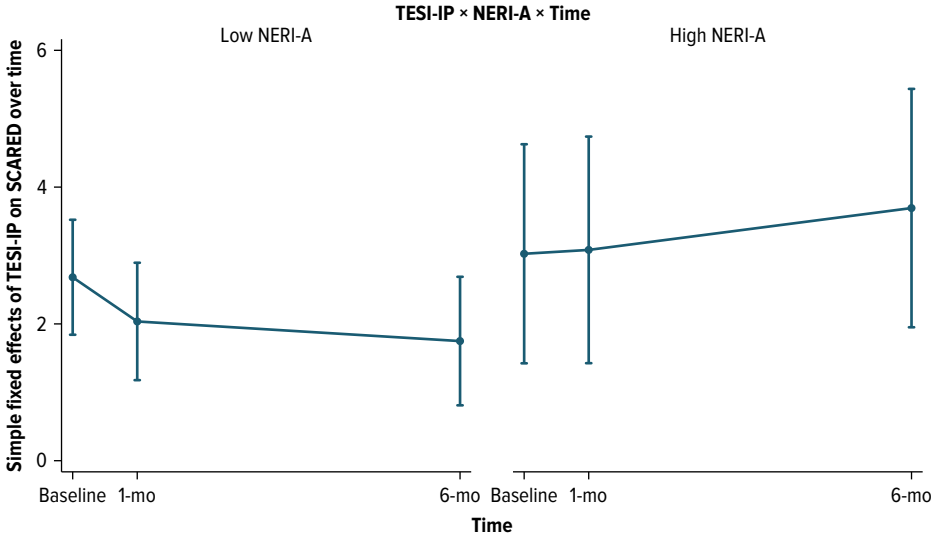
RESULTS

Table 1 shows descriptive data for all measures in this report. The majority of the sample were girls about 15 years of age, who self-identified as White. Somewhat under half had immigrant parents. The majority were receiving some mental health treatment. Youth reported on average 2 IPT and 3 NIPT events that met *DSM-5* PTSD Criterion A. Fewer than 1 in 5 youth indicated any NERI-A.

There was no evidence that any of the predictors included in our models predicted missingness in 1- or 6-month outcomes. We also examined whether dropout was more likely among those who scored higher in NERI-A, SCARED, or PHQ-A. Only those whose PHQ-A scores indicated moderate or more severe depression (≥10) were more likely to be present at the 6-month visit. Coupled with reliance on mixed linear regressions with full information maximum likelihood, these results are encouraging in that for the models estimated, missing data did not likely influence inferences of interest.

Figure 1.

Simple Effects (95% CI) of Interpersonal Trauma Burden (TESI-IP) on Anxiety Symptoms (SCARED) at Each Time Point for Those Low vs High in NERI-A



Abbreviations: NERI-A = negative affect about ethnic-racial identity (measured by the Brief Ethnic Identity Scale-Affirmation Scale), SCARED = Screen for Child Anxiety Related Disorders, TESI-IP = Traumatic Event Screening Inventory-Interpersonal Trauma Burden.

Models

The mixed linear regressions with random person intercepts for both outcomes with the 3-way interactions of NERI-A × TESI-IP × time included (full model) improved overall model fit over the covariates-only model. Table 2 shows the fixed effect coefficients and associated *P* values from the full models for both outcomes. The full model improved overall model fit over the covariates-only model for both outcomes. The nested log-likelihood chi-square for anxiety was significant (−2LL c^2 [8] = 25.66, *P* = .0012). The corresponding values for depression were also significant (−2LL c^2 [8] = 36.84, *P* < .0001).

Anxiety. As shown in Table 2, girls reported higher total anxiety than boys, age was associated with greater anxiety, and both TESI-IP and TESI-NIP trauma burden were associated with higher levels of anxiety. NERI-A was also associated with greater anxiety. The 2-way interactions of TESI-IP with time and the 3-way interaction of NERI-A with TESI-IP and time were significant. These interactions indicate that the effect of TESI-IP on anxiety changes from baseline to 6 months and that this effect is further moderated by NERI-A.

Post hoc tests for the 3-way interaction indicated the following. With respect to group differences (low vs high NERI-A) in the simple effect of TESI-IP on anxiety at each wave: (*a*) the simple effect of TESI-IP on anxiety at 6 months was significantly larger for high NERI-A than those with low NERI-A (difference in simple effect [standard error] = 1.94 [0.97], *P* = .046); in contrast, (*b*) the difference between the simple effects of TESI-IP for those high vs low in NERI-A was not significant at baseline (difference in simple effect [standard error] = 0.34 [0.88], *P* = .697). With respect to the direction of within group change over time in the simple effects of TESI-IP on anxiety, the tests showed (*a*) for those with low NERI-A, the simple effects of TESI-IP on anxiety decreased from baseline to 6 months (difference in simple effect [standard error]= −0.93 [0.37], *P* = .012); in contrast, (*b*) for those with high NERI-A, the simple effects of TESI-IP on anxiety trended in the opposite direction, but the changes were not statistically significant (*P* = .333). Figure 1 depicts these effects.

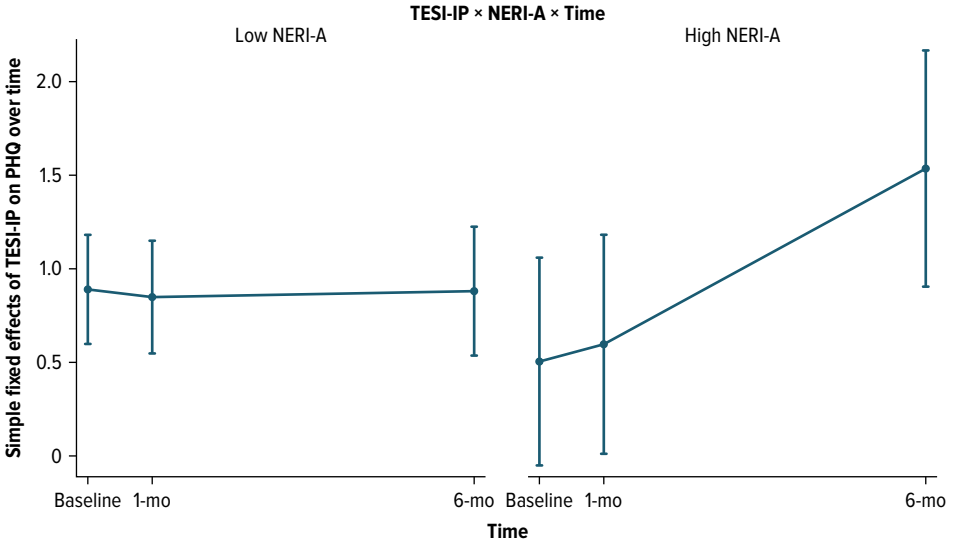
Depression. Table 2 shows that girls and those who were receiving treatment reported greater depression. Age, TESI-IP, and NERI-A were also associated with greater depression.

The 2-way interaction effect of any treatment with time on depression showed that depression levels were higher among those in any treatment compared to those not in treatment at baseline and 1 month (*P*'s < .001), but at 6 months, those differences were not significant (*P* = .724).

The 3-way interaction of NERI-A with TESI-IP and time was significant. The post hoc tests concerning the 3-way interaction indicated the following. With respect to the direction of within group change over time in the simple effects of TESI-IP on depression, the tests showed that (*a*) for those with low NERI-A, the simple effects of TESI-IP on depression did not change as reflected in the

Figure 2.

Simple Effects (95% CI) of Interpersonal Trauma Burden (TESI-IP) on Depressive Symptoms (PHQ-A) at Each Time Point for Those Low vs High in NERI-A



Abbreviations: NERI-A = negative affect about ethnic-racial identity (measured by the Brief Ethnic Identity Scale-Affirmation Scale), PHQ-A = Patient Health Questionnaire for Adolescents, TESI-IP = Traumatic Event Screening Inventory-Interpersonal Trauma Burden.

flat line graph in Figure 2; in contrast, (*b*) for those with high NERI-A, the simple effects of TESI-IP on depression changed from baseline to 6 months (difference in simple effect [standard error] = 1.03 [0.30], $P = .001$). The effects of TESI-IP increased on depressive symptoms from baseline to 6 months.

DISCUSSION

Our findings extend the literature on the negative effects of IPT and NERI-A on psychological outcomes to youth of Latiné background, using a rigorous design that addresses many of the methodological concerns highlighted in the literature.[26] The large sample of Latiné youth who have experienced a broad range of well-categorized traumatic events, and controlling for the presence of NIPT and treatment, bring new information to the literature. The transdiagnostic variables of anxiety and depressive symptoms allow generalization to a range of levels of distress, including those that might not meet all diagnostic criteria for a specific disorder but merit attention.

That IPT takes a greater toll than NIPT is not surprising.[47] Latiné culture in particular places importance on warmth, expressivity, and the giving and taking of social support, particularly within the family.[51] Given that trauma in childhood is linked to impaired social function and emotional regulation,[52,53] there is likely a negative synergy between difficulties with fulfilling social roles and symptoms. Assessing and intervening at the level of interpersonal relationships within the family could be particularly important for Latiné youth who experience IPT.

We found very little variability in NERI-A in our sample. Any negative affect about ERI was present in less than a fifth of our sample, forcing dichotomization to "no" NERI-A vs "some" NERI-A. Our sample is drawn from a geographical location with a concentration of individuals of Latiné background where NERI-A may play a different role than in contexts where Latiné communities are sparse. However, others have also found very low variability for items that are associated with NERI-A. In her recent review of historical approaches to ERI, Umaña-Taylor[35] indicates that items developed originally for the unidimensional Multigroup Ethnic Identity Measure included both positive and negative wordings. However, the latter showed little variance and thus were dropped. The scale's developers postulated that the rejection of central attributes of the self is too intense to be normally distributed in the population. She includes suggestions from other authors that self-hatred captured by NERI-A is corrosive and reflects a deep insecurity and inferiority. Thus, NERI-A might not mirror the variability that might be present with increasingly positive frame of reference for one's ERI. Our findings indicate that although NERI-A is rare, it

is associated with elevations in anxiety and depressive symptoms. More importantly, our findings show that the effects of IPT burden on symptoms increase over time for those with high NERI-A compared to those with low NERI-A.

Our findings have clinical implications for the care of Latiné youth who experience traumatic events. In our sample, more significant symptoms increased the likelihood of being in treatment. That by 6 months, treatment's association with depressive symptoms had decreased suggests a reduction in distress, emphasizing the value of treatment for these youth. Youth who have experienced IPT and express negative feelings about their ethnic-racial group might be prioritized for intervention. Trauma-focused approaches such as trauma-focused cognitive behavior therapy,[54] culturally informed treatments that promote ethnic pride, and positive connection opportunities with family and community might be particularly beneficial.[55]

This new paradigm separating PERI-A and NERI-A has created a need for research that promotes an understanding of the 2 processes. Although these constructs are not entirely overlapping, they are highly correlated ($r = -0.634$).[34] More research is needed about their unique and shared antecedents and consequences. Socioeconomic status, acculturation, and immigrant generation status could be important moderators of their effects on outcomes.

Our findings add to the literature that makes compelling the development and testing of interventions that decrease NERI-A and promote PERI-A. The literature on ethnic-racial identity has examples of universal interventions for adolescents that promote exploration and resolution,[56] processes that are hypothesized to enhance ERI.[57] In most of these studies, the primary outcomes are the targeted processes of exploration and resolution. We were unable to find any intervention studies that report the effects on the affective components of ERI. More research is needed to determine whether NERI-A decreases with interventions promoting ERI. Also needed are efforts to directly target the development of NERI-A and reduce it when it is present.

Study limitations include that our data were gathered in a single large state and may not be generalizable elsewhere, even in the US. Although our strategies increased face validity, some of our scales were not normed for our youngest participants. Lastly, we were limited by the measures that were included in the dataset, which did not include strength-based measures such as PERI-A, bicultural adaptation, and cultural values. We hope that these initial findings serve as a stimulus for additional studies that will provide more nuanced information about the role of NERI-A in racially and culturally diverse youth.

Article Information

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