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Racial Discrimination and Mental Health for Transracially Adopted Adults: The Roles of Racial Identity and Racial Socialization

Candice Diana Presseau
Lehigh University

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Racial Discrimination and Mental Health for Transracially Adopted Adults: The Roles of
Racial Identity and Racial Socialization

by
Candice Presseau

Presented to the Graduate Research Committee
of Lehigh University
in Candidacy for the Degree of
Doctor of Philosophy
in
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Approved and recommended for acceptance as a dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Date:

Arpana G. Inman, Ph.D., Chair
Professor and Chair

Accepted Date

Committee Members:

Arpana G. Inman, Ph.D., Chair
Professor and Chair
Department of Education and Human Services

Cirleen DeBlaere, Ph.D., Co-Chair
Assistant Professor
Department of Counseling and Psychological Services
Georgia State University

J. Gary Lutz, Ph.D.
Vice Provost of Institutional Research

Joyce Maguire Pavao, Ed.D.
Pavao Consulting and Coaching

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Abstract

In response to the growing trend for White parents to adopt children from different racial and cultural backgrounds, and heeding the call for more research on adoption-related issues, the present study examined the relationship between racial discrimination and the mental health for transracially adopted adults adopted by White parents. The study found partial support for a moderated mediation model that included racial identity and racial socialization as mediating and moderating variables, respectively, in the discrimination-mental health link. Specifically, the magnitude and significance of some direct paths and the indirect effect between discrimination and well-being through racial identity were found to differ depending on the adopted adults' level of racial socialization in their homes growing up. Limitations and implications for research and practice are discussed.

Chapter I

INTRODUCTION

Although race and ethnicity are terms often used synonymously, the definition of transracial adoption (i.e., the joining of racially different parents and children; Silverman, 1993) requires that some distinction be made between race and ethnicity. Sue (2003) noted that *race* is a specific term that refers to the biological classification system in which individuals are grouped according to physical characteristics of genetic origin (e.g., skin color, head form, color and texture of body hair, lip form, etc.), whereas *ethnicity* refers to the classification of individuals from a common nation or those sharing a common set of cultural traditions. Given that transracial adoptions are marked by observable physical differences between parents and children, they are perhaps the most obvious forms of adoption (Grotevant, Dunbar, Kohler, & Esau, 2000) and have sparked much controversy, primarily with regard to the adoption of racial minority children by White parents (Morrison, 2004; Park & Green, 2000). Concerns have been raised in both professional and public audiences (e.g., social workers, judges, lawyers, social interest groups and organizations) that racial minority children raised by White parents will not be adequately prepared for experiences of racial denigration and discrimination, will fail to identify with their racial community, and/or will not have their psychological needs met by White parents (Morrison, 2004). However, transracial adoptions have become increasingly common as a result of legislative changes (e.g., Interethnic Adoptions Provisions, the Adoption and Safe Families Act; Bartholet, 2006; Brooks & Barth, 1999; Lee, 2003) and the increased prevalence of international adoptions, gay/lesbian parents, and mixed race families (Farr & Patterson, 2009; Zamostny, O'Brien, Baden, & O'Leary Wiley, 2003; Zhang & Lee, 2011).

The body of literature addressing transracial adoption is growing (Friedlander et al., 2000; McRoy, Zurcher, Lauderdale, & Anderson, 1984; Samuels, 2009; Song & Lee, 2009), yet additional empirical research that accounts for the distinctiveness of the transracial adoptive experience is needed to enrich our understanding of the mental health needs of this population (Lee, 2003). Existing studies of transracial adoption are largely qualitative, conducted with small samples of transracially adopted individuals (e.g., Baden & Steward, 2000; Docan-Morgan, 2010; Samuels, 2009; Song & Lee, 2009), or narrowly focused on children or adolescent samples (e.g., Burrow, Tubman, & Finley, 2004; Friedlander, 1999; Mohanty & Newhill, 2011; Smith, Juarez, & Jacobson, 2011; Thomas & Tessler, 2007; Yoon, 2001). Taken together, the findings of these studies point to a number of factors, including experiential (e.g., marginality), familial (e.g., dialogue about racial issues), and community factors (i.e., racial composition), that may impact adult mental health of transracially adopted persons (Baden & Steward, 2000; Docan-Morgan, 2010; Friedlander, 1999; Lee, 2003; Mohanty, 2011; Samuels, 2009). Of particular relevance to the current investigation, transracially adopted persons interviewed in qualitative studies repeatedly share that they experience challenges related to racial discrimination, racial identity, and racial socialization in transracial families and communities (e.g., Docan-Morgan, 2010; Samuels, 2009; Smith et al., 2011). Because these constructs readily emerge in the qualitative literature, they are important to examine empirically and in relation to one another.

The current study drew from theory and research with adopted samples, focusing on the experiences of individuals who were transracially adopted by White parents, to inform an investigation of the relationship between racial discrimination and mental health for transracially adopted persons. Racial identity and racial socialization were examined as

potential intervening variables in the discrimination-mental health link. Where relevant literature is not presently available with transracially adopted samples, empirical and theoretical literature on the experiences of racial minority persons is used to support the study's rationale and purpose.

Racial Discrimination Experiences of Transracially Adopted Persons

Race represents a prominent, visible means of classifying individuals due to phenotypic characteristics (Sellers, Copeland-Linder, Martin, & Lewis, 2006). Thus, transracially adopted persons may be more conscious of their race as a result of physical dissimilarities with their primary caregivers, family members, and individuals within their neighborhoods (McRoy, Zurcher, Lauderdale, & Anderson, 1982). Indeed, transracially adopted individuals report that they often struggle with a sense of “being different” (p. 193) from those around them, acknowledging that they look different from their family and community members (Friedlander et al., 2000). Experts argue that this physical distinctiveness has the potential to lead to marginalization by the White, majority culture (Feigelman, 2000). Compounding this sense of marginalization, transracially adopted persons may also encounter alienation because their experiences of race and privilege are different from their racial minority peers (Feigelman, 2000).

Harrell (2000) explained that race-related stress, a broad term that encompasses racial discrimination, prejudice, and stereotyping (all forms of marginalization), often varies in frequency and intensity due to physical characteristics (e.g., hair texture, skin color, body shape, size of facial features; Harrell, 2000). *Racial discrimination* refers to the use of derogatory racist names or language, discrimination by people in various professions or professional settings because of one's race, discrimination by strangers because of one's race,

being accused or suspected of wrongdoing because of one's race, or discrimination by institutions or systems of care because of one's race (Landrine & Klonoff, 1996). Together, these literatures suggest that individuals who are transracially adopted by White parents may be especially vulnerable to racial discrimination. Transracially adopted persons have described racial discrimination as a consistent aspect of their experiences in their schools and the communities in which they were raised (Samuels, 2009). Although recent rates of racism among transracially samples are not, to this author's knowledge, available, 53 percent of parents of adopted African American/Black children, 32 percent of parents of adopted Asian children, and 11 percent of parents of Latina/o children reported that their children had experienced racial discrimination sometimes or often by early adulthood (Feigelman, 2000). Members of racial and ethnic minority groups (e.g., African American/Black, Latina/o American, Asian American) have also been shown to report high rates of racism through self-report (e.g., 70.0% in the past year for a sample of African American/Black men; Pieterse & Carter, 2007; 98.0% in the past year for an Asian American sample; Alvarez, Juan, & Liang, 2006; 57.0% peer discrimination throughout adolescence with a sample of African American/Black, East Asian, Latina/o, and South Asian American adolescents; Fisher, Wallace, & Fenton, 2000). Thus, evidence suggests that transracially adopted individuals experience high rates of discrimination and that models of racism-mental health developed with racial minority populations are applicable to transracially adopted persons.

Discrimination and Mental Health of Transracially Adopted Persons

In addition to reporting high prevalence of discrimination experiences, racial minority persons also report mental health concerns at higher rates than White individuals (Huynh & Fuligni, 2010; Kessler, Mickelson, & Williams, 1999). It has been suggested, and

accumulating research suggests, that racial discrimination may be a contributing factor to the higher incidence of mental health concerns reported by racial minority persons (e.g., Pascoe & Smart Richman, 2009; Sellers & Shelton, 2003; Williams, Neighbors, & Jackson, 2003). Providing evidence of a relationship between racial discrimination and mental health outcomes for transracially adopted persons, a recent study by Lee (2010) revealed a significant, positive relationship between parental perceptions of discrimination toward their children and families and problem behaviors of internationally adopted Asian and Latin children (i.e., anxiety, depression, disobedience, cheating). Additional quantitative studies are needed to investigate the discrimination-mental health link with adult transracially adopted persons from their own perspective.

Although investigations of the link between racial discrimination and mental health with transracially adopted samples are sparse (e.g., Cederblad, Hook, Irhammer, & Mercke 1999; Lee, 2010), racial discrimination has been shown to consistently associate with mental health concerns (e.g., anxiety, depression, psychological distress; Hwang & Goto, 2009; Moradi & Risco, 2006) and increased risk of mental health and co-occurring mental health disorders (Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Pascoe & Smart Richman, 2009; Sellers & Shelton, 2003) for racial minority samples. Specifically, a significant, positive link has been found between discrimination and psychological distress with samples of African American/Black college students (Pieterse & Carter, 2007), Asian American and Latina/o college students (Hwang & Goto, 2009), Asian American LGBTQ persons (Szymanski & Sung, 2010), and Latina/o American persons (Moradi & Risco, 2006). Moreover, longitudinal studies indicate that the direction of the relation is from racial discrimination to distress (e.g., Brown, 2000).

In addition to the established link between racial discrimination and distress, authors have also noted the importance of investigating well-being variables (e.g., life satisfaction) as a part of a multidimensional framework of mental health (Massé et al., 1998; Pascoe & Smart Richman, 2009; Williams, Yu, & Jackson, 1997). Some studies have identified significant negative associations between racial discrimination and psychological well-being with racial minority samples (e.g., African American, Latina/o; Ayalon & Gum, 2011; Branscombe, Schmitt, and Harvey, 1999; Pieterse & Carter, 2007), while other studies have not found these relationships (e.g., Barnes & Lightsey, 2005; Ryff, Keyes, & Hughes, 2003). For instance, Pascoe and Smart Richman's (2009) meta-analysis of perceived discrimination and mental health studies reported a consistent and negative relationship between discrimination and well-being (e.g., life satisfaction, self-esteem) across studies. Conversely, with their sample of African American/Black students, Barnes and Lightsey (2005) did not find a significant association between perceived discrimination and life satisfaction. More recently, in a study of Asian American college students, Yoon, Hacker, Hewitt, Abrams, and Cleary (2012) reported a significant and negative correlation between perceived discrimination and life satisfaction; however, the relationship became non-significant in a structural equation model that included other relevant variables (e.g., social connectedness, acculturation). These mixed findings highlight the complexity of the discrimination-well-being link with racially diverse samples. They could also suggest that the link between discrimination and well-being acts through other variables (e.g., Moradi & Risco, 2006). Thus, the current study examined the links between racial discrimination and mental health, both distress and well-being, for adults adopted transracially by White parents. The intervening roles of racial identity and racial socialization were also investigated.

Racial Identity

Racial identity refers to a sense of group or collective identity based on one's perception of a common, shared heritage with a particular racial group (Helms, 1993). Yet, the racial identity of transracially adopted persons' is especially complicated. For example, the Harris Racial Identity Model (Harris, 1997) suggests that there are a number of dimensions that determine how transracially adopted persons identify themselves with regard to race: a) genetic (i.e., facts about birth family), b) imposed (i.e., others' perceptions and assumptions), c) cognitive (i.e., personal thoughts and beliefs), d) feeling (i.e., internal feelings), and e) visual (i.e., reliance on what one looks like). Due to the emphasis on racial group belongingness within the transracial adoption literature, despite its noted dimensionality, there is a strong theoretical rationale for use of one's normative tendency to identify with their racial group (e.g., *racial centrality*; Sellers, Rowley, Chavous, Shelton, & Smith, 1997) as a proxy for racial identity of transracially adopted persons. Mounting literature with racial and ethnic minority populations supports the intervening role of racial identity/racial centrality in the link between racism and mental health (i.e., psychological distress and well-being variables). In particular, racial identity has been investigated as a mediating variable in the discrimination-mental health relation. Because there is limited empirical data on the mediating role of racial identity in this relation with transracially adopted persons, literature pertaining to racial minority samples is discussed.

Racial identity has been found to relate to both racial discrimination and mental health with racial and ethnic minority samples (e.g., Anglin & Wade, 2007; Rowley, Sellers, Chavous, & Smith, 1998; Sellers & Shelton, 2003; Thompson, Anderson, & Bakeman, 2000; Whittaker & Neville, 2010). With regard to discrimination, racial identity has been found to

consistently and positively correlate with perceived racism with samples of African American/Black, Asian American, and Latina/o individuals (adolescent and adult samples; e.g., Greene, Way, & Pahl, 2006; Sellers & Shelton, 2003; Utsey, Payne, Jackson, & Jones 2002). For example, with a sample of African American college students, Sellers and Shelton (2003) reported that racial discrimination was positively related to level of identification with one's racial group.

However, unlike the consistent link between racial identity and perceived discrimination, the relationship between racial identity and psychological distress has been mixed. Some studies report no significant relation between racial identity and distress and other studies have found a significant and negative link. Sellers et al. (2006) summarized the findings regarding racial identity and mental health as "inconclusive" (p. 193). For instance, neither Sellers and Shelton (2003) nor Sellers et al. (2006) obtained significant correlations between racial centrality and measures of anxiety, depression, and perceived stress with African American adolescents and college students. However, racial and ethnic group affiliation was negatively related to interpersonal problems with a sample of Asian American college students (Liang & Fassinger, 2008) and negatively related to anxiety and depression with a diverse ethnic minority sample (i.e., Chinese, Indian, Pakistani; Cassidy, O'Connor, Howe, & Warden, 2004). Furthermore, a study with African American/Black young adults, found that racial centrality was negatively related to perceived stress and psychological distress (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003). Therefore, mounting evidence with racially and ethnically diverse adult samples seems to suggest that racial identity may be negatively related to psychological distress.

In comparison to the literature on the racial identity-distress link, the literature that examines the role of racial identity in relation to psychological well-being is relatively consistent. Although some older studies reported no significant correlation between racial or ethnic identity and well-being (e.g., Phinney, 1990; Rowley et al., 1998), an increasing number of studies have found that feeling pride, belongingness, and attachment to one's racial or ethnic group are positively related to well-being (i.e., self-esteem, overall well-being, life satisfaction) for African American/Black, Asian American, and Latina/o samples (Greene, Way, & Pahl, 2006; Iwamoto & Liu, 2010; Liang & Fassinger, 2008; Rivas-Drake, 2011; Yap, Settles, & Pratt-Hyatt, 2011). In one of the only studies to investigate the identity-well-being link with a sample of transracially adopted persons, Basow, Lilley, Bookwala, and McGillicuddy-DeLisi (2008) found that ethnic identity was positively associated with personal growth for adults transracially adopted from Korea. Consequently, available data with transracially adopted and racial minority groups suggests a positive relationship between racial group identification and well-being.

Evidence from more complex models of racial identity and related constructs, such as group identification and collective ethnic self-esteem, offer further support for racial identity's mediating role in the discrimination-mental health link. Data gathered from samples of ethnically diverse women and men (e.g., Chinese, Indian, Pakistani; Cassidy et al., 2004) and Asian American and Asian young adults (Liang & Fassinger, 2008) indicate that aspects of collective ethnic self-esteem (i.e., perceptions of how others view and experience one's racial or ethnic minority group) partially mediate a significant, positive relationship between participants' experiences of racial discrimination and distress (e.g., anxiety,

depression, interpersonal problems). In particular, these studies found that ethnic self-esteem significantly weakened the link of perceived racial discrimination to psychological distress.

Similarly, Branscombe et al. (1999) investigated the mediating role of racial identity in the racism-well-being link with a sample of African American women and men. They found that racial discrimination had a direct and negative effect on well-being, but this relationship was partially explained by group identification. According to Branscombe et al.'s findings, individuals who perceive more discrimination also identify more strongly with their respective racial or ethnic groups which, in turn, enhances her/his personal and collective well-being. The authors concluded that the negative impact of individuals' perceptions of racial discrimination on their well-being could be somewhat reduced when individuals possess a stronger sense of belonging to their racial or ethnic group. An important extension of these mediational models would be the inclusion of *both* well-being and psychological distress to present a more comprehensive assessment of mental health outcomes with a transracially adopted sample.

Racial Socialization

Analogous to racial identity, racial socialization is thought to influence if and how individuals experience their race(s) in society. *Racial socialization* is defined as the promotion of racial awareness and pride, teaching about racism, and providing tools to cope with racism (Lee, 2003). The development of racial identity and racial socialization are regarded as co-occurring processes both within adoption and racial minority literature and are, accordingly, important to examine concomitantly (Alvarez et al., 2006; Anglin & Wade, 2007; Demo & Hughes, 1990; Miller & MacIntosh, 1999; Mohanty & Newhill, 2011; Seaton, Yip, Morgan-Lopez, & Sellers, 2011; Thompson, Anderson, & Bakeman, 2000; Tummala-

Narra, Inman, & Ettigi, 2011; Yoon, 2000). Considering the literature which suggests that both racial identity and racial socialization are key components of racial minority mental health, and heeding the call by researchers to investigate racial identity and racial socialization together and in relation to discrimination experiences (Sellers et al., 2006), both constructs were included as intervening variables in the proposed model. More specifically, the current study compared the proposed mediation model (i.e., the link of discrimination to mental health through racial identity) at both high and low levels of racial socialization (i.e., moderated mediation).

Arguably, racial socialization prepares racial minority persons and transracially adopted persons alike for experiences of discrimination, and therefore, serves to buffer racial minority persons from negative mental health effects (Hughes et al., 2006). Given the potential benefits of racial socialization, its protective function has begun to receive greater attention within the developing literature that addresses racial socialization within the transracial adoption community (Berbery & O'Brien, 2011; Bergquist, Campbell, & Unrau, 2003; Mohanty & Newhill, 2011; Yoon, 2001). Supporting the notion that transracially adoptive parents can help their children learn to successfully cope with experiences of race, a number of empirical studies have identified relations between awareness and sensitivity of adoptive parents to racial, ethnic, and cultural factors and psychological functioning of adopted persons (Berberry & O'Brien, 2011; DeBerry, Scarr, & Weinberg, 1996; Thomas & Tessler, 2007; Mohanty & Newhill, 2011).

DeBerry et al. (1996), for instance, reported a significant, positive relationship between family racial socialization and competency to navigate oppression by African American/Black adopted persons. More recently, Mohanty and Newhill (2011) found that

racial socialization was associated with a decreased sense of marginalization and higher self-esteem among Asian adopted adolescents and young adults. The findings of the study led the authors to conclude that racial socialization positively influences the well-being of transracially adopted persons by making them aware of and preparing them for racial prejudices and discrimination. This body of literature clearly suggests that parents play a key role in shaping their children's experiences of race within their homes and communities. The studies also point to racial socialization's capacity to influence the relationship between transracially adopted persons' experiences of racial discrimination and mental health. At present, however, little is known about racial socialization functions in inoculating adopted persons against experiences of discrimination.

With other groups of racial and ethnic minority individuals, racial socialization has been found to serve as a protective factor in the discrimination-mental health link (Brown, 2008; Fischer & Shaw, 1999; Granberg, Edmond, Simons, Gibbons, & Lei, 2012). For instance, with a sample of African American/Black young adults, Fischer and Shaw (1999) investigated the moderating role of racial socialization in the link between racial discrimination over the past year and mental health functioning. Mental health functioning was assessed with a composite of well-being and psychological distress items. The authors found that at low levels of racial socialization, the relationship between racism and mental health was significant and negative. However, at high levels of socialization, discrimination was unrelated to mental health. Similarly, Brown (2008) found that racial socialization messages predicted greater resiliency levels (i.e., ability to overcome adversity) with African American/Black college students.

Collectively, the available literature suggests that racial socialization is an important variable in the discrimination and mental health experiences of transracially adopted persons and buffers the relationship between racial discrimination and mental health for racial minority persons. In addition, there is strong evidence that racial socialization aids in the development of racial identity (Hughes et al., 2006). Thus, racial socialization appears to be an important moderating variable to investigate in the proposed discrimination-mental health model that includes racial identity as a mediating variable with transracially adopted persons.

The Present Study

The present study examined the discrimination-mental health link with a sample of transracially adopted adults adopted by White parents. Additionally, the study explored racial identity's mediating function in the links of racial discrimination to psychological distress and well-being. The potential moderating role of racial socialization was also investigated in the mediation model. Path analyses were used to test both direct effects between perceived racial discrimination and mental health indicators (i.e., psychological distress and psychological well-being) and indirect effects through racial identity (Figure 1). Path analysis is ideal because it allows for simultaneous examination of the variables of interest and tests of direct and indirect relations among the variables concurrently (Brown, 1997). Further, the moderating role of racial socialization was considered as the magnitude and significance of paths as well as the fit of the proposed model were tested for transracially adopted persons with high and low levels of racial socialization. Based on the literature reviewed, the current study tested the following hypotheses:

1) The researcher hypothesized a positive relationship between racial discrimination and psychological distress and a negative relationship between racial discrimination and psychological well-being (i.e., direct effects).

2) The researcher hypothesized that racial identity would function as a partial mediator in the discrimination and mental health link. In order to demonstrate partial mediation and based on prior research, a positive relationship between racial discrimination and racial identity, a negative relationship between racial identity and psychological distress, and a positive relationship between racial identity and well-being (i.e., indirect effects) were expected.

3) The researcher hypothesized that the associations among exogenous (i.e., racial discrimination, racial identity) and endogenous (i.e., psychological well-being, psychological distress) study variables would vary for transracially adopted persons who reported high and low levels of racial socialization. The researcher anticipated that the associations between racial discrimination and both mental health outcomes (i.e., psychological distress and psychological well-being) would be of a lesser magnitude for adopted persons who reported high levels of socialization compared to those who report low levels of racial socialization. Although previous conceptualizations of racial identity and racial socialization would suggest that there could be variability in racial identity's mediating role in the discrimination-mental health link for individuals who report high and low levels of racial socialization (e.g., Sellers et al., 2006), no prior studies have tested moderation of this mediation. Thus, these analyses were exploratory and no directional hypotheses were provided a priori.

Chapter II

LITERATURE REVIEW

The “transracial adoption paradox”, as it is termed by Lee (2003), consists of a set of contradictory experiences that occur as individuals who are members of racial minority groups in society are raised by parents who are members of the White culture. Many questions surface in response to the paradoxical nature of transracially adopted persons’ lived experience, wherein individuals simultaneously belong to both minority and majority groups. Questions about the transracial adoptive experience emerge most often in regards to anticipated mental health consequences for transracially adopted persons, transracially adopted persons’ racial identity development, and parents’ role in overcoming racial differences to facilitate positive psychological adjustment (Lee, 2003). Additionally, experiences of discrimination within White families and communities are thought to increase vulnerabilities to mental health problems for transracially adopted persons (Feigelman, 2000).

Racial discrimination refers specifically to the use of derogatory racist names or language, discrimination by people in various professions or professional settings because of one’s race, discrimination by strangers because of one’s race, being accused or suspected of wrongdoing because of one’s race, or discrimination by institutions or systems of care because of one’s race (Landrine & Klonoff, 1996). A hallmark of discrimination is the “subjective perception of unfair treatment” (Noh, Beiser, Kaspar, Hou, & Rummens, 1999, p. 194). Therefore, it has been suggested that one’s perceptions of racial discrimination may be related to identification with a racial group (i.e., racial identity) and preparedness for discrimination experiences (i.e., racial socialization; Scott, 2003; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Yoo & Lee, 2005).

The present study examined racial discrimination as it pertains to the mental health outcomes of transracially adopted persons. In addition, it explored the impact of racial identity and racial socialization as intervening variables in the discrimination-mental health links. *Racial identity* refers to a sense of group or collective identity based on one's perception of a common, shared heritage with a particular racial group (Helms, 1993). *Racial socialization* is defined as the promotion of racial awareness and pride, teaching about racism, and providing tools to cope with racism (Lee, 2003). Accordingly, the current review will emphasize racial identity and racial socialization's mediating and moderating roles, respectively, in the relationship between discrimination and mental health. Positioning transracial adoption first in a sociohistorical context, the current literature review presents relevant findings from the literature in the areas of: 1) mental health of transracially adopted persons, 2) discrimination experiences of transracially adopted persons 3) the link between racial discrimination and mental health, 4) racial identity, and 5) racial socialization. Throughout the review, where literature specific to adopted persons is not available, literature focusing on racial and ethnic minority groups and their experiences are presented.

The History of Transracial Adoption

Although increased acceptance has occurred in recent decades, much controversy surrounding transracial adoption remains within social and political sectors. Critics of transracial adoption express concerns over the well-being of individuals who are transracially adopted, who they presume are lacking opportunities to explore their cultural and racial backgrounds and identity when raised by White families (Baden, 2002). Poignantly, critics have argued that transracial adoption perpetuates the disenfranchisement of racial and ethnic minority groups by allowing White individuals with more resources and power as members

of the dominant culture to adopt children that are often relinquished due to lack resources within their own racial and ethnic communities (e.g., poverty, unemployment, limited health care access; Roorda, 2007). Transracial adoption is an issue that is clearly rooted in a complex national racial history.

The history of transracial adoption in the United States consists of a number of key political and philosophical shifts spanning the 20th century. At the start of the Social Work Era (1930-1960), the poor economy led to a rise in the number of applications by adoption-seeking parents and couples. During this time, social workers began to employ matching strategies that sought to place children with adoptive families that were similar to them in terms of heredity, religion, ethnicity, and other physical characteristics (Bartholet, 1991; Esposito & Biafora, 2007). Matching strategies served an additional function of assisting parents with the adoption of children that looked more physically similar to, and would therefore be able to pass as, their children by birth.

In the late 1950s, Child Welfare League of America (CWLA), an organization of public welfare agencies that governs adoption practices, expressed concerns over the placement of children who were racially dissimilar from their adoptive families. At this time, transracial adoption and, in particular the adoption of African American/Black children by White families, had not received strong support (McRoy, 1989). Yet difficulties emerged as children could not be easily categorized into specific groups according to skin tone (e.g., black, white, light, medium, dark), a challenge that continues to this day (Bartholet, 1991). In the 1960s, following the Korean War, an influx of South Korean children who had been displaced or altogether abandoned, became available for adoption (Bartholet, 1991). Relatedly, the civil rights movement brought increased attention to racial minority children

who had remained in foster care systems for exceptionally long periods of time without same-race families available to adopt them (Bartholet, 1991). Although they had distinctive racial and ethnic features and darker skin than many available families, adoptive parents and adoption agencies alike increasingly grew accustomed to the idea of adopting non-White children in need, both domestically and internationally (Bartholet, 1991). Whether in response to the growing number of African American/Black children in the institutional and foster care systems, shortages of White infants in the United States, or increases in transcultural adoptions, support for adoptions that crossed racial, ethnic, and cultural lines grew throughout the late 1960s (McRoy, 1989). The shortage of infants is typically regarded as the primary impetus for increased transracial adoptions during this time, which also coincided with the legalization of abortion, more frequent use of contraception, and lessened shame around children conceived out of wedlock (Esposito & Biafora, 2007). The CWLA issued a new statement in support of transracial adoption, and subsequently, the National Association for the Advancement of Colored People (NAACP) and the National Urban League encouraged transracial adoptions for members of society as a viable means of creating families (McRoy, 1989). In the early 1970s, the number of transracial adoptions rose dramatically, as the number of adoptions of African American/Black children by White families increased from 23.0% in 1968 to 35.0% in 1971 (McRoy, 1989). In response to the increase in the prevalence of transracial adoptions, opposition re-emerged.

Specifically, addressing increases in transracial adoption of African American/Black children by White families, the National Association of Black Social Workers (NABSW) issued a statement declaring that African American/Black children belonged with African American/Black families and that placements with White families were detrimental to the

development of African American/Black children. In 1973, the CWLA reversed adoption policy in new standards that indicated preference for same-race placements; a reduction in the number of transracial adoptions between 1970 and 1975 followed (McRoy, 1989).

For the remainder of the 1970s and into the 1980s, interest in transracial adoption outcomes continued. Researchers, policy makers, and advocacy groups brought complexities associated with transracial adoption to the forefront of debate (McRoy, 1989). The primary standpoint on transracial adoption for a large portion of the 1980s was that same-race placements were preferred, but multi-ethnic placements were acceptable as a last resort and in order to avoid lengthy delays in finding homes for children (McRoy, 1989). Approaching the late 1980s and into the 1990s, White families began to contest what they deemed discriminatory practices on the part of adoption agencies when they were prohibited from adopting children on the basis of their race (McRoy, 1989). Debate also swirled around the impact of refusing to place children of color with White families, which were available and willing to offer placements to children that would otherwise remain in foster or institutional settings (Esposito & Biafora, 2007). A number of issues were also raised with regard to differential parental fitness criteria, as African American/Black adoptive families were moved to the tops of lists simply on the basis of race, despite often having less financial means, being significantly older, and being more likely to be single than prospective White adoptive parents (Bartholet, 1991).

The U.S. Congress' passing of the Multiethnic Placement Act of 1994 and its later amendments in 1996 demarcate a clear turning point in adoption legislation (Bartholet, 2006). The act explicitly stated that race should not be a factor of consideration when evaluating a potential adoptive or foster care placement, as children of color should not be forced to wait

longer for adoptive or foster care placements simply because a suitable racially similar family was not available (Bartholet, 2006; Roorda, 2007). The reform operated under the premise that agencies would be more proactive and eager in their efforts to recruit diverse families and parents with which to place children (Roorda, 2007). In 2000, a federal law called the Child Citizenship Act was passed that allows children who are adopted internationally to be given U.S. citizenship immediately following adoption, thereby removing the former stipulation that parents apply for citizenship for their internationally adopted children and further reducing the financial and bureaucratic burdens placed on adoptive parents who adopt internationally (Bartholet, 2007).

At the turn of the century, transracial adoptions became an increasingly common way of creating families, now comprising a large proportion of United States adoption every year, both domestic and international. According to the 2007 National Survey of Adoptive Parents, 40 percent of adopted children have parents who report that they or their spouse or partner are of a different race, ethnicity, or culture than their child (Vandivere, Malm, & Radel, 2009). Data from the Census 2000 indicated that approximately 2.5 percent of all children under the age of 18 in American households are adopted and that one in six of these children is adopted by a parent of a different race (Kreider, 2003). Additionally, an astounding 73 percent of adopted parents identify as White even though adopted children are less likely to be White or Hispanic than children in the general population, and are more likely to be African American/Black (Vandivere et al., 2009).

A large majority of international adoptions (i.e., 84.0%) are transracial in nature, compared to 28 percent and 21 percent, respectively, of foster care and private domestic adoptions (Vandivere et al., 2009). China (33.0%), Guatemala (11.0%), and South Korea

(11.0%) are among the most commonly cited countries of origin for internationally adopted children (Vandivere et al., 2009). Taken together, these statistics are evidence of a growing trend for White parents in the United States to adopt children from diverse racial groups that differ from their own. Given the high prevalence of transracial adoptions in the United States and its global scope, more research that addresses mental health correlates of transracially adopted persons is needed.

Mental Health of Transracially Adopted Persons

Leading scholars in the field of counseling psychology have provided commentary on the relative “silence” (Zamostny, Wiley, O’Brien, Lee, & Baden, 2003, p. 647) around adoption issues within the mental health community, calling for research that is applicable to the practice of adoption-related counseling (Henderson, 2002; O’Brien & Zamostny, 2003). In particular, transracial adoption represents a relatively understudied and underdeveloped area in the counseling psychology adoption literature. The research that is available with transracially adopted samples is derived from developmental psychology, child psychology, marriage and family therapy, and social interest journals (e.g., Baden & Steward, 2000; Burrow, Tubman, & Finley, 2004; Cederblad, Hook, Irhammer, & Mercke, 1999; Docan-Morgan, 2010; Friedlander, 1999; Hughes et al., 2006). The current literature available in these sources primarily utilize qualitative methodological approaches (e.g., Bausch & Serpe, 1997; Samuels, 2009), longitudinal studies (e.g., Brooks & Barth, 1999; Feigelman, 2000; Vroegh, 1997), and comparisons with same-race adopted samples (e.g., Feigelman & Silverman, 1984) to examine various aspects of the transracial adoptive experience. Existing qualitative studies highlight a number of prominent themes in the experiences of transracially adopted persons, including discrimination, feeling a sense of differentness from those around

them with regard to their physical appearance, and being socialized within White families and communities (Huh & Reid, 2000; Samuels, 2009). Furthermore, longitudinal studies and studies that compare groups of adopted persons are useful in demonstrating how the emergent themes from the qualitative literature are related to mental health outcomes over adopted persons' lifetimes.

Longitudinal studies as well as studies that compare transracially adopted individuals across various racial minority groups or with same-race adopted individuals offer mixed findings on mental health of transracially adopted persons (e.g., adjustment, depression, self-worth; Burrow et al., 2004; Feigelman & Silverman, 1984, Hollingsworth, 1997; Juffer & IJzendoorn, 2007). For example, in an early meta-analysis of six studies with transracial, same-race, and non-adopted samples, Hollingsworth (1997) found a negative effect of transracial/transethnic adoption on a composite racial and ethnic identity and self-esteem variable for U.S. racial and ethnic minority children. Likewise, Burrow et al. (2004) found higher levels of self-worth for African American/Black children adopted by either African American/Black parents or White parents as compared to White and Asian children adopted by White parents (Burrow et al., 2004). However, in two hallmark studies of racial identity with transracially adopted samples, McRoy, Zurcher, Lauderdale, and Anderson (1982, 1984) reported finding few, if any, differences in self-esteem for African American/Black transracial and same-race adopted persons. The lack of significant differences between transracial and same-race adopted persons was confirmed in a more recent meta-analysis on mental health of adopted individuals (Juffer & IJzendoorn, 2007). Juffer and IJzendoorn's (2007) comprehensive meta-analytic review of 88 studies, found that there were no differences in self-esteem for individuals who were adopted compared to those who were not.

Juffer and IJzendoorn further concluded that the lack of differences between adopted and non-adopted individuals with regard to self-esteem was consistent for transracially, internationally, and domestically adopted persons. Assessing mental health using reports of parents who adopted African American/Black, Colombian, and Korean children, Feigelman and Silverman (1984) found that African American/Black adopted children were comparable to White, same-race adopted children six years after placement. However, parents who had adopted from Korea reported a slightly greater frequency of children's discomfort with their appearance than parents of other racial groups.

Thus, the available literature on mental health of transracially adopted persons suggests that there are some nuances in the racial dynamics between parent and child that may help to explain variations in mental health. In addition, they suggest that there are factors apart from racial difference between parent and child—and perhaps related to discrimination or socialization—that influence adopted persons' mental health and evaluations of self. Indeed, in a follow-up to their previous study, Feigelman found that discrimination experiences and discomfort with appearance were significant predictors of adjustment challenges (Feigelman, 2000). These findings suggest that individuals adopted transracially may have an increased susceptibility to racial discrimination experiences that are related to mental health concerns. Further empirical research on the topic of racial discrimination and mental health functioning within the transracial adoptive community will help to elucidate these relations.

Racial Discrimination Experiences of Transracially Adopted Persons

Informing the study of racial discrimination with a transracially adopted sample, Harrell's (2000) framework contends that physical features (e.g., skin color, hair texture, size

of facial features) influence the type and frequency of racial discrimination experiences of differing racial groups. Skin color represents one marker of racial discrimination within the African American/Black community, as darker skin is associated with more frequent reported discrimination (Klonoff & Landrine, 2000). Darker skin and other phenotypic characteristics (e.g., lip thickness, nose width) have also been shown to elicit more negative reactions from White individuals (Hagiwara, Kashy, & Cesario, 2012). These findings highlight transracially adopted individuals' specificity as a racial minority group within White families and communities, perhaps making them even more vulnerable to incidents of discrimination (Feigelman, 2000).

Race is especially salient for transracially adopted persons who live in predominantly White communities, as they may lack access to individuals that look like themselves within and outside of their families (Feigelman, 2000; Samuels, 2009). Parents of transracially adopted children have also reported that their children experienced significantly more discomfort with appearance and more adjustment difficulties when they were raised in predominantly White neighborhoods (Feigelman, 2000). Transracially adopted persons have reportedly been more inclined to express ease about their racial differences when they live in more racially diverse communities (Feigelman, 2000). In a study with an adult multiracial sample who had been transracially adopted, Samuels (2009) found that a small number of transracial adoptive parents (i.e., 3 out of 25) selected to move to more diverse neighborhoods following the adoption of their children. The majority of adopted individuals, however, reported that they grew up in predominantly White communities and had awareness of stigma associated with being a racial minority person with White parents. Participants identified opportunities to racially integrate as important to them, but often lacking in their

own experiences. Overall, adopted persons reported that they often felt “racially alone” (Samuels, 2009, p. 87) in their adoptive families and communities, even if they had lighter skin tones and were typically assumed to be White.

Parents of transracially adopted young adults have reported that their children were often discriminated against due to their race (Feigelman, 2000). Although recent rates of racism among transracially samples are not, to this author’s knowledge, available, 53 percent of parents of adopted African American/Black children, 32 percent of parents of adopted Asian children, and 11 percent of parents of Latina/o children reported that their children had experienced racial discrimination sometimes or often by early adulthood (Feigelman, 2000). Yet, rates reported by adoptive parents are not as high as rates of discrimination reported among racial minority adults or by transracially adopted individuals. A study of adolescent and young adult internationally adopted persons in Canada indicated rates of lifetime racial discrimination of 85 percent and 82 percent among males and females, correspondingly (Westhues & Cohen, 1998). Additionally, rates of discrimination have been shown to be especially high in U.S. racial minority groups (e.g., 98.0% in the past year for an Asian American sample; Alvarez, Juan, & Liang, 2006; 70.0% in the past year for a sample of African American/Black men; Pieterse & Carter, 2007; 57.0% peer discrimination throughout adolescence with a sample of African American/Black, East Asian, Latina/o, and South Asian American adolescents; Fisher, Wallace, & Fenton, 2000). In a study of African American/Black college students by Sellers and Shelton (2003), 54.7 percent of participants reported that they had been insulted, called a name, or harassed and 87.6 percent reported that they had been treated rudely or disrespectfully in the past year due to their race. These statistics could suggest that parents who adopt transracially are not fully aware of the

discrimination experiences faced by their children or how commonly they occur over the course of their lifetimes; such reports could represent underestimations of actual experiences. Additional quantitative studies are needed to further explore the racial discrimination-mental health link with adult transracially adopted persons from their own perspective.

Discrimination and Mental Health of Transracially Adopted Persons

In addition to reporting high prevalence of discrimination experiences, racial minority persons also report mental health concerns at higher rates than White individuals (Huynh & Fuligni, 2010; Kessler, Mickelson, & William, 1999). It has been suggested, and accumulating research supports, that racial discrimination may be a contributing factor to the higher incidence of mental health concerns reported by racial and ethnic minority persons (e.g., Pascoe & Smart Richman, 2009; Sellers & Shelton, 2003; Williams, Neighbors, & Jackson, 2003). Indeed, racial discrimination has been linked with poorer mental health (e.g., Barnes & Lightsey, 2005; Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Kessler et al., 1999; Kwate, Validimarsdottir, Guevarra, & Bovbjerg, 2003; Pascoe & Smart Richman, 2009; Pieterse & Carter, 2007; Syzmanski & Sung, 2010; Williams, Neighbors, & Jackson, 2003) and identified as a precursor to the manifestation of health problems for racial minority individuals (Gee & Walsemann, 2009; Pascoe & Smart Richman, 2009). Although investigations of the relationship between racial discrimination and mental health with transracially adopted persons are sparse (e.g., Cederblad et al., 1999; Lee, 2010), the multitude of studies that have examined the discrimination and mental health relation with racial minority groups (e.g., African American/Black, Asian American, Latina/o; Alvarez et al., 2006; Cassidy, O'Connor, Howe, & Warden, 2004; Moradi & Risco, 2006) offer strong support for the examination of this relation with a transracially adopted sample as well.

Link between discrimination and psychological distress. Although limited, research on the link between discrimination and psychological distress with transracially adopted persons does suggest that racial discrimination experiences negatively impact mental health. In a recent study of racial discrimination and mental health outcomes among transracially adopted persons, a significant and positive relationship was found between parental perceptions of discrimination toward their children and families and internalizing (e.g., anxious, depressed) and externalizing (e.g., disobedient, cheats) problem behaviors of individuals adopted from Latin and Asian countries (Lee, 2010). Offering empirical support specifically for the potential of physical dissimilarity from others to increase mental health vulnerabilities of transracially adopted persons, Cederblad et al. (1999) found significant positive correlations between discrimination (i.e., being teased for foreign looks) and mental health problems (e.g., anxiety, depression, somatic complaints) for a sample of adolescent and young adult individuals adopted internationally. Considered together, these studies provide preliminary support for the current study's examination of the discrimination-mental health link with a transracially adopted sample.

Studies with racial minority individuals provide further support for the proposed model, as they have consistently found a positive and significant relationship between racism and psychological distress (Brown et al., 2000; Bynum, Burton, & Best, 2007; Hwang & Goto, 2009; Kwate et al., 2003; Moradi & Risco, 2006; Neblett, White, Ford, Philip, and Sellers, 2008; Pieterse & Carter, 2007; Syzmanski & Sung, 2010). With samples of African American/Black adolescents and adults, discrimination has been shown to relate positively to perceived stress (Brown et al., 2000; Neblett et al., 2008; Kwate et al., 2003). Specifically, a study of African American/Black women found that experiences of racism, both over the

lifetime and within the past year, were significantly and positively correlated with psychological distress (Kwate et al., 2003). Similar findings (i.e., positive correlations between racial discrimination and psychological distress) have also been reported with Latina/o and Asian American women and men (Hwang & Goto, 2009; Moradi & Risco, 2006). For instance, with a combined sample of Latina/o and Asian American young adults, Hwang and Goto (2009) found that lifetime perceived discrimination (i.e., assessed using the General Ethnic Discrimination [GED, Landrine & Klonoff, 2006]) was significantly associated with a number of indicators of psychological distress (e.g., general distress, anxiety, suicidal ideation, and depression).

Suggesting that racial discrimination precedes experiences of psychological distress for racial minority persons, Brown et al. (2000) examined three waves of data with an African American/Black sample. Perceived racial discrimination was assessed using a single question that asked participants if either they or their families had experienced racial discrimination within the past month. Individuals who reported having experienced racial discrimination within the past month during the first wave of data collection had a statistically significant and increased likelihood of psychological distress in the second wave of data collection nearly a decade later. Brown et al.'s findings, in addition to the literature reviewed with transracially adopted and racial minority samples, offer clear support for a positive, predictive relationship between discrimination and psychological distress in the proposed model.

Link between discrimination and well-being. In addition to the established link between racial discrimination and psychological distress, authors have also noted the importance of investigating psychological well-being variables (e.g., life satisfaction) as a

part of a multidimensional framework of mental health (Massé et al., 1998; Pascoe & Smart Richman, 2009; Williams, Yu, & Jackson, 1997). Harrell (2000) posited that racial discrimination has the potential to influence a host of outcomes comprising domains of overall well-being for racial minority persons (e.g., physical, psychological, social, functional, spiritual). Compared to findings on the discrimination-distress link, however, results emerging from studies on the relationship between discrimination and well-being are more inconsistent.

Several studies with racial and ethnic minority youth have found that discrimination negatively impacts psychological well-being for samples of racial minority individuals (e.g., African American/Black, Latina/o American, Asian American; Barnes & Lightsey, 2005; Huynh & Fuligni, 2010; Neblett et al., 2008; Ryff, Keyes, & Hughes, 2003). Huynh and Fuligni (2010), for example, found that discrimination experiences, ranging from unfair treatment to name-calling, were predictive of lower self-esteem for Latina/o American and Asian adolescents. In contrast, Barnes and Lightsey (2005) did not find a direct relationship between perceived discrimination and life satisfaction for a sample of African American/Black young adults.

The mixed findings regarding discrimination and well-being feasibly emerge, at least in part, due to differing conceptualizations of well-being across studies. Yet even studies that have similarly operationalized well-being have yielded mixed findings. For instance, Neblett et al.'s (2008) study of African American/Black adolescents, which used a measure that contained a number of well-being dimensions (i.e., self-acceptance, positive relations with others, autonomy, mastery, life purpose, and personal growth; Psychological Well-Being Scale [Ryff, 1989]), found that discrimination was related to lower overall psychological well-

being. However, considering each dimension of well-being separately, Ryff et al. (2003) found a number of discrepancies between African American/Black and Mexican American women and men. For example, high levels of discrimination were associated with decreases in personal growth for women, but not for men. Similarly, men's level of autonomy remained consistent across levels of discrimination, whereas women reported less autonomy as discrimination increased.

Perhaps, a more compelling explanation for the mixed results is offered by the acknowledgment that the relation between discrimination and well-being often does, and should, include other factors (e.g., demographic characteristics, facets of identity, coping) that are presumed to influence racial minority individuals' assessments of themselves (i.e., self-esteem) and the conditions of their lives (i.e., life satisfaction). A recent study of Asian American young adults, Yoon, Hacker, Hewitt, Abrams, and Cleary (2012) illustrates how the addition of other variables related to one's racial minority status can impact the discrimination-well-being link. Yoon et al. found a significant negative correlation between perceived discrimination and life satisfaction when these variables were examined independently. However, the relationship became non-significant in a structural equation model that included other relevant variables (e.g., social connectedness, acculturation). These results suggest that more complex models, including relevant intervening variables, of the discrimination-well-being link can further clarify the mechanisms through which discrimination is related to well-being. The current study investigated the links between racial discrimination and mental health (i.e., distress and well-being), inclusive of the potential intervening roles of racial identity and racial socialization in these links, with a sample of adults who were transracially adopted by White parents.

Racial Identity

Racial identity refers to a sense of group or collective identity based on one's perception of a common, shared heritage with a particular racial group (Helms, 1993). Identifying oneself with regard to race may be especially challenging for racially adopted persons. The Harris Racial Identity Model (Harris, 1997) suggests that there are a number of dimensions that determine how racially adopted persons identify themselves with regard to race: a) genetic (i.e., factual basis), b) imposed (i.e., others' perceptions and assumptions), c) cognitive (i.e., a person's own thoughts and beliefs), d) feeling (i.e., internal feelings, regardless of others' views), and e) visual (i.e., reliance on what one looks like). Harris' model attends to the complexity involved as racially adopted persons come to learn of and identify themselves as racial beings. Moreover, the Harris model accounts for experiences with other individuals in interracial environments that could lead to racial identity conflict (Bartholet, 2006; Bausch & Serpe, 1997; Kim, Suyemoto, & Turner, 2010; Lee, 2003). Indeed, identification with one's racial birth group has been shown to be especially complex for racially adopted persons. In one study of African American/Black individuals who were racially adopted, McCroy, et al. (1984) asked adopted persons to identify themselves in accordance with a particular racial group. A majority of the participants (53.0%) identified themselves as being mixed, part White, or Black/White. As such, racially adopted persons appear to exhibit variability in terms of how they align themselves with their racial minority group. Similar variation in terms of belongingness to a racial minority group was also reported by a sample of individuals adopted racially from Korean in a qualitative study (Kim et al., 2010). The sample was asked to share their experiences of belongingness and exclusion with both White and Asian

American racial groups. Fourteen participants were interviewed in the study and reported a range of affiliations with the Asian American group and their identity as a racial minority person. A majority of participants identified themselves as belonging to their families, yet they experienced racism that led them to feel excluded from the White racial group. Given that the definition of race supposes that there is a genetic basis for classification in a particular racial group (Sue, 2003), adopted persons' identification with their White parents and families likely coincides with experiences of discrimination in society, as found for Kim et al.'s Korean transracial adoptive sample. The present model examined how differing levels of association with a racial minority group help to explain the associations between discrimination and mental health for transracially adopted persons.

Although racial identity has not been studied in relation to the discrimination-mental health link quantitatively with a transracially adopted sample, some literature has explored racial identity as an outcome of transracial adoption, or as a correlate of mental health for transracially adopted individuals (e.g., Brooks & Barth, 1999; Hollingsworth, 1997). In a longitudinal study with transracial and same-race Asian and African American/Black adult adopted persons, transracially adopted persons from Asia reported hardly ever or never feeling pride in their racial birth group at relatively high rates (i.e., 65.5% female, 63.5% male; Brook & Barths, 1999). However, Brook and Barths's (1999) study also provided evidence of positive racial identity attitudes among transracially adopted persons. The majority of African American/Black individuals who were transracially adopted (i.e., 66.7% of females, 57.9% of males) reported that they sometimes or all the time felt a sense of pride toward their racial birth group. Additionally, a majority of transracially adopted individuals (i.e., over 65% of Asian and African American/Black individuals) never felt

shame/embarrassment over their racial birth group. Likewise, in a sample of adolescent and young adult adopted persons who had been adopted internationally, individuals reported varying levels of comfort with their race (Westhues & Cohen, 1998). A majority of individuals reported being very comfortable (33.3%) or comfortable (40.5%) with their race, yet noteworthy proportions reported being neither comfortable nor uncomfortable (16.2%), uncomfortable (7.2%), or very uncomfortable (2.7%) with their race. Within the same sample, 17.3 percent of participants indicated that they do not identify themselves racially. These mixed results regarding transracially adopted persons' thoughts, feelings, and attitudes about their racial group underscore the complexity associated with racial identification for this population. They also suggest that, at least to some extent, transracially adopted individuals' attitudes about their birth race may be influenced by their experiences within the dominant White culture (e.g., discrimination, socialization) and their degree of affiliation with that group (i.e., racial centrality).

In contrast to specific thoughts and feelings or attitudes about one's racial group, *racial centrality* refers to a specific component of racial identity that addresses one's tendency to define the self in terms of race (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) and is an indicator of identification with a racial group (Ashmore, Deaux, & McLaughlin-Volpe, 2004). Because thoughts and feelings about one's racial group (i.e., *private regard*; Sellers et al., 1997) may vary from context to context or by circumstance (Major, Quinton, & Schmader, 2003; Spears, Doosje, & Ellemers, 1997), they may not represent the best way of assessing racial identity. Their continued use in some studies as indicators of racial identity may help explain, at least in part, the inconclusive results regarding racial identity's functionality as a construct with racial and ethnic minority

individuals (Sellers et al., 2006). For example, conditions of group threat (i.e., challenges to their group's status or distinctiveness as a group) have been shown to elicit self-stereotyping responses (i.e., perceive oneself as a stereotypical group member) for members of minority groups (e.g., women; Spears et al., 1997). As such, individuals who more strongly identify with the group under threat may have an increased likelihood of self-stereotyping. In accordance with these findings, transracially adopted persons' affiliation with their racial minority group may determine the extent to which they apply negative societal stereotypes to themselves, particularly when racial discrimination occurs. Transracially adopted persons, similar to multiracial individuals, may also exhibit greater malleability with regard to their racial identities (i.e., identify with different racial identities in different social contexts; Sanchez, Shih, & Garcia, 2009). More malleable identities have been shown to associate positively with psychological distress and negatively with well-being (Sanchez et al., 2009).

Sellers et al. (1997) claimed that racial centrality is the stable, enduring component of racial identity and is accordingly less amendable to situational factors. Adoption literature references racial centrality, without racial resemblance to family members, as a key component of the experience of transracially adopted persons and their constructions of identity (Samuels, 2009). Consequently, given its encapsulation of both collective and personal aspects of racial identification and its purported stability, centrality was used to operationalize racial identity in the current study.

Potential mediating role of racial identity. Limited research is available pertaining to how racial identity may account for the anticipated relationship between discrimination and mental health for transracially adopted persons. However, there is strong evidence of racial identity's role as an intervening variable in the discrimination-mental health link with

racial and ethnic minority groups. Baron and Kenny (1986) argue that in order to establish a mediation effect, the following criteria must be met: a) the independent variable must be correlated with the dependent variable, b) the independent variable must be associated with the mediating variable, and the c) the mediating variable must be associated with the outcome variable. Given that the relationship between discrimination and mental health is supported by available literature and theory discussed previously, evidence of racial identity as a mediator in these links can be drawn from the literature with racial minority groups. The available literature with racial minority individuals demonstrates direct links between discrimination and racial identity and racial identity and mental health (e.g., Yap, Settles, Pratt-Hyatt, 2011). Additional support for racial identity's mediating function is provided by studies that examine racial identity as an intervening variable (e.g., Branscombe et al., 1999; Tummala-Nala et al., 2011). Linkages between racial identity and distress and well-being are presented separately.

Direct links of racial identity to discrimination and mental health. With regard to discrimination, racial identity has been found to consistently and positively correlate with perceived racial discrimination with samples of African American/Black, Asian American, and Latina/o individuals (adolescent and adult samples; Greene, Way, & Pahl, 2006; Sellers & Shelton, 2003; Stevenson & Arrington, 2009; Utsey, Payne, Jackson, & Jones, 2002; Yap et al., 2011). For example, utilizing the same measure that was used to operationalize racial identity (i.e., racial centrality) in the current investigation, Sellers and Shelton (2003) examined level of identification with one's racial group and racism with a sample of 267 African American/Black college students at two different time periods (i.e., beginning and end of the semester). The bivariate correlation results indicated that racial discrimination

was positively related to racial centrality at time 1 and maintained a positive significant correlation several months later.

In contrast to the consistency of findings across studies pertaining to discrimination and racial identity, studies that have examined the relationship between racial identity and psychological distress have yielded mixed and “inconclusive” results (p. 193, Sellers et al., 2006). Neither Seller and Shelton (2003) nor Sellers et al. (2006) found a significant relationship between racial centrality and psychological distress (i.e., a composite variable comprised of depression, anxiety, and perceived stress) with their respective samples of African American/Black college students and adolescents. Despite the fact that a significant correlation between centrality and distress was not obtained, participants in Sellers et al.’s study tended to report that their race was a central component of their identity. Interestingly, the study found that the private regard component of racial identity was negatively correlated with depression and perceived stress. Similar to this latter finding, with another sample of African American/Black young adults, Sellers, Caldwell, Schmeelk-Cone, and Zimmerman’s (2003) found a significant and negative correlation between racial centrality and psychological distress. Additionally, racial and ethnic group affiliation was negatively related to interpersonal problems with a sample of Asian American college students (Liang & Fassinger, 2008) and negatively related to anxiety and depression with a diverse ethnic minority sample (i.e., Chinese, Indian, Pakistani; Cassidy, O’Connor, Howe, & Warden, 2004). Therefore, mounting evidence with more racially and ethnically diverse samples seems to suggest that racial identity may be negatively related to psychological distress.

In comparison to the literature on the racial identity-distress link, the literature that examines the role of racial identity in relation to psychological well-being is relatively

consistent, tending to find a positive identity-well-being relation. Although some older studies reported no significant correlation between racial or ethnic identity and well-being (e.g., Phinney, 1990; Rowley, Sellers, Chavous, & Smith, 1998), an increasing number of studies have found that feeling pride, belongingness, and attachment to one's racial or ethnic group are positively related to well-being (i.e., self-esteem, overall well-being, life satisfaction) for African American/Black, Asian American, and Latina/o samples (Greene et al., 2006; Iwamoto & Liu, 2010; Liang & Fassinger, 2008; Rivas-Drake, 2011; Seaton et al., 2011; Yap et al., 2011). Advanced developmental stages of identity (e.g., exploration of and commitment to one's racial or ethnic group) have been associated with improved psychological well-being for Asian American and Asian individuals (Iwamoto & Liu, 2010), African American/Black adolescents (i.e., self-worth; Seaton, Yip, Morgan-Lopez, & Sellers, 2012), and African American/Black, Asian American, and Latina/o adolescents (i.e., self-esteem; Greene et al., 2006).

Perhaps most relevant to the current study because they examined identical constructs, Yap et al. (2011) found a positive, significant relationship between racial centrality and life satisfaction for a community sample of African American/Black women and men. While no studies, to this author's knowledge, have examined racial identity, as operationalized in this study (i.e., racial centrality), with transracially adopted individuals, it was expected that a similarly positive, significant relationship between racial identity and well-being would emerge for the current transracially adopted sample. In apparent support of this assertion, Basow, Lilley, Bookwala, and McGillicuddy-DeLisi (2008) found that higher ethnic identity scores were associated positively with personal growth components for their sample of Korean transracially adopted young adults. However, ethnic identity was unrelated to self-

acceptance and positive relationship components of well-being. These findings could suggest that for transracially adopted persons in particular, identity variables are complex and are more appropriately examined as intervening variables.

Indirect links through racial identity. Racial identity, and other related constructs that capture belongingness to one's racial minority group (e.g., ethnic identity, collective self-esteem) are often theorized to either moderate (e.g., Cassidy et al., 2004; Deng, Kim, Vaughan, & Li, 2010; Seaton et al., 2011; Yoo & Lee, 2003; Telzer & Garcia, 2009) or mediate (e.g., Branscombe et al., 1999; Tummala-Narra et al., 2011) the relationship between discrimination and mental health outcomes (e.g., well-being, self-esteem, psychological distress). Although some prior literature has examined the moderating effect of racial and ethnic identification in the relationship between racial discrimination and psychological distress for racial minority samples (e.g., Cassidy et al., 2004; Liang & Fassinger, 2008; Seaton et al., 2011; Yoo & Lee, 2005), there is increasing evidence that racial identity variables do not function as effective moderators in this link. For example, Yoo and Lee (2005) found that ethnic identity did not consistently buffer a sample of Asian American college students from the negative mental health effects of racial discrimination. Contrary to expectations, ethnic identity only protected Asian American college students from negative mental health outcomes when levels of discrimination were low, not high.

Further refuting the moderation hypothesis, Cassidy et al. (2004) found no support for the moderating effect of ethnic self-esteem (i.e., individuals evaluations of the racial or minority group with which they identify) on the discrimination- distress relationship with their sample of young, ethnically diverse women and men (e.g., Chinese, Indian, Pakistani). Rather, results of a hierarchical multiple linear regression provided partial support for ethnic

self-esteem as a mediator in the relationship between two discrimination-mental health links (i.e., anxiety and depression) for male participants. Addressing the mediator/moderator debate on how racial identity functions in the relationship between discrimination and distress, Liang and Fassinger (2008) examined the specific role of collective self-esteem for a sample of Asian American and Asian young adults. The authors found that a specific component of collective self-esteem, public collective ethnic self-esteem (i.e., perceptions of how others view and experience one's racial or ethnic minority group), mediated and reduced, rather than moderated, the positive relationship between participants experiences of racial discrimination and distress (i.e., self-esteem and interpersonal problems). In particular, these studies found that ethnic self-esteem significantly weakened the link of perceived racial discrimination to psychological distress.

With regard to racial identity's mediating role in the discrimination-well-being link, and consistent with Liang and Fassinger's (2008) findings, Branscombe et al.'s (1999) mediation model proposed that group identification partially explained the relationship between perceptions of pervasive discrimination and psychological well-being for a sample of African American/Black individuals. The results of the study indicated that the negative relationship between racial discrimination and well-being was significantly reduced when individuals identified more strongly with their racial minority group (Branscombe et al., 1999). The authors found that racial centrality and private regard aspects of racial identity mediated the relationship between individuals' perceptions of racial discrimination and life satisfaction. The relationship between attributions of discrimination and life satisfaction remained negative, but was lessened through the inclusion of belongingness to racial groups. The current study expanded upon existing mediation models of discrimination and mental

health by examining the moderating role of racial socialization in these links with a sample of transracially adopted persons.

Racial Socialization

Racial socialization is regarded as the primary means through which racial minority children and adolescents are prepared for bias and incidents of discrimination in society (Hughes et al., 2006). *Racial socialization* is defined as the promotion of racial awareness and pride, teaching about racism, and providing tools to cope with racism (Lee, 2003). Through racial socialization, racial minority individuals receive information and messages about race and race-related experiences they may encounter as racial minority persons (e.g., discrimination, prejudice; Lesane-Brown, 2006). If and how parents deliver messages to their children about race has been shown to vary by parental perceptions of children's exploration of their racial identity and according to personal experiences of racial discrimination (Thornton, Chatters, Taylor, & Allen, 1990; Johnson, Swim, Saltsman, Deater-Deckard, & Petrill, 2007). Thus, it appears that parents often take their children's lead in determining if and when to approach topics of race in their households. Also, parents may be limited by their own awareness and exposure to racial discrimination. These tendencies are demonstrative of the need to more closely examine racial socialization in the context of transracial adoption, where children may be less inclined to approach topics of race in their families (Docan-Morgan, 2011). As previously stated, given the inherent differences in experiences of racial discrimination in society among White and non-White racial groups, White parents may not be aware of the frequency of racial discrimination experienced by their racial minority children. Consequently, they may be less inclined to prepare their transracially adopted children and adolescents for racism experiences.

In what are termed *racially aware adoptive familial contexts* (i.e., family's racial attitudes and extent of exposure to same-race persons), adoptees reportedly develop more positive racial identities and have higher self-esteem (Kallgren & Caudill, 1993). As such, adoptive homes that provide racially aware contexts are considered to be most ideal for transracially adopted persons. Within these contexts, children are likely exposed to greater diversity and become more familiar and involved with their cultures of origin (Kallgren & Caudill, 1993).

Distinguishing between more general cultural socialization and racial socialization (i.e., preparation for bias) in a sample of White mothers who adopted from China and Korea, Johnson et al. (2007) found that birth country, child's age, and connectedness to Asian Americans functioned as effective predictors of patterns of cultural socialization behaviors for White mothers of children adopted from Asian countries. More specifically, mothers who adopted their children from China and who were more connected to the Asian American community were more inclined to engage in cultural socialization practices with their children, regardless of their own identification with the White majority culture (Johnston et al., 2007). Yet Johnston et al.'s study indicated somewhat limited socialization of children by their White mothers with respect to race, ethnicity, and culture. This finding was also reported by Berbery & O'Brien (2011) in a study of transracial White adoptive parents. Although a variety of socialization practices of transracial adoptive parents have been identified (e.g., preparation of ethnic foods, involvement in cultural camps, activism for racial equality; Crolley-Simic & Vonk, 2008; Vonk et al., 2010), transracial adoptive parents are reportedly most likely to endorse practices that involve the least amount of interaction and contact with individuals from the child's race (Vonk et al., 2010).

In addition to limited exposure to same-race individuals, transracially adopted persons have shared perceptions of limited or nonexistent dialogue around racial issues within their families. Trepidation to discuss issues of race with adoptive parents has been noted in a qualitative investigation of topic avoidance of transracially adopted individuals within adoptive families (Docan-Morgan, 2010). Docan-Morgan (2010) reported that Korean adults adopted transracially by White parents typically avoided talking to their parents about race-related incidents, such as discrimination related to phenotypic racial characteristics. For most adopted persons, the presumption of lack of responsiveness on the part of parents was based on a past history of lack of responsiveness or thoughts that parents could not or would not understand their experiences of racial denigration. When racial perspectives were presented, they tended to negate race. For instance, in a qualitative study of transracially adopted individuals by Samuels (2009), adopted persons frequently reported that their adoptive parents operated from a colorblind perspective, and often rejected racial grouping or expressed preferences to view “people as people”, rather than according to racial categories (Samuels, 2009, p. 87). Despite some of the potential benefits associated with use of proactive racial socialization (i.e., prior to incidents of discrimination) on racial minority mental health (e.g., increased positive affect; Hughes et al., 2006), only 4 of 25 participants in Samuel’s study regarded their parents’ racial socialization practices as proactive and allowing for open and comfortable communication around issues of race and racism.

Relating communication about race within families to the mental health, DeBerry, Scarr, & Weinberg (1996) found a significant, positive relationship between family racial socialization and competency to navigate oppression by African American/Black adopted persons. More recently, Mohanty and Newhill (2011) found that racial socialization was

associated with a decreased sense of marginalization and higher self-esteem among Asian adopted adolescents and young adults. The findings of the study led the authors to conclude that racial socialization has a positive influence on the well-being of transracially adopted persons by preparing them for and making them aware of racial prejudices and discrimination. Collectively, this body of literature clearly suggests that parents play a key role in shaping their children's experiences of race within their homes and communities. The studies point to racial socialization's capacity to influence the relationship between transracially adopted individuals' experiences of racial discrimination and mental health. At present, however, little is known about racial socialization's functionality in inoculating adopted persons against experiences of racial discrimination.

With other groups of racial and ethnic minority individuals, racial socialization has been found to serve as a protective factor in the discrimination-mental health link (e.g., depression, distress, well-being; Fischer & Shaw, 1999; Granberg, Edmond, Simons, Gibbons, & Lei, 2012; Neblett et al., 2008). For instance, with a sample of African American/Black young adults, Fischer and Shaw (1999) investigated the moderating role of racial socialization in the link between racial discrimination over the past year and mental health functioning. Mental health functioning was assessed with a composite of well-being and psychological distress items. The authors found that at low levels of racial socialization, the relationship between racism and mental health was significant and negative. However, at high levels of socialization, discrimination was unrelated to mental health. Similarly, with a sample of Latina women, Telzer and Garcia (2009) found that racial socialization helped to buffer the link between darker skin color (i.e., a phenotypic characteristic associated with greater discrimination) and negative self-perceptions. Although darker skin was associated

with lower self-esteem, lessened attractiveness, and an increased desire to change skin color, racial socialization was shown to ameliorate these outcomes. As such, Latina participants who had darker skin and reported being more prepared for bias as a result of their socialization experiences (i.e., high socialization) reported higher levels of satisfaction with their skin color than those who reported a low level of preparedness. These findings, considered together, reflect the potential for socialization strategies to facilitate more positive functioning in response to discrimination among racial minority individuals.

Of particular relevance to the experiences of transracially adopted persons, racial socialization has been found to be positively related to resiliency (i.e., ability to overcome adversity) with African American/Black young adults (Brown, 2008). When included in a multiple regression analysis, racial socialization and perceived social support were found to explain a significant amount of variance in resiliency. Brown's (2008) findings suggest that supportive and encouraging social environments that foster preparation and awareness for incidents of discrimination (i.e., racially aware adoptive familial contexts) enhance minority individuals' ability to adapt and adjust, thereby improving mental health.

While the literature generally supports the notion that racial socialization acts as moderator in the relationships between discrimination and mental health outcomes, more research that examines the potential for racial socialization to function similarly for specific subsets of racial minority groups and with regard to psychological well-being are needed. This body of literature clearly suggests that parents play a key role in shaping their children's experiences of race within their homes and communities. The studies also point to racial socialization's capacity to influence the relationship between transracially adopted individuals' experiences of racial discrimination and mental health. The current study builds

upon prior research by testing the moderating role of racial socialization with a more diverse sample of transracially adopted persons and in relation to distress. The present study also accounts for transracially adopted persons' identification with their racial group.

Racial Socialization and Racial Identity

Racial socialization and racial identity are theoretically tied to one another under the assumption that racial socialization enhances individuals' understanding of race and who they are as racial beings. Given that critics argue that transracial adoption places adopted persons at risk for poorer racial identity development (Kallgren & Caudill, 1993), examinations of how racial socialization interacts with racial identity to influence mental health for transracially adopted persons are needed. Baden and Steward's Cultural-Racial Identity model (2000) posits that an adopted person's sense of self interacts with the adoptive family context.

The Cultural-Racial Identity model (Baden & Steward, 2000) suggests that adopted persons' knowledge, awareness, competence, and comfort with 1) their own birth culture, 2) their adoptive parents' culture, and 3) multiple cultures are determinants of adopted persons' identification with a particular culture (i.e., their birth and adoptive cultures). Family climates in which adopted individuals develop their cultural-racial identities are characterized as: 1) affirming or discounting adoptive parents' culture and/or racial group members, 2) affirming or discounting adopted persons' racial group's culture and/or their racial group membership, or 3) providing some combination of affirmation and discounting of adoptive parents' and cultures and racial groups of adopted persons. Affirmation offers obvious support for adopted persons' identification with their birth culture and racial group through acknowledgement, acceptance, and approval of racial group membership and birth culture.

In contrast, discounting is characterized by a lack of acceptance, or emphasis, on culture or racial group membership.

The Cultural-Racial Identity Model accounts for the varying combinations of parental attitudes and beliefs, transmitted either actively or passively, intentionally or unintentionally, to adopted children, that might serve to affirm or discount the racial group membership and culture (e.g., parent affirming-child affirming, parenting affirming-child discounting, etc.) of adopted persons. Considering identity of adopted persons and that of their parents along two axes (i.e., cultural and racial identity), further categorizations are used to delineate among pro-self, undifferentiated, bicultural, and pro-parent patterns of identification for adopted persons. Pairing each of the four types of cultural identities and the four possible racial identities results in 16 possible identity combinations (e.g., pro-self cultural identity, pro-parent racial identity; bicultural-racial identity, pro-parent cultural identity). In accordance with the model, adopted individuals experience and are socialized differently with respect to culture and race.

Baden and Steward's (2000) model garners support from growing evidence of an association between socialization and identity variables with racial minority samples. Racial socialization is argued to be a precursor to the development of racial identity and has been shown to predict racial identity for samples of African American/Black (Demo & Hughes, 1990; Hughes, Witherspoon, Rivas-Drake, West-Bey, 2009; Neblett, Smalls, Ford, Nguyen, & Sellers, 2009; Rodriguez, Umaña-Taylor, Smith, & Johnson, 2009; Stevenson & Arrington, 2009; Thompson, Anderson, & Bakeman, 2000) and Asian American individuals (Alvarez et al., 2006). Generally, studies have shown that racial socialization is related to

more advanced racial identity statuses (e.g., Alvarez et al., 2006; Rodriguez et al., 2009) and a stronger sense of group belongingness to one's racial group (Hughes et al., 2009).

A longitudinal study of African American/Black parents and their children found that particular patterns of racial socialization were associated with differing components of racial identity (Neblett et al., 2009). Specifically, a combination of low frequency and highly positive racial socialization messages were related to greater racial centrality for adolescents over the course of two waves of data collection. Similarly, in a study that addressed the identity development of Korean American adopted persons, aspects of cultural socialization were positively correlated with ethnic identity (Song & Lee, 2009). In particular, positive correlations between socialization and ethnic identity were obtained with respect to heterogeneity of the community in which the adopted person was raised, awareness of the meaning of being adopted *and* a member of a racial and ethnic minority group, and connections to birth roots (e.g., visits to Korea, search for birth and foster families). These findings demonstrate racial socialization's potential as a moderator of racial identity's mediating role in the proposed model. However, because the literature does not provide a clear indication of how racial socialization interacts with racial identity to influence the discrimination-mental health link, the directionality of the moderation was exploratory.

The Present Study

The present study examined the discrimination-mental health link with a sample of adults adopted transracially by White parents. In addition, the study explored the potential for racial identity to mediate the links of racial discrimination to psychological distress and psychological well-being. Path analyses were used to test direct effects between perceived racial discrimination and mental health indicators (i.e., psychological distress and well-being)

and indirect effects through racial identity (Figure 1). Path analysis is ideal because it allows for simultaneous examination of the variables of interest and tests of direct and indirect relations among the variables concurrently (Brown, 1997). The moderating role of racial socialization was also examined as the magnitude and significance of paths were examined for transracially adopted persons with high and low levels of racial socialization. Based on the literature reviewed, the current study tested the following hypotheses:

1) The researcher hypothesized a positive relationship between racial discrimination and psychological distress and a negative relationship between racial discrimination and psychological well-being (i.e., direct effects).

2) The researcher hypothesized that racial identity would function as a partial mediator in the discrimination and mental health link. In order to demonstrate partial mediation and based on prior research, a positive relationship between racial discrimination and racial identity, a negative relationship between racial identity and psychological distress, and a positive relationship between racial identity and well-being (i.e., indirect effects) were expected.

3) The researcher hypothesized that the associations among exogenous (i.e., racial discrimination, racial identity) and endogenous (i.e., psychological well-being, psychological distress) study variables would vary for transracially adopted persons who reported high and low levels of racial socialization. The researcher anticipated that the associations between racial discrimination and both mental health outcomes (i.e., psychological distress and psychological well-being) would be of a lesser magnitude for adopted persons who reported high levels of socialization compared to those who report low levels of racial socialization. Although previous conceptualizations of racial identity and racial socialization would suggest

that there could be variability in racial identity's mediating role in the discrimination-mental health link for individuals who report high and low levels of racial socialization (e.g., Sellers et al., 2006), no prior studies have tested moderation of this mediation. Thus, these analyses were exploratory and no directional hypotheses were provided a priori.

Chapter III

METHOD

Participants

The study sample included 206 transracially adopted adults. Participation was restricted to individuals who self-identified as (1) 18 years or older, (2) a member of a racial minority group, and (3) a transracially adopted person adopted by two White, non-Hispanic parents or a White, non-Hispanic single parent. Based solely on physical characteristics, participants predominantly identified as Asian or Pacific Islander (60.2%); however, other racial groups were represented in the study sample as well, including: Hispanic or Latino (15.0%), Biracial or multiracial (10.7%), Other (6.3%, e.g., Salvadoran, Black Italian), Black or African American (5.3%), and American Indian/Native American (1.9%). One participant did not identify with any racial group, but reported having two racial minority birthparents and was included. Participants identified ethnically as Asian or Pacific Islander (30.1%), Caucasian, White, or Non-Hispanic (27.2%), and Biethnic or multiethnic (9.2%), Hispanic or Latino (6.8%), and Black or African American (6.8%); 8.7% of participants did not identify with an ethnic group.

Participants ranged in age between 18 and 61 years of age ($M = 31.78$, $SD = 8.90$) and were predominantly women (83.5%), with men (15.0%), a transman (0.5%), and an individual who identified as pangender (0.5%) accounting for the remainder of the sample. The sample included differing sexual orientations: exclusively heterosexual (74.3%), mostly heterosexual (13.6%), exclusively lesbian/gay (4.9%), bisexual (4.4%), mostly lesbian/gay (1.9%). Various geographic regions throughout the U.S. were also represented (Northeast,

32.5%; Midwest, 30.0%; Southwest, 10.7%; Northwest, 9.7%; Southeast, 8.3%; Multiple regions, 5.8%).

The sample was comprised of primarily internationally adopted adults (73.8%), who were raised by two adoptive parents (91.7%) in suburban (68.4%) neighborhoods that were not at all diverse (62.1%). All participants reported that they had been adopted prior to 3 years of age. The majority of adoptions were closed (93.7%). Participants reported that they were currently living mostly in somewhat diverse (37.4%) or diverse (9.2%), and suburban (51.0%) or urban (37.4%) neighborhoods. Participants indicated that their own personal social class was either middle (50.0%) or upper middle class (26.7%), whereas, their birthparents' social class was either unknown (52.9%) or lower class (22.8%). They identified their adoptive family's social class as similar to their own (i.e., 36.5% upper middle class, 43.2% middle).

Procedure

Participants were recruited using online advertisement. The advertisement was sent to adoption-related organizations, email lists, listservs, and prominent adoption and diversity scholars to recruit participants (Appendix A). After providing informed consent (Appendix B), participants were asked to complete an online survey consisting of a demographic questionnaire and five measures (Appendix C-Appendix H). The order of the five measures was counterbalanced (i.e., half of participants completed the mental health measures first and the other half completed the mental health measures last). Three validity check items were included in the survey. An example validity of a check item is, "Please select the response associated with *strongly disagree*". These items are intended to minimize spurious responding and to determine whether or not participants are reading items and

comprehending their content. Data from participants who answered more than one validity check item wrong were not analyzed. The survey took approximately 20-30 minutes to complete. At the end of the survey participants were provided with a debriefing form that explained the study's purpose (Appendix I).

Measures

Demographic questionnaire. A demographic questionnaire was used in order to obtain information about the participant: gender, age, race, ethnicity, sexual orientation, socioeconomic status (SES), religion, and geographic location. Participants were also asked to provide information relevant to their adoptions, including adoption type (e.g., closed/open, international/domestic), age at adoption, race of adoptive parents (i.e., to establish inclusion criteria), race of birth parents, SES of adoptive parents, and SES of birth parents. The demographic questionnaire included questions on the racial diversity of participants' neighborhoods (both current and previous).

Perceived racial discrimination. Perceived racial discrimination was assessed using a modified version of the recent subscale of the General Ethnic Discrimination Scale (i.e., GED-recent; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006). The GED-recent is an 18-item, self-report inventory that assesses the frequency of racial discrimination experiences over the past year. Because this study focuses specifically on experiences of racial discrimination, language that references ethnicity were removed (i.e., "race/ethnic group" were replaced with only "race"). Sample items included, "How often have you been treated unfairly by neighbors because of your race?" and "How often have people misunderstood your intentions and motives because of your race?" Participants were asked to select responses associated with the frequency of discrimination using a 6-point scale (i.e., 1 =

never to 6 = almost all of the time [more than 70.0% of the time]). Scores were obtained by averaging scores of individual items. Higher scores suggest a greater frequency of perceived racial discrimination over the past year.

The original GED Scale has yielded promising reliability and validity data when used with a number of racial and ethnic groups (e.g., African American/Black, Latina/o, Asian, and White; Landrine et al., 2006). More specifically, Landrine et al. (2006) verified the construct validity of the GED-recent by obtaining significantly higher scores (i.e., higher frequencies of reported racial discrimination) from racial minority participants (e.g., African American/Black, Latina/o) than from White participants and confirming the proposed three-factor structure of the full GED scale (i.e., lifetime, recent, and appraisal dimensions) for all racial and ethnic groups considered (i.e., White, African American/Black, Latina/o, Asian American, members of other minority groups). Demonstrating predictive validity, composite GED scores were found to account for a greater amount of variance in psychiatric symptoms than demographic characteristics alone (i.e., age, ethnicity, and gender). Landrine et al. provided evidence of the reliability of the GED-recent subscale as well by obtaining a Cronbach's alphas of .94 with their racially diverse sample (i.e., African American,/Black, Asian American, Latina/o, White, members of other minority groups) of college students and members of the community. The alpha coefficient for this sample was .93.

Racial identity. Racial identity was assessed with a modified version of the racial centrality subscale (i.e., Centrality subscale) of the Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1997). The Centrality subscale is a measure of racial identity that addresses an individual's identification of self in accordance with their respective racial group. A modified version of this scale was used to assess the extent to which the

transracially adopted persons regard their belongingness to their respective racial group as central to their identity. The current study made modifications to the MIBI by removing references to Black or Black people. Participants were asked to substitute their own racial reference group for a blank line. The instructions read, “As you read the following statements, please insert the name of your racial group in place of _____ in the text.” For example, the item “Overall, being Black has very little to do with how I feel about myself” was changed to “Overall, being _____ has very little to do with how I feel about myself”, and the item “I have a strong sense of belonging to Black people” was changed to “I have a strong sense of belonging to _____ people.” Participants were asked to rate the eight, self-report items of the Centrality subscale on a 7-point Likert-type scale (1 = *strongly disagree* to 7 = *strongly agree*). After reverse scoring appropriate questions, items were averaged in order to obtain a composite score. Higher scores on the Centrality subscale are indicative of race being a more important aspect of one’s definition of self.

The original MIBI’s factor structure has been confirmed with factor analysis, demonstrating good construct validity with African American/Black college student samples (Sellers et al., 1997; Rowley et al., 1998). In addition, the Centrality subscale is a widely-used measure of racial identity, yielding alpha coefficients above .70 with African American/Black samples (Rowley et al., 1998; Sellers & Shelton, 2003). Modified versions of the MIBI have been shown to produce comparable reliability estimates. For example, Settles (2004) utilized two modified versions (i.e., changing language to refer to different components of identity; e.g., woman, scientist) to assess identity centrality for a sample of female undergraduate students in the sciences, achieving alpha coefficients of .78 and .79, respectively. Similarly, Knowles and Peng (2005) made alterations to Centrality subscale in

order to measure White identity centrality for a sample of White college students (i.e., Cronbach's alpha = .82). The alpha coefficient for this sample was .82.

Racial socialization. Racial socialization was assessed using the Racial Socialization (RS) subscale of the Ethnic and Racial Socialization of Transracial Adoptee Scale (ERSTAS; Mohanty, 2010). The RS consists of six, self-report items that measure parental involvement in preparations for, and development of coping mechanisms to manage, racial prejudices and discrimination for adopted individuals. Sample items include, "Teaching me a variety of coping strategies from which to choose when faced with prejudice or bias" and "Talking about race and racism openly within the family." Participants were asked to indicate the extent to which their parents placed importance on various developmental activities by responding to positively worded items on a 5-point Likert scale (i.e., 1 = *not at all important* to 5 = *extremely important*). Scores were calculated by averaging individual subscale items. Higher total scores are suggestive of higher levels of perceived parental involvement and/or support with regard to racial socialization for transracially adopted persons.

In terms of validity, an exploratory factor analysis supported the hypothesized two-factor structure of the ESTAS, which distinguishes between ethnic and racial socialization (Mohanty, 2010). In addition, participants' mean scores on the ESTAS differed significantly from a related measure of American Socialization and the Ethnic Socialization subscale of the ERSTAS, suggesting strong divergent validity (Mohanty, 2010). The scale has also been shown to significantly relate in the anticipated directions with self-esteem ($r = .22, p = .028$) and depressive symptomology ($r = -.22, p = .025$; Mohanty, 2010). Providing evidence of the scale's reliability, an alpha coefficient of .93 was obtained for a sample of adult

transracially adopted Asian individuals (Mohanty, 2010). The alpha coefficient for this sample was .96.

Psychological distress. Psychological distress was assessed with the Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988), a 21-item abbreviated version of the Hopkins Symptoms Checklist (Derogatis, Lipman, Richels, Uhlenhuth, & Covi, 1974). Example items included, “Blaming yourself for things” and “Trouble concentrating”. Participants were asked to indicate the level of distress they have experienced in the past week using a 4-point Likert-type scale (i.e., 1 = *not at all*, 4 = *extremely*). Scores were averaged across items, with higher scores indicating greater levels of psychological distress.

The HSCL-21 has been shown to be a valid measure. For example, positive correlations with other measures of psychological distress (i.e., convergent validity) and significant differences between treatment seeking and non-seeking individuals samples have been found (i.e., construct validity; Deane, Leathem, & Spicer, 1992). The hypothesized factor structure of the measure has also been supported with samples of African American/Black, European American, and Latina/o individuals (Cepeda-Benito & Gleaves, 2000). High alpha coefficients have been reported with psychotherapy clients, Asian American sexual minority individuals, and, college students (i.e., .89 and higher; Deane et al., 1992; Szymanski & Sung, 2010; Vogel & Wei, 2005). The alpha coefficient for this sample was .93.

Psychological well-being. The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) was used to assess the subjective psychological well-being of transracially adopted persons. The SWLS includes five, self-report items. For

example, “I am satisfied with life” and “In most ways my life is close to my ideal.”

Participants were asked to indicate their level of agreement with items on a 7-point Likert-type scale (i.e., 1 = *strongly disagree* to 7 = *strongly agree*). Item responses were summed together to obtain a total score and then divided by the number of items to obtain an average score per item. Higher scores indicate greater satisfaction with the conditions of one’s life.

The SWLS has yielded meaningful results with racially, ethnically, and culturally diverse samples (e.g., African American/Black, Asian American, Canadian, Russian, Korean, and Chinese samples; Barnes & Lightsey, 2005; Pavot & Diener, 1993; Yoo & Lee, 2005). With regard to validity, the SWLS has been found to correlate positively with self-esteem and negatively with measures of psychological distress (Pavot & Diener, 1993). Moreover, SWLS was found to be unrelated to participant differences in intensity of affect and impulsivity (Diener, 1985). The reliability of the SWLS is indicated by alpha coefficients in the range of .79 to .89 with a number of ethnically and racially diverse samples (Barnes & Lightsey, 2005; Pavot & Diener, 1993). The alpha coefficient for this sample was .91.

Chapter IV

RESULTS

Preliminary Analyses

Although 427 individuals consented and began the study survey, 35.6% ($n = 152$), did not meet eligibility criteria due to: a) identifying as Caucasian, White, Non-Hispanic ($n = 10$) or not providing an answer to the item that asked them to identify with a racial group ($n = 117$), b) reporting that they grew up in a home with at least one racial minority parent ($n = 18$) or not responding to the item asking about the race of their parents in the home growing up ($n = 4$), or c) not being 18 years of age or older as indicated by self-report ($n = 3$). Respondents were also eliminated if they responded to reliability items incorrectly (i.e., answering two or more items incorrectly or answering one item incorrectly and not completing the other two items correctly; $n = 33$) or failed to complete 80.0% or more of all study measures ($n = 34$). Mean imputation was used to address missing data for those who completed at least 80.0% of each study measure.

Prior to conducting the path analyses, assumptions of univariate and multivariate normality were investigated. Although the values of skewness and kurtosis statistics and Mardia's coefficient (2.09; Mardia, 1970) fell within acceptable ranges (i.e., less than 3.0 for skewness, 10.0 for kurtosis, and 3.0 for Mardia's coefficient; Bentler, 2001; Ullman, 2006, Weston & Gore, 2006), violations of normality were detected when considering the associated standard errors of these values. Skewness and kurtosis statistics, and Mardia's coefficient, were found to lie outside the traditionally recommended range of two times their standard errors on number of occasions, which could suggest an issue with skewness or kurtosis depending on the accuracy of the standard errors generated (Wright & Herrington,

2011). Given the robustness of maximum likelihood estimation procedures to violations of normality (Ollson, Foss, Troye, & Howe, 2000), the researcher proceeded, but results should be interpreted with caution. Mahalanobis distance was also used as an indicator of multivariate normality (Rousseeuw & van Zomeren, 1990). Of note, examination of the Mahalanobis distance values indicated the presence of two multivariate outliers ($p < .001$); these participants were not included in subsequent analyses, resulting in the final sample of 206 adopted adults.

Potential covariates were assessed by conducting MANOVAs on psychological distress and well-being for gender (Wilks' $\lambda = .99$, $F(4, 300) = .48$, $p = .751$), sexual orientation (Wilks' $\lambda = .98$, $F(8, 300) = .39$, $p = .926$), international adoption status (international vs. domestic; Wilks' $\lambda = .10$, $F(2, 150) = .24$, $p = .789$), openness of adoption (open vs. closed; Wilks' $\lambda = .10$, $F(2, 150) = .17$, $p = .846$), and self-identified race based on phenotypic characteristics (Wilks' $\lambda = .95$, $F(12, 300) = .70$, $p = .756$); none were significant at the .05 level. Groups were also compared to ensure that scores did not vary significantly for participants who completed outcome measures first versus last; no significant difference was found (Wilks' $\lambda = .10$, $F(2, 203) = .29$, $p = .746$).

Descriptive statistics. Descriptive statistics, internal consistency reliabilities, and interrelations among all study variables of interest are provided in Table 1. Following Cohen's (1992) suggestions for the interpretation of effect sizes (i.e., small, $r = .10$; medium, $r = .30$), large, $r = .50$), the study correlation matrix includes a number of significant correlations worth noting. As expected, the two study outcomes, psychological distress and psychological well-being, were significantly and inversely correlated ($r = -.53$, $p < .001$). Furthermore, and consistent with study hypotheses, racial discrimination was significantly

positively associated with psychological distress ($r = .31, p < .001$) and significantly negatively associated with psychological well-being ($r = -.18, p < .01$). As expected, racial identity was significantly and positively correlated with racial discrimination ($r = .28, p < .001$). Of interest, the study's moderator, racial socialization, was positively and significantly correlated with psychological well-being ($r = .18, p < .01$).

Path Analyses

Moderated mediation (Edwards & Lambert, 2007; Fairchild & MacKinnon, 2009; Preacher, Zyphur, & Zhang, 2010) with path analysis was utilized to test the mediating role of racial identity in the relationship between racial discrimination and mental health (i.e., psychological distress and psychological well-being) for transracially adopted persons reporting high and low levels of racial socialization. The initial model included all participants in one group. Subsequent nested models with all paths constrained to be equal and then paths freely estimated for high and low socialization groups were compared to determine if racial socialization moderates the relationship between the exogenous and endogenous variables in the original model. The paths tested across models included: direct paths between racial discrimination and psychological distress and racial discrimination and psychological well-being (i.e., 2 direct paths) as well as indirect paths between racial discrimination and psychological distress and racial discrimination and psychological well-being, through racial identity (Figure 1).

As previously stated, Baron and Kenny's (1986) criteria for mediation includes: a) a correlation between the independent and dependent variables, b) an association between the independent variable and the mediating variable, and c) an association between the mediating variable and the outcome variable. Baron and Kenny (1986) contend that partial mediation

occurs when the effect of the independent variable on the dependent variable is reduced nontrivially by the inclusion of the mediating variable, yet remains significant. These criteria were used to assess racial identity's mediating function within the proposed model.

The significance of the indirect effects of racial discrimination to psychological distress and well-being, through racial identity, were also considered using bootstrapping procedures (Preacher & Hayes, 2004). Bootstrapping generates a large number of samples from the data through random sampling with replacement in order to produce mean indirect effects and associated confidence intervals (CIs) for each mediation path. Consistent with Shrout and Bolger (2002), 95% CIs for indirect effects that do not include zero are significant at the .05 level. When appropriate, model fit was assessed using several fit indices (i.e., chi-square statistic, comparative fit index [*CFI*], goodness-of-fit [*GFI*], and root-mean-square error of approximation [*RMSEA*]). *CFI* and *GFI* values of .95 or higher and *RMSEA* values of .05 are generally used to indicate good fit for the data (Bentler & Bonnett, 1980; Browne & Cudeck, 1993; Hu & Bentler, 1999). Although the chi-square statistic will be considered, given its sensitivity to large sample sizes, it will not serve as a primary indicator of model fit. Rather, the *CFI*, *GFI*, and *RMSEA* statistics will be used to determine acceptable fit in this investigation. Results, including standardized regression weights, confidence intervals for indirect effects, and R^2 for all models are summarized in Table 2.

Initial path model. The initial path model was just-identified and therefore demonstrated perfect fit to the data. Accordingly, an examination of fit indices was not appropriate and regression weights and associated *p*-values were used to make inferences about the extent to which the model appropriately fit the data. The initial model accounted for: 7.5% of the variance in racial identity, 10.4% of the variance in psychological distress,

and 5.1% of the variance in psychological well-being. As expected, significant direct links were found between: discrimination and racial identity ($\beta = .28, p < .001$), discrimination and distress ($\beta = .34, p < .001$), discrimination and well-being ($\beta = -.22, p = .002$), and racial identity and well-being ($\beta = .15, p = .037$). Contrary to study hypotheses, the direct path between racial identity and distress was not significant ($\beta = -.08, p = .222$).

Because direct paths from discrimination to racial identity, racial identity to well-being, and discrimination to well-being were all significant when considered together in the path model, Baron and Kenny's criteria for mediation were met. Moreover, a significant indirect effect was obtained for discrimination and well-being through racial identity (95% CI: .01, .23, $p = .023$). On the other hand, given that neither the direct path of racial identity to distress nor the indirect effect for discrimination to distress through racial identity were significant (95% CI: -.06, .01, $p = .159$), racial identity was not found to partially mediate or have an indirect effect on the discrimination-distress relation.

Moderated mediation. To examine racial socialization as a moderator in the discrimination-mental health relation, a multigroup comparison was conducted for participants in high socialization and low socialization groups. Participant designation in high and low socialization groups was determined using the median for racial socialization (i.e., 2.50), which was also the midpoint of the racial socialization scale. The high socialization group included participants with a score of 2.50 and above ($n = 106$), whereas the low socialization group included all participants with a score below 2.50 ($n = 100$). In an effort to better understand differences between socialization groups, independent sample *t*-tests were conducted to directly compare the means for high and low socialization groups on all variables (e.g., discrimination, racial identity, distress, and well-being). One significant

difference was detected at the .05 level: the well-being of the high socialization group ($M = 5.05$) was significantly higher than the low socialization group ($M = 4.39$, $t(204, 2) = -3.09$, $p = .002$).

To test for factorial invariance between groups, a model in which all path coefficients were constrained to be equal for both groups and a model that allowed free estimation of all paths were compared. The chi-square test comparing the chi-square statistics was significant, $\chi^2(5, N = 206) = 11.18$, $p = .048$, suggesting that the model that allowed parameters to be freely estimated provides a better fit to the data. When parameters were freely estimated, the model accounted for 7.1% the variance in racial identity, 6.3% of the variance in psychological distress, and 10.6% variance in psychological well-being for the high socialization group. For the high socialization group, direct paths were all significant (i.e., discrimination to distress, $\beta = .22$, $p = .022$; discrimination to well-being, $\beta = -.26$, $p = .007$; discrimination to racial identity, $\beta = .27$, $p = .005$; racial identity to well-being, $\beta = .28$, $p = .004$), with the exception of the direct path from racial identity to distress, $\beta = -.19$, which approached but did not reach significance ($p = .055$). The indirect effect of discrimination on well-being through racial identity (95% CI: .03, .39, $p = .011$) was significant. The indirect effect of discrimination on distress through racial identity approached, but did not reach significance (95% CI: -.10, .00, $p = .051$).

For the low socialization group, the model accounted for 8.1% of the variance in racial identity, 20.6% of the variance in psychological distress, and 3.4% of the variance in psychological well-being. For this group, two direct paths were significant: discrimination to racial identity ($\beta = .29$, $p = .003$) and discrimination to distress, ($\beta = .46$, $p < .001$). However, direct paths from discrimination to well-being ($\beta = -.19$, $p = .061$), racial identity to distress,

($\beta = -.01, p = .930$), and racial identity to well-being ($\beta = .05, p = .645$) were not significant, nor were the indirect paths for discrimination to distress through racial identity (95% CI: $-.06, .19, p = .925$) and discrimination to well-being through racial identity (95% CI: $-.12, .19, p = .650$).

When paths were set to be equal such that parameters between groups were not free to vary, the model accounted for 8.4% of the variance in racial identity, 10.5% of the variance in psychological distress, and 6.4% of the variance in psychological well-being. The direct paths for this model were all significant (i.e., discrimination to racial identity [$\beta = .26, p < .001$], discrimination to distress [$\beta = .33, p < .001$], discrimination to well-being [$\beta = -.23, p < .001$], and racial identity to well-being [$\beta = .17, p = .020$]) with the exception of racial identity to distress [$\beta = -.09, p = .271$]). The indirect path for discrimination to well-being through racial identity was significant (95% CI: $.01, .23, p = .031$), although the indirect effect for discrimination to distress through racial identity did not achieve significance (95% CI: $-.06, .01, p = .206$). Because this model constrained five paths, fit indices were available for the constrained model and demonstrated good fit to the data (e.g., $GFI = .97, CFI = .94, RMSEA = .08$).

Chapter V

DISCUSSION

Findings from this empirical investigation inform the understanding of transracially adopted persons' experiences of race and the relationship of these experiences to mental health. Literature has consistently demonstrated that racial discrimination impacts the mental health of racial minority persons (e.g., Brown, 2000, Hwang & Goto, 2009; Moradi & Risco, 2006). Yet, studies with transracially adopted individuals call attention to the complexities of transracial adoptive racial identity development and socialization (Docan-Morgan, 2010; Samuels, 2009; Smith et al., 2011). As such, it has remained unclear to what extent existing models of discrimination-mental health apply to transracial adopted persons, or how factors such as racial identity and socialization influence this relation for adults who were transracially adopted.

In recent decades, there has been an increase in the number of racial minority individuals doing adoption research as well as a greater emphasis on systemic factors and how they relate to the experiences of transracially adopted individuals (e.g., Baden, 2002; Lee, 2003). Such a movement away from pathologizing transracially adopted persons has allowed for improved specificity in identifying variables that may influence transracial adoption mental health and provides a context for researching, and potentially intervening in, the lives of transracially adopted individuals. This is the first study to consider the intervening roles of racial identity and racial socialization in tandem and as they relate to both distress and well-being for transracially adopted adults. The proposed moderated mediation model included direct and indirect paths to examine racial identity's mediating role in discrimination-mental health links, as well as the potential moderating role of racial socialization in these links. Significant positive and negative relations with discrimination

were anticipated for distress and well-being, respectively (Hypothesis 1). It was hypothesized further that participants who more strongly identified with their racial minority group would report more frequent racial discrimination and that racial identity would partially mediate the discrimination-mental health link (Hypothesis 2). Third, the strength of relations amongst study variables was expected to vary depending on participants' level of racial socialization (Hypothesis 3). Findings add to the current literature by confirming as well as challenging existing trends in the literature with racial minority individuals. Specifically, the magnitude and significance of some direct paths and racial identity's mediating function were found to differ for participants who reported high and low levels of racial socialization. Therefore, the present study found partial support for a moderated mediation model of discrimination and mental health for a sample of transracially adopted adults adopted by White parents.

Links Between Discrimination and Mental Health

Generally, the pattern of relations between discrimination and mental health for this sample of transracially adopted adults were consistent with prior research with racial minority persons. Providing partial support for the first hypothesis, discrimination was positively associated with psychological distress in a bivariate correlation and when examined simultaneously with other factors through path analyses. A significant positive link was found in the initial model that included all participants and all three models used to make a multi-group comparison (i.e., high socialization only, low socialization only, and model constraining all paths to equal for both groups). These findings are in line with studies that have reported a positive relationship between racial discrimination and psychological distress for samples of African American/Black, Asian American, and Latina/o individuals

(e.g., Pieterse & Carter, 2007; Hwang & Goto, 2009; Szymanski & Sung, 2010) as well as those reporting positive associations between discrimination (e.g., being teased for foreign looks, racial discrimination) and mental health problems among adopted adolescents and young adults (Cederbald et al, 1999; Lee, 2010). Reviewing descriptive statistics, it is important to highlight that the sample's reported experiences of recent racial discrimination (i.e., mean total score of 32.04) were comparable to, but slightly lower than, means reported with other racial minority adults (e.g., African American/Black, Asian/Asian American, Latina/o, and "Other" categories with total scale scores of 42.43, 37.54, 36.55, 35.88, respectively; Landrine et al., 2006). Slightly lower rates of discrimination in this sample could reflect a diminished ability to recognize racial discrimination when it was encountered, rather than fewer incidents of discrimination. As is investigated to some degree by the inclusion of racial socialization as a moderating variable in this study, transracially adopted adults may not as easily identify discrimination following their upbringing in White households, where White parents may be less aware of discrimination themselves and provide less education about the potential for such occurrences. Nevertheless, the comparable levels of reported discrimination obtained for this sample, coupled with the emergence of a significant discrimination-distress relation, suggests that racial discrimination may function similarly for transracially adopted adults as for other racial minority individuals.

With regard to the direct path between discrimination and psychological well-being, findings were mixed. Despite the presence of a significant negative bivariate correlation between discrimination and well-being, this relationship was not observed across all path models. In particular, the negative relationship was significant in the initial model and in the models that isolated the high socialization participants or constrained paths to be equal for

both groups. However, a negative relationship was not present when the low socialization group was considered alone. Overall, these findings offer partial support for Hypothesis 1 (i.e., discrimination will be negatively associated with well-being). The lack of consistency across high and low socialization groups provides evidence for the third study hypothesis (i.e., the relationships between discrimination and mental health will vary depending on level of socialization). Such mixed results align with previous research indicating that the discrimination-well-being link is not consistent across racial minority samples (e.g., Barnes and Lightsey, 2005; Neblett et al., 2008; Ryff et al., 2003) and may disappear altogether when other relevant factors are included in more complex models (e.g., social connectedness; Yoon et al., 2012). Because not all studies investigating the discrimination-well-being relation have accounted for both racial identity and racial socialization, the current study's findings may provide some insight into the varied results obtained when exploring discrimination and well-being with racial minority persons. It could be that different levels of racial socialization account for some of the assorted findings about the link between racial discrimination and well-being.

Racial Identity as a Mediator

To determine whether racial identity mediated the links between discrimination and mental health (Hypothesis 2), the direct relations between discrimination and racial identity, racial identity and psychological distress, and racial identity and well-being, were investigated. For this sample of transracially adopted adults, a significant, positive correlation in the small to medium range ($r = .28, p < .001$; Cohen, 1992) was found between discrimination and racial identity in a bivariate correlation. Additionally, although the magnitude of regression weights differed across path models, significant positive

associations between discrimination and racial identity were found in the initial model and in all three models of the multi-group comparison. Research has shown that racial minority individuals who identify more strongly with their racial identity tend to report racial discrimination at higher rates than their less strongly identified peers (e.g., Greene et al. 2006; Sellers & Shelton, 2003). The same trend was observed in this study.

Regarding racial identity-mental health relations, bivariate results did not provide evidence of significant associations between racial identity and psychological distress or well-being. Existing studies with racial minority samples have indicated that racial identity is not reliably associated with psychological distress when investigated as a direct relationship (Seller & Shelton, 2003; Sellers et al., 2006). Unlike the racial identity-distress link, however, accumulating evidence suggests that racial identity is positively associated with indicators of well-being for racial minority individuals (e.g., Greene et al., 2006; Iwamoto & Liu, 2010; Liang & Fassinger, 2008; Rivas-Drake, 2011; Seaton et al., 2011; Yap et al., 2011). Thus, the findings gathered herein are somewhat contrary to what has been reported in prior research. One explanation for this finding is that the distinction in this study between race and ethnicity resulted in a relatively narrower conceptualization (and measurement) of identity for transracially adopted persons, such that no significant relationship to well-being emerged when studied directly.

To further test for mediation between discrimination and mental health for transracially adopted adults, direct paths from racial identity to distress and well-being were examined simultaneously in path models with the previously noted discrimination-mental health links. For psychological distress, the direct path from racial identity to psychological distress remained non-significant in the initial model and the three models used to test for

group differences. Furthermore, no significant indirect effect, or mediation, of racial identity was found in the discrimination-distress link for any model, demonstrating further that racial identity did not explain the negative relation between discrimination and psychological distress for transracially adopted adults. One possible reason for the lack of mediation in discrimination-distress is the complexity of transracially adopted individuals' racial identity, which could be more malleable (Sanchez et al., 2009) and function similarly to multiracial identity. For transracially adopted adults, adoptive, ethnic, or other identities may become more salient in the face of discrimination and better explain the relationship between discrimination and distress for these individuals. Moreover, it could be that the intersection of multiple dimensions of identity is not effectively captured when examining them individually (Harris, 1997; Jones & McEwen, 2000). Future investigations including other important facets of identity in more complex mediation models while accounting for the multidimensionality of identity for transracially adopted adults may obtain alternative results.

The results showing no mediation do, however, echo inconsistencies of former research exploring racial identity as a mediator of discrimination and mental health. As previously discussed, racial identity has been examined both as a mediator and moderator of the discrimination-mental health link, with increasing support for a mediating function with samples of African American and Asian American individuals (Branscombe et al., 1999; Liang & Fassinger, 2008). Revisiting the body of literature that has explored racial identity as a moderating factor in the discrimination-mental health link is helpful in making sense of the absence of a racial identity-distress relation for this sample. In their meta-analysis of discrimination and health literature, Pascoe and Smart Richman (2009) concluded that levels of discrimination as well as type and complexity of one's group identification may operate

together to determine how group identification influences the effects of discrimination on mental health. Thus, another plausible explanation for this study's findings is that racial identity more appropriately serves as a buffer (moderator), rather than a mediator, in the discrimination-distress link for transracially adopted adults under certain circumstances.

Contrasting the findings obtained when investigating racial identity as a mediator of the link between discrimination and distress, racial identity did partially mediate the discrimination-well-being relation in all but the low socialization model. With regard to the direct path between racial identity and well-being in the path analyses, significant and positive direct links from racial identity to well-being were found in the initial model, the high socialization group, and the constrained model of the multigroup comparison. A non-significant direct path from racial identity to well-being was only obtained when the model was tested for the low socialization participants. This result suggests that under conditions of lower socialization, racial identity may not contribute to the well-being of transracially adopted adults. A lack of significance also serves to inform our understanding of the non-significant correlation between racial identity and well-being, which appeared to contradict prior research (e.g., Greene et al., 2006; Liang & Fassinger, 2008; Yap et al., 2011). Perhaps it is not that racial identity is unrelated to well-being for all transracially adopted individuals, but that this relation emerges under certain conditions (e.g., higher racial socialization). Because racial identity functions differently for high and low socialization participants, the anticipated direct relationship between racial identity and well-being was not apparent when they were considered altogether.

The fact that racial identity was also found to partially mediate the discrimination-well-being relationship, but not for the low socialization group, could be evidence of another

mechanism underlying this link. For instance, adopted adults who received more racial socialization and who reported higher levels of racial identity may also have been provided more social support within their families and learned early in their development that loved ones can serve as resources to share and process experiences of discrimination, thus improving well-being. Nonetheless, discrepant findings about racial identity's mediating function indicate that different variables may intervene in the discrimination-mental health depending on the mental health outcome being examined. These nuanced findings also reiterate the importance of considering racial identity and racial socialization concomitantly as has been suggested in the literature (e.g., Sellers et al., 2011; Tummala-Narra et al., 2011).

Racial Socialization as a Moderator

The relationship between racial identity and racial socialization was not evident when considered in a bivariate correlation; however, when examined simultaneously in a multi-group comparison path analysis, these variables were found to interact with one another in meaningful ways. The inclusion of the low socialization group dampened the direct and indirect effect of racial identity on well-being when all participants were grouped together. Such dampening is evident when considering changes in the magnitude and significance of direct and indirect paths across models. Racial identity was only shown to contribute positively to well-being and act as a mediator in the discrimination-well-being link when participants from both groups were considered together or when investigating the high socialization group alone.

Further, the findings demonstrated that mental health outcomes were differentially influenced by racial discrimination for transracially adopted persons depending on level of racial socialization. For instance, the strength of the relationship between discrimination and

distress was greater for transracially adopted adults who reported low levels of racial socialization. Of particular interest, discrimination explained more of the variance in distress for the low socialization participants, than the high socialization participants (20.6% vs. 6.3%), despite fewer significant direct paths being present in the low socialization group's model. Thus, although transracially adopted adults who reported less socialization indicated similar levels of discrimination as those in the high socialization group ($M = 1.69$ vs. $M = 1.70$, $t(204, 2) = -.19$, $p = .851$), the discrimination they did experience was associated with more psychological distress ($\beta = .46$, $p < .001$ vs. $\beta = .22$, $p = .022$).

Importantly, the negative association between discrimination and well-being only approached significance for the low socialization group ($\beta = -.19$, $p = .061$), whereas it was significant and of a larger magnitude for the high socialization group ($\beta = -.26$, $p = .007$). It appears that the strength of the negative discrimination-well-being link for the high-socialization group may have accounted for the notable increase in well-being variance explained by the model (10.4%) compared to the other models (6.4% at most). Therefore, the high socialization group reported significantly higher levels of well-being than the low socialization group overall, but their well-being was more strongly negatively influenced by discrimination. Taken together, these findings serve as a reminder that although racial socialization may operate as a protective factor and potentially mitigate some of the negative effects of discrimination, it may not be without some detriment to overall mental health and well-being.

Coinciding with increased awareness of and preparedness for racial discrimination presumed to develop as a result of racial socialization (Hughes et al., 2006; Lee, 2003), racial minority persons may be more apt to identify discrimination under conditions of higher

socialization, offsetting some of its mental health benefits. A growing body of literature argues that increased awareness of racial injustice can be emotionally exhausting or even anger-inducing (Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009). Increased preparedness for discrimination that accompanies stronger identification with one's racial minority group can also lead to the use of avoidant coping strategies (Sanders Thompson, 2006), which have been found to be negatively associated with well-being variables (i.e., life satisfaction and self-esteem; Utsey, Ponterotto, Reynolds, & Cancelli, 2000). Therefore, racial socialization may act as a double-edged sword. On the one hand, it can help minority persons to prepare for discrimination. Conversely, the heightened awareness of discrimination inherent to racial socialization can also lead to a comprised sense of well-being.

Allowing the parameters to vary across models for different levels of socialization yielded important results. Although a just-identified model precludes interpretation of fit indices, because the constrained model, a model with the same structure, demonstrated good fit with constraints, one can surmise that the freely estimated model also fits the data well. As previously discussed, the results of the chi-square difference test ($\chi^2 [5, N = 206] = 11.18, p = .048$) suggest that the model that allowed parameters to be freely estimated provided a better fit to the data.

Despite identification of a good fitting model, study findings seem to suggest that the model, with its emphasis on strengths and optimization of mental health through racial socialization and identification, may better explain the well-being of transracially adopted adults who report higher levels of racial socialization. The proposed model accounted for markedly less of the variance in psychological distress for the high socialization group,

despite the finding that the high and low socialization groups reported comparable levels of distress. Future studies should investigate other variables that may better account for distress with this group. In contrast, this study's model explained more than 20.0% of the variance in distress and notably less of the variance in well-being for the low socialization group. Of importance, racial identity was not significantly related to either mental health outcome for the low socialization group, despite both high and low socialization groups reporting similar levels of racial identity. Collectively, the results underscore the importance of preparing transracially adopted adults for racial discrimination and providing them with tools for managing such experiences (Leslie, Smith, Hrapczynski, & Riley, 2013) in order to improve overall mental health and functioning. They also affirm the need to investigate racial identity and racial socialization together and in relation to multiple mental health outcomes.

Limitations

Considering the potential uniqueness of the transracial adopted experience, this study examined a number of established race-related statistical relationships within the racial minority literature with transracially adopted individuals. The use of a multidimensional approach to operationalizing mental health (i.e., measures of distress and well-being; Pascoe & Smart Richman, 2009) allowed for increased specificity in deciphering racial identity's role and interaction with racial socialization for adults in the transracial adoptive community adopted by White parents. Moreover, the large sample of transracially adopted adults and quantitative approach contribute to the empirical understanding of how socialization experiences influence mental health functioning of transracially adopted adults as they encounter racial discrimination.

Although the study addressed some of the research gaps in the area of transracial adoption, several validity considerations should be noted. First of all, the study's methodology contains an inherent mono-method bias due to reliance on single, self-report measures to operationalize all constructs. In particular, single, self-report measures can be problematic because of the tendency for individuals to respond in socially desirable ways (Heppner, Wampold, & Kivlighan, 2008). The predominant groups represented in the study sample were Asian or Pacific Islander (60.2%) and women (83.5%), thus limiting the generalizability of study findings. Relatedly, participants reported that they had been adopted primarily through international adoptions (73.8%), which may suggest differences in socioeconomic status of adoptive parents, increased reliance on private adoption agencies, and differences in the circumstances through which adopted adults were placed with their adopted parents as compared to domestically adopted individuals (e.g., child welfare). Race, adoption type, and gender were examined as potential covariates in the model prior to analyses, but it remains unclear to what extent the variability within the sample on these characteristics influenced study results. Of consideration, potential issues with normality were detected and could have affected the interpretation of results.

Threats to external validity are also present given the specific subpopulation of transracial adopted adults by White parents; results may not generalize to adopted persons raised by parents who are of the same race or who are non-White. Similarly, individuals who chose to participate in the study had to self-identify not only as transracially adopted, but also as members of racial minority groups, introducing a self-selection bias. Arguably, individuals who identified more strongly with their racial groups and heritages or with their adoptive statuses were more inclined to participate and impacted the internal validity of the

study (i.e., creating a more homogeneous, potentially biased sample) as well as the generalizability of study findings to transracially adopted adults in general. A similar issue emerges with regard to the use of online recruitment, which has been shown to bias sampling on a variety of social and psychological factors, including socioeconomic status, education levels, and race, in prior research (e.g., Gosling, Vazire, Srivastava, & John, 2004; Kraut et al., 2004).

A final validity concern relates to the confounding of variables. Evidence suggests that individuals may be more likely to identify incidents of racial discrimination as such to the extent that they possess knowledge and awareness of discrimination and identify as a member of a marginalized group. Accordingly, responses to the GED, for which participants indicated the frequency of their racial discrimination experiences, may in reality have measured, at least to some degree, how much participants knew about and could recognize racial discrimination in their lives. In addition, the survey used in this study asked participants to respond retrospectively (e.g., assessed socialization during upbringing, discrimination experiences). Researchers investigating discrimination and mental health outcomes have raised concerns about the accuracy of retrospective recall of discrimination experiences (Williams et al., 2003).

Related to methodological approach, the creation of groups for the multigroup comparison required the dichotomization of a continuous variable (i.e., racial socialization). In particular, the use of a median split eliminated the range of racial socialization scores for participants, which could provide additional information about how racial socialization relates to other study variables. Data was also collected at one time point and was descriptive, limiting conclusions that can be drawn from study findings. While causation

cannot be determined, study results do offer preliminary evidence of relationships between study variables deserving of further research. Of note, there were three effects that approached but did not reach significance at the .05 level (i.e., the negative direct path from discrimination to distress [$p = .055$] for the high socialization group; the indirect relation of discrimination and distress through racial identity for the high socialization group [$p = .051$]; the negative direct path from discrimination to well-being for the low socialization group [$p = .061$]). It is unknown if these paths would have reached significance if a larger sample had been used. These relations may provide avenues to consider in future research.

Implications and Future Directions

This study has several implications for future research and clinical practice. Addressing the limitations, it would be worthwhile in future research to test the mediation model for different racial groups. It would also be useful to gather information about socialization and discrimination experiences of transracially adopted adults through means other than self-report. For example, collecting data from both adopted adults and their parents would enable comparisons between perceptions of socialization for parents and adopted persons themselves. This information could be used to guide the development of programs and interventions. Because transracial adoptive parents may underestimate racial discrimination experienced by their transracially adopted children (Feigelman, 2000), they may also overreport their socialization practices or misperceive the effectiveness of their socialization strategies.

Longitudinal and clinical research could extend the findings of this research. For instance, collecting data from transracially adopted persons across the lifespan would enable a more comprehensive understanding of how early experiences of socialization shape racial

identity and subsequent abilities to manage discrimination, enhancing overall mental health and functioning. Clinical research might also explore the impact of parental education programs focused on socialization on the mental health and racial identity development of transracial adopted individuals, both immediately following implementation and as adopted youth develop into adults. Such research would be able to further clarify how racial socialization influences mental health outcomes among transracially adopted adults and could provide evidence of directionality and causal relationships amongst variables.

Considering the strong association between discrimination and distress found in this study; and the lack of consistency in establishing racial identity as a mediator of that relation, future research should consider alternative intervening variables that may better explain the mechanisms through which discrimination impacts psychological distress. Coping, which has been frequently linked in the literature to both discrimination and mental health, might further explain some of the variation in mental health relations across socialization groups (Brondolo et al., 2009). The inclusion of coping would serve to strengthen any replication or extension study by investigating additional variables at work within the discrimination-mental health paradigm examined, and partially supported, in this study.

Present results imply that socialization practices during transracially adopted youths' upbringing are important and influence how they interpret and manage discrimination experiences in adulthood. Transracial adoptive White mothers have reported increased involvement with cultural rather than race-specific socialization practices (e.g., exposure to same-race individuals; Vonk et al., 2010); however, study findings reiterate the importance of preparing transracially adopted children specifically for racial discrimination that they will likely experience during adulthood. Thus, prevention and early intervention are key to

clinical approaches within the transracially adopted community. Working with adopted children, adolescents, or adoptive families, clinicians can be instrumental in providing psychoeducation to parents, or youths themselves, about racial socialization and how it may influence the mental health of their children. In accordance with study findings, clinicians may remind parents that as much as preparation for discrimination can buffer the effects of racial discrimination, it can also introduce a level of awareness of discrimination that may impact overall well-being. Part of the therapeutic experience for both parents and adopted persons may be exploring negative feelings that are associated with knowledge and awareness of discrimination.

This study highlights the need for increased sensitivity among mental health providers delivering services to transracially adopted adults, as there are a variety of factors influencing their construction of identity and mental health. Based on study results showing a consistent association between discrimination and distress in all models, providers might consider exploring themes of discrimination and racial identity in conjunction with adoption-related issues that may surface in the context of counseling (e.g., loss, search; Baden & Steward, 2007). Clinicians may also wish to gather information about the socialization practices within adopted persons' homes growing up to better understand how transracially adopted clients interpret and process discrimination experiences. Clinicians can provide adopted clients with validation and support around potential inadequacies related to race they may have experienced.

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Table 1.
Intercorrelations and Descriptive Statistics for Study Variables of Interest (N = 206)

Variable	1	2	3	4	5
1. Racial Discrimination	1.00				
2. Racial Identity	.28***	1.00			
3. Psychological Distress	.31***	.01	1.00		
4. Psychological Well-being	-.18*	.09	-.53***	1.00	
5. Racial Socialization	.05	.05	-.09	.18**	1.00
<i>M</i>	1.78	4.38	3.76	4.73	2.74
<i>SD</i>	0.64	1.23	1.72	1.54	1.42
<i>α</i>	.93	.82	.93	.91	.96

* $p < .05$ ** $p < .01$ *** $p < .001$

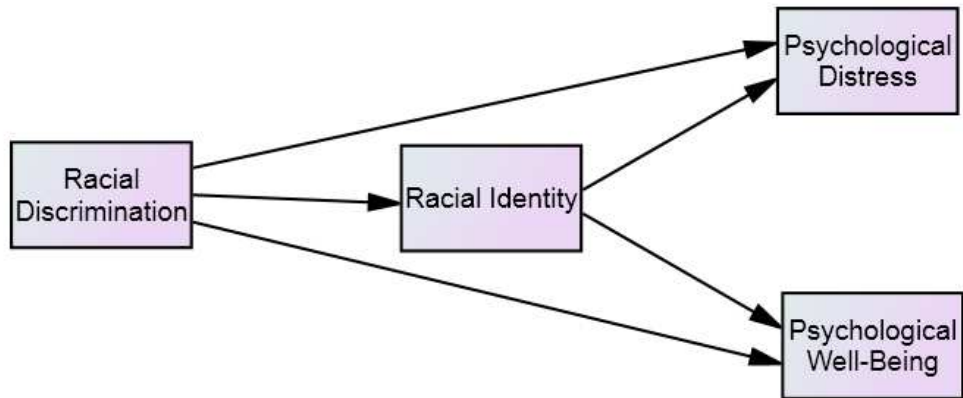
Table 2.
Comparison of Standardized Regression Weights, 95% Confidence Intervals, and R² for Study Models

Path	Model			
	Initial	Multigroup Comparison		
	(N = 206)	High (n = 106)	Low (n = 100)	Constrained to be Equal (N = 206)
<i>Direct</i>				
RD → PD	.34***	.22*	.46***	.33***
RD → WB	-.22**	-.26**	-.19	-.23***
RD → RI	.28***	.27**	.29**	.26***
RI → PD	-.08	-.19	-.01	-.09
RI → WB	.15*	.28**	.05	.17*
<i>Indirect</i>				
RD → RI → PD	-.06, .01	-.10, .00	-.06, .19	-.06, .01
RD → RI → WB	.01, .23*	.03, .39*	-.12, .19	.01, .23*
<i>R²</i>				
RI	7.5%	7.1%	8.1%	8.4%
PD	10.4%	6.3%	20.6%	10.5%
WB	5.1%	10.6%	3.4%	6.4%

Note. RD = Racial discrimination; RI = Racial Identity; PD = Psychological Distress; WB = Psychological Well-Being.

* $p < .05$ ** $p < .01$ *** $p < .001$

Figure 1. *Proposed moderated mediation model.*



Note. All variables are observed variables. The model includes direct paths between racial discrimination and mental health outcomes as well as indirect paths through racial identity. The model was examined for high and low socialization groups in order to test a moderated mediation effect.

Appendix A

Sample Recruitment Email:

Hello, my name is Candice Presseau and I am a graduate student at Lehigh University. I am currently completing my doctoral dissertation research study under the supervision of my advisor, Dr. Cirleen DeBlaere, and am interested in investigating the life experiences and well-being of transracially adopted persons, a group that has been severely underrepresented in the psychological literature to date. I am collecting data for this study using an online survey. If you feel it is appropriate, I would very much appreciate your cooperation forwarding the following study advertisement to your organization's listserv and/or individuals you know that might be interested in participating. Thank you very much in advance for your thoughtful consideration of our request.

Sincerely Yours,
Candice Presseau

Study Advertisement:

Hello! My name is Candice Presseau, and I am graduate student in the College of Education at Lehigh University. I am currently completing my doctoral dissertation research study under the supervision of my advisor, Dr. Cirleen DeBlaere, and am interested in studying the life experiences and well-being of racial minority individuals who have been transracially adopted by White parents or a White single parent. It is our hope that with this study, we can contribute to the understanding of the experiences of adopted persons raised by parents with different racial backgrounds and experiences from their own. Your participation is essential to achieving this goal, so we hope that you will take part in our study.

In order to participate, you must identify as a member of racial minority group, have been transracially adopted by White parents or single White parent, currently live in North America, and be 18 years of age or older. If you would like to participate in our study, please click on the link below and you will be directed to the online survey:

<https://www.surveymonkey.com/TBD>

Thank you very much in advance for your time! Please feel free to pass on this link to other people who might be eligible. If you have any question about this study, please feel free to contact me at cdp309@lehigh.edu. This research has been approved by the Lehigh University Institutional Review Board (IRB# *****).

Sincerely,
Candice Presseau, M.A.

Appendix B

Informed Consent

Dear Participant,

We are conducting a study on the experiences and perspectives of individuals who were transracially adopted by White parents. With this study, we hope to gain a better understanding of the experiences of adopted persons within their families, homes, and communities. We are also interested in knowing more about how adoptees identify themselves. Participation in our study will involve completing a survey that will take approximately 20-30 minutes of your time. You have been invited to participate because you are affiliated with an organization or individual that has some relation to the field of adoption. In order to participate, you must be 18 years of age or older. Your participation in the study is entirely voluntary and should you choose to discontinue participation, you may exit the survey at any time without consequence.

No data will identify you individually. Responses will be reported in the form of group averages that include data from the other participants; therefore all responses will be anonymous and confidential. If you do choose to participate, completion and submission of the online survey indicates your consent to the above conditions. You may choose to exit the survey at any time. There is no compensation or direct benefit to you for participating in this study. However, your participation will help us better understand the concepts that are important to adoption and transracial adoption communities and will have implications for service availability and delivery. The study represents my doctoral dissertation research, which is being conducted under the supervision of my advisor, Dr. Cirleen DeBlaere. If you have any questions about this research and what is expected of you in this study, you may contact myself (cdp309@lehigh.edu) or Dr. Cirleen DeBlaere (cid209@lehigh.edu).

You may report problems that may result from participation or direct questions in regard to your rights as a participant in this study to the Office of Research and Sponsored Programs, Lehigh University, 610-758-3021 or email inors@lehigh.edu. All reports or correspondence will be kept confidential.

Thank you,

Candice Presseau, M.A.

Dr. Cirleen DeBlaere, Ph.D.

Lehigh University

Appendix C

Demographic Questionnaire

1. Do you identify yourself as an adopted person?
 - Yes
 - No
2. Based strictly on physical appearance and characteristics, with which racial group to you identify?

Black or African American
Hispanic or Latino
Asian or Pacific Islander
American Indian/Native American
Biracial or Multiracial *Please indicate which races
Caucasian, White, Non-Hispanic
Other, please specify
I do not identify with a racial group

3. With which of the following ethnic groups do you most strongly identify?

Black or African American
Hispanic or Latino
Asian or Pacific Islander
American Indian/Native American
Biethnic or Multiethnic: *Please indicate which ethnicities
Caucasian, White, Non-Hispanic
Other, please specify
I do not identify with an ethnic group

4. What is the race of your birth mother?

Black or African American
Hispanic or Latino
Asian or Pacific Islander
American Indian/Native American
Biracial or Multiracial
*Please indicate which races
Caucasian, White, Non-Hispanic
Other, please specify
I don't know

5. What is the race of your birth father?

Black or African American
Hispanic or Latino
Asian or Pacific Islander
American Indian/Native American
Biracial or Multiracial
*Please indicate which races
Caucasian, White, Non-Hispanic
Other, please specify
I don't know

6. What is the ethnicity of your birth mother? _____

7. What is the ethnicity of your birth father? _____

8. Was your adoption international or domestic?
- International
 - If international, what country were you adopted from?
 - Domestic
9. By how many parents were you raised?
- 1
 - 2
 - 3 or more
10. Please indicate the number of parents belonging to each of the following racial groups in your home growing up?

Black or African American	
Hispanic or Latino	
Asian or Pacific Islander	
American Indian/Native American	
Unknown or Multiracial	
Caucasian/White, Non-Hispanic	

11. Are you of the same race as any of the parents that lived in your home growing up?
- Yes
 - No
12. Were any of the parents in your home growing up from a racial minority group?
- Yes
 - If yes, please indicate which group:
 - No
13. How would you describe the racial composition of your neighborhood growing up (i.e., childhood and adolescence)?
- Not at all diverse
 - Somewhat diverse
 - Diverse
 - Moderately diverse
 - Extremely diverse

14. Please indicate the percentage of individuals from different racial groups represented in your neighborhood growing up. The total should add up to 100.

Black or African American	
Hispanic or Latino	
Asian or Pacific Islander	
American Indian/Native American	
Unknown or Multiracial	
Caucasian/White, Non-Hispanic	

15. In what type of neighborhood did you grow up?

- Suburban
- Urban
- Rural
- Other: _____

16. How would you describe the racial composition of your high school?

- Not at all diverse
- Somewhat diverse
- Diverse
- Moderately diverse
- Extremely diverse

17. Please indicate the percentage of individuals from different racial groups represented in your high school. The total should add up to 100.

Black or African American	
Hispanic or Latino	
Asian or Pacific Islander	
American Indian/Native American	
Unknown or Multiracial	
Caucasian/White, Non-Hispanic	

18. In what type of neighborhood did you attend high school?

- Suburban
- Urban
- Rural
- Other: _____

19. How would you describe the racial composition of your current neighborhood?

- Not at all diverse
- Somewhat diverse
- Diverse
- Moderately diverse
- Extremely diverse

20. Please indicate the percentage of individuals from different racial groups represented in your current neighborhood. The total should add up to 100.

Black or African American	
Hispanic or Latino	
Asian or Pacific Islander	
American Indian/Native American	
Unknown or Multiracial	
Caucasian/White, Non-Hispanic	

21. In what type of neighborhood do you currently live?

- Suburban
- Urban
- Rural
- Other: _____

22. What is your gender?

- Man
- Woman
- Trans-man
- Trans-woman
- Other (please specify): _____

23. What is your sexual orientation?

- Exclusively lesbian/gay
- Mostly lesbian/gay
- Bisexual

- Mostly heterosexual
- Exclusively heterosexual
- Asexual
- Other (please specify): _____

24. What is your primary adoptive parent's gender?

- Man
- Woman
- Trans-man
- Trans-woman
- Other (please specify): _____

25. What is primary adoptive parent's sexual orientation?

- Exclusively lesbian/gay
- Mostly lesbian/gay
- Bisexual
- Mostly heterosexual
- Exclusively heterosexual
- Asexual
- Other (please specify): _____

26. What is your secondary adoptive parent's gender? If applicable.

- Man
- Woman
- Trans-man
- Trans-woman
- Other (please specify): _____

27. What is secondary adoptive parent's sexual orientation?

- Exclusively lesbian/gay
- Mostly lesbian/gay
- Bisexual
- Mostly heterosexual
- Exclusively heterosexual
- Asexual
- Other (please specify): _____

28. What is the marital status of your adoptive parents? If you only have one adoptive parent, please indicate the marital status of your one adoptive parent.

- Married
- Divorced
- Single
- Widowed
- Civil Union
- I don't know

29. Was your adoption legal or emotional (e.g., grandparent, stepparent, aunt/uncle “adopted” you but it was not made legal)?
- Legal
 - Emotional
 - If emotional: please explain the circumstances of the adoption to the degree that you are comfortable
30. At what age were you adopted? _____
31. Was your adoption open or closed?
- Open
 - Please explain the nature of the current contact with your birth family or relatives:
 - How many and what members of your birth family are you in contact with?
 - What is the frequency of your contact with your birth family?
 - At what age did you begin contact with each of the members of your birth family whom you have contact with?
 - Please provide any additional information about your relationship with birth family members that you think is important to share.
 - Closed
32. What is your current age? _____
33. How would you categorize your religious beliefs?
- Buddhist
 - Christian
 - Hindu
 - Jewish
 - Muslim
 - Agnostic
 - Atheist
 - Spiritual, but not religious
 - I do not affiliate myself with a religion
 - Other (please specify): _____
34. What is the highest professional degree you have completed (please select the one best descriptor)?
- Elementary School
 - Middle/Junior High School
 - High School
 - Some College/Technical School
 - College
 - Some Professional/Graduate School
 - Professional/Graduate School

35. What is your social class?
- Lower class
 - Working class
 - Middle class
 - Upper middle class
 - Upper class
36. What was the social class of adoptive family?
- Lower class
 - Working class
 - Middle class
 - Upper middle class
 - Upper class
37. What was the social class of birth family?
- Lower class
 - Working class
 - Middle class
 - Upper middle class
 - Upper class
 - I don't know
38. What is was your approximate annual household income last year (select one)?
- \$0-15,000
 - \$15,000-20,000
 - \$20,000-30,000
 - \$30,000-40,000
 - \$40,000-50,000
 - \$50,000-60,000
 - \$60,000-70,000
 - \$70,000-80,000
 - greater than \$80,000
39. In what region of the U.S. was your home growing up?
- Northeast
 - Southeast
 - Midwest
 - Northwest
 - Southwest
 - Multiple regions
40. In what region of the U.S. do you currently reside?
- Northeast

- Southeast
- Midwest
- Northwest
- Southwest
- I do not live in the U.S.

Appendix D

The General Ethnic Discrimination Scale-Recent-Modified

We are interested in your experiences with racism. As you answer the questions below, please think *the past year*. For each question, please circle the number that best captures the things that have happened to you.

Never	Once in a while	Sometimes	A lot	Most of the time	Almost all of the time
1	2	3	4	5	7

1. How often in the past year have you been treated unfairly by teachers and professors because of your race?
2. How often in the past year have you been treated unfairly by your employers, bosses, and supervisors because of your race?
3. How often in the past year have you been treated unfairly by your co-workers, fellow students, and colleagues because of your race?
4. How often in the past year have you been treated unfairly by people in service jobs (by store clerks, bartenders, bank tellers and others because of your race?
5. How often in the past year have you been treated unfairly by strangers because of your race?
6. How often in the past year have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers, and others) because of your race?
7. How often in the past year have you been treated unfairly by neighbors because of your race?
8. How often in the past year have you been treated unfairly by institutions (schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office, and others) because of your race?
9. How often in the past year have you been treated unfairly by people you thought were your friends because of your race?
10. How often in the past year have you been accused or suspected of doing something wrong (such as stealing, cheating, not doing your share of the work, or breaking the law) because of your race?
11. How often in the past year have people misunderstood your intentions and motives because of your race?

12. How often in the past year did you want to tell someone off for being racist towards you but didn't say anything?

13. How often in the past year have you been really angry about something racist that was done to you?

14. How often in the past year have you been forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some racist thing that was done to you?

15. How often in the past year have you been called a racist name?

16. How often in the past year have you gotten into an argument or a fight about something racist that was done to you or done to another member of your race?

17. How often in the past year have you been made fun of, picked on, shoved, hit, or threatened with harm because of your race?

The same as now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally Different
1	2	3	4	5	6

18. How different would your life be now if you HAD NOT BEEN treated in a racist and unfair way in the past year?

Appendix E

Ethnic and Racial Socialization of Transracial Adoptee Scale (ERSTAS): Racial Socialization Subscale

Think about the cultural activities your adoptive parents are providing to you or had provided while you were growing up. For each item below, please *rate how important you think each development activity is to your parent*. For example, if your parents felt that “learning the history of the people of your birth culture” is (or was) *very important*, you would choose “4” on the 1 to 5 scale. Please rate each item.

Not at all important	Slightly important	Moderately important	Very much important	Extremely important
1	2	3	4	5

1. Educating me about the realities of prejudice, racism, and discrimination
2. Teaching me a variety of coping strategies from which to choose when faced with prejudice or bias
3. *Please select the response associated with “not at all important.”* (Validity check)
4. Learning about racial differences
5. Teaching what to do when a non family member uses racist language
6. Talking about race and racism openly within the family
7. To be proud of my skin color

Appendix F

Multidimensional Inventory of Black Identity: Modified Version
Racial Centrality Subscale

As you read the following statements, please insert the name of your racial group in place of _____ in the text. Please rate your level of agreement with the following items using the scale provided.

Strongly Disagree	Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

1. Overall, being _____ has very little to do with how I feel about myself.
2. In general, being _____ is an important part of my self-image.
3. My destiny is tied to the destiny of other _____ people.
4. Being _____ is unimportant to my sense of what kind of person I am.
5. I have a strong sense of belonging to _____ people.
6. *Please select the response associated with "strongly disagree."* (Validity check)
7. I have a strong attachment to other _____ people.
7. Being _____ is an important reflection of who I am.
8. Being _____ is not a major factor in my social relationships.

Appendix G

Hopkins Symptom Checklist-21

How have you felt during the past seven days including today? Use the following scale to describe how distressing you have found these things over this time.

Not at all

A little

Quite a bit

Extremely

1. Difficulty in speaking when you are excited.
2. Trouble remembering things.
3. Worried about sloppiness or carelessness.
4. Blaming yourself for things.
5. Pains in the lower part of your back.
6. Feeling lonely.
7. Feeling blue.
8. Your feelings being easily hurt.
9. Feeling others do not understand you or are unsympathetic.
10. Feeling that people are unfriendly or dislike you.
11. Having to do things very slowly in order to be sure you are doing them right.
12. Feeling inferior to others.
13. Soreness of your muscles.
14. *Please select the response associated with "extremely."* (Validity check)
15. Having to check and double-check what you do.
16. Hot or cold spells.
17. Your mind going blank.
18. Numbness or tingling in parts of your body.
19. A lump in your throat.
20. Trouble concentrating.
21. Weakness in parts of your body.
22. Heavy feelings in your arms and legs.

Appendix H

The Satisfaction with Life Scale

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

Strongly Disagree	Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

1. In most ways my life is close to my ideal.
2. The conditions of my life are excellent.
3. I am satisfied with life.
4. *Please select the response associated with "agree."* (Validity check)
5. So far I have gotten the important things I want in life.
6. If I could live my life over, I would change almost nothing.

Appendix I

Debriefing Form

Thank you for participating in my dissertation study. The goal of this study is to learn more about the experiences, attitudes, and feelings of transracially adopted persons. Specifically, we are interested in better understanding transracially adopted individuals' experiences of race both within their families and in society. In addition, we are interested in identifying how experiences within families and in society influence perceptions of self and current functioning.

We urge you to not reveal the purpose of this study to others because if they choose to participate, then their responses might be biased and would invalidate the study. However, please feel free to encourage other transracially adopted persons to participate.

As a reminder, you may contact Candice Presseau, M.A. cdp309@lehigh.edu or at 401-450-1543 with additional questions or concerns about this study or my advisor, Dr. Cirleen DeBlaere (cid209@lehigh.edu). You may also report problems that may result from participation or direct questions in regard to your rights as a subject in this study to the Office of Research and Sponsored Programs, Lehigh University, 610-758-3021 or email inors@lehigh.edu. All reports or correspondence will be kept confidential.

Again, we greatly appreciate your participation.

Candice Presseau, M.A.

Candice Presseau, M.A.
Curriculum Vitae
College of Education
Lehigh University
Iacocca Hall, 111 Research Drive
Bethlehem, PA 18015
Cdp309@lehigh.edu

EDUCATION

- 2009 - present Ph.D., Counseling Psychology
Lehigh University
Bethlehem, PA
- 2008 - 2010 M.A., Quantitative Methods in the Social Sciences
Columbia University
New York, NY
- 2006 - 2008 M.A., Counseling Psychology
Boston College
Chestnut Hill, MA
- 2002 - 2006 B.A., Psychology
Providence College
Providence, RI

CLINICAL EXPERIENCE

July 2014 - present

Practicum Trainee

Providence VA Medical Center PTSD Clinic, Providence, RI

- Provide individual therapy services to Veterans presenting with trauma-related disorders, including comorbid PTSD and substance use disorders
- Employ evidence-based psychotherapy for PTSD (i.e., Cognitive Processing Therapy)
- Engage in weekly consultation for certification in Cognitive Processing Therapy
- Routinely conduct CAPS and SCID assessments within Research Service
- Completed comprehensive assessments to determine the mental health functioning and needs of recently deployed Veterans during Post-Deployment Health Reassessment
- Supervisors: Christy Capone, Ph.D.; Tracie Shea, Ph.D.

June 2013 - August 2013

Psychology Extern

VA Connecticut Healthcare System, Substance Abuse Day Program/Outpatient Substance Abuse Clinic, West Haven, CT

- Provided therapeutic services for diverse Veterans with substance use disorders in the intensive outpatient and outpatient programs
- Facilitated psychoeducation groups, coping skills groups, and process groups within the Substance Abuse Day Program
- Co-facilitated a weekly CBT group in the Outpatient Substance Abuse Clinic
- Supervisors: David Pilkey, Ph.D.; Sarah Meshberg-Cohen, Ph.D.

August 2012 - May 2013

Testing & Assessment Track Extern

Friends Hospital, Philadelphia, PA

- Assessed Veterans to provide diagnostic clarification for complex cases.
- Functioned as a member of a multidisciplinary team and presented integrated psychological reports in response to referrals throughout the hospital
- Provided individual psychotherapy for clients in crisis and employed motivational interviewing and problem-solving interventions
- Conducted group psychotherapy focusing on cognitive-behavioral skills (e.g., Seeking Safety, CBT)
- Supervisors: Catherine Barber, Ph.D.; Dawn DeBrocco, Psy.D.; Donna Toro, Psy.D.

June 2012 - June 2013

Mental Health & Substance Use Therapist

Step By Step, Inc., Allentown, PA

- Provided individual psychotherapy for low-income adults diagnosed with co-occurring mental health and substance use disorders in a community mental health setting
- Applied a range of cognitive-behavioral and humanistic interventions to best meet the needs of each client
- Engaged in collaborative treatment planning to improve sobriety maintenance, including self-monitoring of substance use as well as urine drug screening
- Completed biopsychosocial assessments regarding mental health and substance use
- Supervisors: Charles Dauerty, M.A.; Timothy Silvestri, Ph.D.

August 2011 - May 2012

Clinical Practicum Trainee

Lafayette College Counseling Center, Easton, PA

- Provided individual counseling services to college students presenting with a range of mental health problems, including adjustment challenges, mood disorders, anxiety disorders, and eating pathology
- Assisted with outreach programming to increase the accessibility of services for college students struggling with mental health difficulties
- Conducted psychosocial assessments for clients new to treatment
- Presented complex cases to clinical staff
- Supervisors: Karen Forbes, Ph.D.; Timothy Silvestri, Ph.D.

February 2010 - May 2011

Clinical Practicum Trainee/Outpatient Psychotherapist

Pinebrook Family Services, Allentown/Easton, PA

- Provided mental health services to diverse, low-income youth and families presenting with a range of difficulties related to adolescent psychosocial functioning
- Engaged in collaborative treatment planning with adolescents and their families
- Delivered individual psychotherapy to children and adolescents presenting with mood, anxiety, substance use, and trauma symptoms
- Provided family psychotherapy to address difficulties related to family systems functioning
- Facilitated referrals for resources in the community
- Supervisor: Jeffrey Kindler, Ph.D.

July 2007 - August 2008

Clinical Practicum Trainee/Fee-For-Service Clinician

Center For Family Connections (CFFC), Cambridge, MA

- Provided individual psychotherapy to diverse youth, families, and couples
- Developed a short-term group psychotherapy for adopted youth experiencing difficulties with family adjustment and mental health
- Provided consultation services for clients presenting with familial concerns
- Conducted comprehensive multisystemic intake assessments for clients new to treatment
 - Provided administrative support for monthly and annual agency trainings
 - Supervisors: Judy Hu, LMHC; Joyce Maguire Pavao, Ed.D.

SUPERVISION EXPERIENCE

June 2012 - June 2013

Clinical Practicum Supervisor

Step By Step, Inc., Allentown, PA

- Supervised clinical trainees in all aspects of training including provision of psychotherapy services, professional development, and case management
- Provided individual and group supervision on a weekly basis
- Presented clinically relevant topical seminars on a weekly basis
- Reviewed and offered feedback on audio recordings submitted by supervisees
- Submitted formal evaluations of trainees' clinical and professional development
- Received supervision of supervision
- Recruited, interviewed, and hired prospective trainees
- Supervisors: Charles Dauerty, M.A.; Timothy Silverstri, Ph.D.

August 2011 - May 2012

Clinical Practicum Supervisor

Lehigh University, Bethlehem, PA

- Supervised clinical trainees engaged in first practicum experiences
- Provided individual weekly individual supervision for five supervisees (i.e., three international, two local students)
- Co-facilitated group supervision for four trainees
- Received supervision of supervision
- Supervisor: Arpana Inman, Ph.D.

RESEARCH EXPERIENCE

June 2014 - present

Treatment Research Coordinator (Health Science Specialist)

Providence VA Medical Center, Providence, RI

Project: Treatment of Trauma-Related Anger in OEF/OIF/OND Veterans, Funded by VA Rehabilitation Research and Development Service

- Coordinate recruitment, participant assessments, and participant treatment
- Deliver study interventions: Cognitive Behavioral Therapy for Anger and Supportive Therapy for Anger
- Conduct comprehensive baseline assessments to determine participant eligibility using structured diagnostic interviews (e.g., CAPS-V; SCID-I, SCID-II)

- Manage study functions, including selecting and adapting measures, corresponding with the PVAMC IRB, and troubleshooting problems with study protocol
- Supervisor: Tracie Shea, Ph.D.

Project: Pilot Testing the Efficacy of Exercise and Health Interventions for Veterans with PTSD, Funded by VA Rehabilitation Research and Development Service

- Conduct post-treatment diagnostic assessments
- Participate in a multidisciplinary team to address study-related issues
- Contributed to the design of participant handouts and manuals
- Code audio-recorded diagnostic interviews to establish inter-rater reliability of measures utilized
- Supervisor: Tracie Shea, Ph.D.

December 2013 - present

Study Assessor

Providence VA Medical Center, Providence, RI

Project: Group CBT for Chronic PTSD: Randomized Clinical Trial with Veterans

- Conduct study - post-treatment diagnostic assessments
- Administer structured diagnostic interviews i.e., CAPS-V, SCID-I) and psychosocial questionnaires
- Supervisor: William Unger, Ph.D.

June 2013 - June 2014

Project Coordinator

Brown University Center for Alcohol and Addictions Studies/Providence VA Medical Center Providence, RI

Project: Project SUPPORT (Substance Use and PTSD Program for OEF/OIF/OND Returning Veterans Treatment), Funded by NIDA Grant 5R01DA030102-03, “Integrated CBT For Co-Occurring PTSD And Substance Use Disorders”

- Coordinated study activities, including recruitment, participant assessments, participant treatment, and research team meetings
- Managed database and conducted preliminary data analyses
- Trained on study protocol, Integrated Cognitive Behavioral Therapy (ICBT) for the treatment of co-occurring substance abuse/dependence and Posttraumatic Stress Disorder
- Conducted baseline assessments (e.g., CAPS-IV) to determine participant eligibility
- Assisted with dissemination of findings
- Supervisor: Christy Capone, Ph.D.

July 2012 - present

Student Reviewer, Student Advisory Board

Psychology of Women Quarterly

- Provide detailed peer reviews of articles as requested

February 2013 - June 2013

Research Assistant, Quantitative Team

Lehigh University, Bethlehem, PA

State University of New York at Albany, Albany, New York

Project: Meta-Analysis of Supervision-Related Studies

- Reviewed selected articles

- Implemented coding procedures to determine study quality and statistical rigor
- Supervisor: Michael V. Ellis, Ph.D.

August 2010 - August 2012

Graduate Assistant, Office of Institutional Research

Lehigh University, Bethlehem, PA

- Responded to requests from the Vice Provost of Institutional Research for data analyses, summary reports, and literature reviews
- Developed and provided feedback on survey items and questionnaires
- Managed databases and presented findings to institution
- Supervisor: J. Gary Lutz, Ph.D.

July 2010 - December 2011

Research Assistant

Lehigh University, Bethlehem, PA

Project: Lesbian and Bisexual Women of Color; LGB Latino/Latina Men and Women

- Created and maintained study database
- Assisted with the recruitment of participants from organizations, listservs, and online forums
- Collaborated on a manuscript submitted for publication
- Supervisor: Cirleen DeBlaere, Ph.D.

October 2008 - August 2009

Research Associate

Healthcare Innovation and Technology (HIT) Lab, New York, NY

- Prepared articles for submission to peer-reviewed journals
- Assisted with grant proposal development and submission
- Conducted literature reviews
- Supervisor: Stan Kachnowski, MPH

February 2007 - April 2010

Co-Investigator

Boston College, Chestnut Hill, MA

Project: Entering “The Real World”: An Empirical Investigation of the Post-College Transition

- Developed and executed an online research study of college student well-being following graduation
- Maintained database, analyzed results, and presented findings to research team
- Supervisor: David L. Blustein, Ph.D.

PEER-REVIEWED PUBLICATIONS

1. DeBlaere, C., Brewster, M. E., Bertsch, K. N., DeCarlo, A. L., Kegel, K. A., & Presseau, C. D. (2013). Multiple perceived discrimination experiences and psychological distress of sexual minority women of color: The moderating role of collective action. *Psychology of Women Quarterly*, 38, 20-32.
2. Edwards, A., Fitzpatrick, L., Augustine, S. Trzebucki, A. Cheng, S., Presseau, C., et al. (2009). Synchronous communication facilitates interruptive workflow for attending physicians and nurses in clinical settings. *International Journal of Medical Informatics*, 78, 629-637.

PRESENTATIONS

1. McGrath, A.C., Presseau, C., McLehman, B. M., McGovern, M., & Capone, C. (2014, June). A comparison of military veterans and civilians seeking treatment for substance use disorders and PTSD. Poster presented at the 37th Annual RSA Scientific Meeting and 17th Congress of ISBRA.
2. Presseau, C., Inman, A., DeBlaere, C., & Luu, L. (2013, August). Trainee multicultural competency and social justice advocacy attitudes and behaviors. Poster presented at the APA 2013 Convention: Honolulu, Hawaii.
3. Presseau, C., DeBlaere, C., & Luu, L. (2013, August). Racial discrimination and mental health for transracially adopted persons. Poster presented at the APA 2013 Convention: Honolulu, Hawaii.
4. Inman, A., Devdas, L, Heard, S., & Presseau, C. (2011, August). *Curriculum, practicum, and supervision: Salient features of multicultural training*. Roundtable presentation at the Section for Supervision and Training at the APA 2011 Convention: Washington, D.C.
5. DeBlaere, C., Brewster, M., Kegel, K., Bertsch, K., DeCarlo, A., & Presseau, C. (January, 2011). *Multiple perceived discrimination experiences and psychological distress of sexual minority women of color: The moderating role of collective action*. In K. Anhalt & N. Nakamura (Chairs), Risk and resiliency among LGBT people of color: Linking science and practice. Symposium presented at the National Multicultural Conference and Summit, Seattle, WA.
6. Presseau, C., Heard, S., Ladany, N., & Ancis, J. (2010, October). *Means of interpersonal functioning in supervision: Improving preparedness for critical events*. Workshop presented at the 2010 Boston College Diversity Challenge: Chestnut Hill, Massachusetts.
7. Austin, A., Heard, S., Kegel, K., & Presseau, C. (2010, February). *Incorporating social justice into graduate school curricula*. Roundtable discussion presented at the 2010 Columbia University, Teachers College Roundtable: New York, New York.
8. Presseau, C., Gao, Q., Sayan, O, Augustine, S., Kachnowski, S., & Hollin, I. (2010, April). *Communication trends amongst hospital personnel: A multi-site methodology*. Presented at the 7th International Conference on E-Governance: Bangalore, India.
9. Pathak, S., Presseau, C., Rai, N., Hollin, I., Fox, R., & Kachnowski, S. (2010, April). *A Narrative Review: Information technology (IT) use for the management of chronic diseases*. Presented at the 7th International Conference on E-Governance: Bangalore, India.
10. Dembiski, M., Pathak, S., Chin, K., Presseau, C., Odeh-Ramadan, R., & Buck, S. (2010, April). *ROI Calculators: A tool to evaluate the economic impact of medication therapy management (MTM)*. Presented at the 7th International Conference on E-Governance: Bangalore, India.
11. Chin, K., Buck, S., Mahboub, M., Dembiski, M., Presseau, C., Odeh-Ramadan, R., et al. (2010, April). *What pharmacists can learn from a review of physician-patient e-mail exchange*. Presented at the 7th International Conference on E-Governance: Bangalore, India.
12. Dembiski, M., Chin, K., Presseau, C., Kachnowski, S., Odeh-Ramadan, R., Buck, S., & Mahboub, M. H., & Klepser, D. (2009, November). *Return on investment calculators: Development, considerations, and limitations*. Poster presented at American Public Health Association's (APHA) Annual Meeting: Philadelphia, PA.
13. Presseau, C. (2008, October). *Visual representations: The trauma of adoption and foster care*. Workshop presented at the 2008 Boston College Diversity Challenge, Chestnut Hill, Massachusetts.

14. Presseau, C., Tanner, S., Blustein, D. L., & Arnett, J. (2008, August). *Entering "The real world": An investigation of college graduate transitions*. Poster presented at the 2008 APA Convention: Boston, Massachusetts.

GRANTS

December 2011: Diversity Committee Equity and Community Initiative Grant (\$1,500)

October 2007: Boston College Graduate Student Association Grant (\$800)

August 2007: Boston College Graduate Student Association Grant (\$125)

CONSULTATION PROJECTS

March 2014 - present

Research Design and Statistical Consultant

Project: Case Management Intervention for High Risk/Vulnerable Elderly Population in a Family Medicine Center; Funded by Robert Wood Johnson Foundation, "Population Management of High Risk/Vulnerable Patients"

February 2014 - present

Research Design and Statistical Consultant

Project: The Impact of Implementing a Care Management Function for Patients with Depression in a Family Medicine Residency Practice; Funded by Robert Wood Johnson Foundation, "Population Management of High Risk/Vulnerable Patients"

November 2013 - present

Research Design and Statistical Consultant

Project: Practice Transformation/Milestones Among Family Medicine Residents, Faculty and Staff; Program Evaluation within the JFK Family Medicine Residency Program

TEACHING EXPERIENCE

January 2011 - May 2011

Teaching Assistant (Instructor: David Weiskotten, Ph.D.)

Lehigh University, Bethlehem, PA

- Provided written and verbal evaluative feedback to students as well as supervision for interactive tasks
- Contributed to and delivered lectures

PROFESSIONAL LEADERSHIP

2014-present Student Liaison, Division 18 Diversity Committee

2014-present Member, Division 18 Mentoring Committee

2014-present Campus Representative, APAGS Advocacy Coordinating Team

2011-2012 Student Representative, COE Graduate Student Council

2010-2012 Student Representative, Counseling Psychology Doctoral Program

HONORS, AWARDS, & DISTINCTIONS

2012 AWP Women of Color Psychologies Award (Co-Author)

2012 APA Division 35 Psychotherapy with Women Award for 2012

2008 Quantitative Methods in the Social Sciences Scholarship (\$5,000)

2005 Recipient of Full Support for APA's Advanced Statistical Training

2005 Elected Member: Psi Chi, Providence College

PROFESSIONAL MEMBERSHIP

American Psychological Association of Graduate Students

Society of Counseling Psychology, Division 17

Society for Public Service, Division 18

Society for the Psychology of Women, Division 35

Society for the Psychological Study of Ethnic Minority Issues, Division 45

Society of Addiction Psychology, Division 50

Division of Trauma Psychology, Division 56

PROFESSIONAL DEVELOPMENT – TRAINING AND WORKSHOPS

September 2014: *Cognitive Processing Therapy for PTSD Regional Training*. Providence VA Medical Center, Providence, RI.

July 2014: *SCID-I Training Seminar*. Butler Hospital, Providence, RI.

June 2014: *NIAAA Grantsmanship Workshop*. The 37th Annual RSA Scientific Meeting and 17th Congress of ISBRA, Bellevue, WA.

May 2014: Think Tank Group that developed ideas for *Struggling Together: Stakeholder Collaboration to Address the Internship Crisis*. Panel discussion held at the 122nd Annual Convention of the American Psychological Association, Washington, D.C.