

Inconsistency within Expressed and Observed Racial Identifications: Implications for Mental Health Status

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Abstract

The present study extends previous work on distress that arises from discrepancy *between* self and interviewer racial identifications. Using the National Longitudinal Study of Adolescent to Adult Health (Add Health) data, we examine mental health consequences of inconsistency over time *within* expressed (self) and observed (interviewer) racial identifications among American Indians. Given that phenotype signals race, we also contribute to prior research by examining whether skin color moderates inconsistency's mental health consequences. Analyses show that observed racial inconsistency increased American Indians' depressive symptoms and suicidal ideation. That is, when interviewers labeled a respondent "American Indian" at one wave of data but not another, there were deleterious implications for mental health status. In addition, an interaction between observed inconsistency and skin color demonstrated that observed inconsistency tended to be harmful when respondents were observed as having light skin. We argue observed inconsistency captures the distressing experience of being not readily classifiable.

Keywords

race, identity, mental health, racial identification, American Indian

Racial identifications (e.g., black, white, American Indian, Asian, multiracial, etc.) are labels signifying racial group membership and allow individuals to claim their own or categorize others' group membership (T. N. Brown 1999; Hogg and Abrams 1988; Thornton, Taylor, and Brown 2000). Racial identifications are often conceived of as fixed categories, and there is an assumed consistency when individuals classify their own and others' group membership. Indeed, research shows consistency is high when individuals classify blacks or whites (see Saperstein 2006), partly because phenotype signals racial group membership. However, other groups' racial identifications are far more complex. For example, Hispanics and American Indians have low rates of consistency across self- and other-reported racial identifications (e.g., Campbell and Troyer 2007; Wilkinson 2010), and approximately half of American Indians and Pacific Islanders chose a different racial identification in the 2010 U.S. Census than they did in the 2000 U.S.

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Census (Liebler et al. 2014). Regardless of whether they are *self-reported* or *interviewer-reported*, inconsistent racial identifications may signal cognitive dissonance or a disjointed identity standard, which can produce distress (Burke 1991; Campbell and Troyer 2007).

Building upon prior research (see Campbell and Troyer 2007, 2011; Cheng and Powell 2011), we examine inconsistent racial identifications among American Indian respondents in the National Longitudinal Study of Adolescent to Adult Health (Add Health). Prior research confirms negative mental health consequences due to inconsistency *between* expressed (i.e., self-reported) and observed (i.e., interviewer-reported) racial identifications. In the present study, we increment prior research by investigating mental health consequences of inconsistency *within* expressed and observed racial identifications. Given that phenotype signals race, we also contribute to prior research by examining whether skin color moderates inconsistency's mental health consequences. Analyses show that observed racial identification inconsistency increased American Indians' depressive symptoms and suicidal ideation. That is, when interviewers labeled a respondent "American Indian" at one wave of the data collection but not another, there were deleterious implications for the respondent. In addition, a statistical interaction between observed inconsistency and skin color demonstrated that observed inconsistency tended to be harmful when respondents were reported to have light skin.

In what follows, we invoke identity theory to situate the significance of racial identifications and suggest why skin color matters. Next, we discuss why inconsistent racial identifications may cause distress, especially among American Indians. Then, we provide more detail about our methods and measures before presenting the findings. Finally, we conclude by suggesting that racial group membership is salient for everyone, and confirmation of membership via observed racial identification is affirming.

Identities, Identifications, Inconsistency, and Skin Color

The Self and Identities

Viktor Gecas and Peter Burke (1995:42) define the self as ". . . composed of various identities, attitudes, beliefs, values, motives, and experiences, along with evaluative and affective components in terms of which individuals define themselves." Morris Rosenberg (1979) further argues that the self has three regions: (1) the *expectant self* represents how an individual sees herself, (2) the *desired self* represents how an individual would like to see herself, and (3) the *presenting self* is how an individual shows herself to others. Through ongoing negotiations among the expectant, desired, and presenting regions, the self is formed.

William Cross (1991) and David Demo and Michael Hughes (1990) argue that racial identities are a component of the self and are also comprised of multiple regions. For example, David R. Harris and Jeremiah Sim (2002) describe three regions of racial identities. First, what an individual believes about his or her own race is *internal racial identity*. Second, words and actions that convey beliefs about an individual's race are *expressed racial identities*. Finally, what an observer believes about an individual are *external racial identities*. It follows that dimensions of racial identities are interdependent (Harris and Sim 2002; Rosenberg 1979). This means people of color (and whites) often develop internal racial identities based upon external appraisals, and, in turn, one's own appraisals can affect others' appraisals (Gecas and Burke 1995). The idea that identities are situational and dynamic is well established in social psychology (e.g., Cooley 1902).

Racial Identifications

Expressing racial group membership or being labeled a member of a racial group could be the first step in racial identity development. We do not argue that racial identifications are equivalent

to the self or identity(ies), but rather that they shape how both are experienced and encoded. As such, racial identifications provide a *proxy* for survey researchers interested in racial identities.

Informed by Wendy Roth's (2010) typology of racial identifications, we consider a respondent's reply to a race question on a survey represents an *expressed racial identification*. Similarly, an interviewer's assessment of a respondent's race during a survey represents an *observed racial identification*. Considering their situational and dynamic nature (as with identities), racial identifications can be inconsistently self-reported and even inconsistently interviewer-reported (see Saperstein and Penner 2014). Relevant to the present study, we suspect that such *within reporter variation*, whether the reporter is self or interviewer/other, could signal failures in the environment to confirm the desired (*racial*) self.

Inconsistent Expressed and Observed Racial Identifications

Prior research has examined conflicts *between* expressed (self) and observed (interviewer/other) racial identifications (e.g., see Campbell and Troyer 2007; Roth 2010; Saperstein 2006; Vargas 2013; Veenstra 2011; Wilkinson 2010). We focus, however, on discrepancies *within* expressed and observed identifications. For example, using Add Health data, Harris and Sim (2002) found that 12 percent of adolescents provide inconsistent expressed racial identifications due to survey context (i.e., in-home vs. in-school interviews). They argued that having a family member present for an in-home interview affected adolescents' expressed racial identifications because it heightened salience of familial racial identifications (see also Liebler 2004).

Scholars have also studied changes in expressed racial identifications over time. Steven Hitlin, J. Scott Brown, and Glenn H. Elder (2006), also using Add Health data, found that 4 percent of adolescents reported inconsistent racial identifications over time and that multiracial youth were four times as likely to switch rather than self-identify consistently as multiracial. In addition, multiracial youth with high parental socioeconomic status and ambiguous phenotype (i.e., light skin) were more likely to experience inconsistency in expressed racial identifications (Doyle and Kao 2007; Hitlin et al. 2006). In a study using National Longitudinal Survey of Youth data, Aliya Saperstein and Andrew M. Penner (2012) examined changes in both expressed and observed racial identifications and found that 20 percent of respondents experienced some inconsistency over two decades. In a more recent study, Aliya Saperstein and Andrew M. Penner (2014) tracked both expressed and observed racial inconsistency in Add Health data to determine whether changes in racial identification over time resolved previously incongruent classifications. They found that incongruence between self and interviewer was not resolved through changing racial identifications over time; rather, more cases of discordance between self and interviewer were created over time than were resolved.

Inconsistent racial identifications among American Indians. American Indians have high rates of inconsistent expressed and observed racial identifications (Liebler 2004; Liebler et al. 2014). Using Add Health data, Simon Cheng and Brian Powell (2011:348) reported that 80 percent of the 436 self-identified American Indians at Wave 3 did not self-identify as American Indian at Wave 1. Furthermore, census enumerators routinely misclassified American Indians prior to 1960 (Snipp 1992), and research shows American Indians have gone through historical shifts that shaped how they identify with their racial group (Nagel 1995). In addition, Karl Eschbach (1993) found that 80 percent of American Indians were not identified as American Indians by their own parents (see Liebler 2004 analysis of *thin and thick ties* among American Indians for context to this surprising finding). Notably, comparing all racial groups, American Indians have the highest rates of expressed racial identification inconsistency over time (Doyle and Kao 2007; Harris and Sim 2002; Hitlin et al. 2006; Saperstein and Penner 2014). In fact, Mary Campbell and Lisa Troyer (2007) contend that American Indians are the exemplar case for

investigating inconsistency because of the groups' heterogeneity, history of forced assimilation, and ambiguous phenotype.

Skin color and inconsistent racial identifications. Given the significance of phenotype in signaling racial group membership, skin color should not be neglected as a correlate of racial identification. For instance, Roth (2010) further distinguishes the category of observed racial identification in her typology and contends that it can be (1) *appearance-based*, which is imputed by physical features such as skin color, and (2) *interaction-based*, which is imputed by characteristics signaled in interactions such as accent. Whereas interviewers can detect both appearance and interactions while administering a survey, skin color, a strong marker of appearance, is one indicator that is often recorded in surveys.

Research (Brebner et al. 2011; Saperstein 2012) confirms that skin color is important to how observers classify individuals. The *determinant features hypothesis* asserts that observers rely on certain physical features to distinguish between racial groups (Herman 2010). For instance, Terry D. Brown, Francis C. Dane, and Marcus D. Durham (1998) found that observers chose skin color as the most important characteristic when identifying a target's race. In a similar study, Melissa Herman (2010) found that observers racially classified individuals shown in photographs based primarily on targets' phenotypes. Also, in Herman's study, observers' own racial identifications did not predict inconsistency among targets' observed racial identifications.

Skin color is also important for expressed racial identification. For example, Kerry Ann Rockquemore and Patricia Arend (2003) found that skin color constrained multiracial individuals' ability to identify as white. Those with lighter skin opted for white whereas those with darker skin could not. Not only are individuals aware of their skin color, they are aware of how others perceive their skin color (see Veenstra 2011), which has implications for choice of racial identification.

Skin color and inconsistent racial identifications among American Indians. Skin color plays a role in American Indians' racial identifications. Hilary N. Weaver (2013) suggests that most people view American Indians as having ". . . medium brown skin; long, dark, straight hair; and dark eyes. The image might also include 'props' assumed to accompany an 'Indian' identity, such as horses, tepees, and—of course—feathers" (p. 287). Despite this monolithic depiction of American Indians, there is considerable skin color variation within the American Indian population (Nagel 1995; Vaughan 1982; Weaver 2013). Phenotypic divergence from an identity standard could produce racial inconsistency, especially among those with light skin because they are ambiguous (Doyle and Kao 2007). Let us say, for instance, there are two young adults who self-identify as American Indian, express this racial identification, and have select American Indian features (e.g., thick, dark, straight hair)—except that one has darker skin tone and the other has light skin tone. Both may choose an American Indian identification, but observers may be more likely to identify them as American Indian and white, respectively (see Cheng and Powell 2011). Taking this example further, the light skinned American Indian might recognize their ability to pass as white and change their own racial identification. In the next section, we connect identities, inconsistency, and skin color to derive hypotheses about American Indians' mental health status.

Racial Inconsistency, Skin Color, and American Indians' Mental Health Status

Although there is now ample evidence that racial inconsistency is common in some groups, psychological implications of inconsistency remain unclear. It is reasonable to hypothesize that inconsistent racial identifications would produce distress. Identity control theory suggests inconsistency

creates lack of control over the self (Burke 1991). The identity standard, or a set of meanings defining oneself, is constantly adjusted from input from the environment; that is, perceptions from others and one's own reflected appraisals (Burke 1991). According to Peter Burke (2006),

... error or discrepancy between the perceptions and the identity standard not only governs behavior, but also produces an emotional response. We feel distress when the discrepancy is large or increasing; we feel good when the discrepancy is small or decreasing. (p. 83)

Therefore, inconsistent racial identifications, representing discrepancy in identity standards and lack of control over the self, may have deleterious mental health implications.

In support of this notion, Campbell and Troyer (2007) addressed whether individuals who self-identify with one racial group, but are observed by interviewers as belonging to a different racial group—what they term *misclassification*—experience poor mental health status. Using Add Health data, they found that misclassified American Indians (58 percent) reported increased levels of suicidal ideation and attempts, and fatalism. However, Cheng and Powell (2011) identified several flaws in Campbell and Troyer's study. Of relevance here, Cheng and Powell demonstrated that most misclassified American Indians report inconsistent *expressed* identifications. That is, Cheng and Powell (2011) questioned whether misclassification was real because many American Indians inconsistently self-identify as such. We increment this line of research by examining the psychological consequences of inconsistency *within* expressed racial identifications. Moreover, we reason that inconsistency within expressed racial identification indicates lack of control over the self, which could, in turn, have negative mental health consequences. Thus, we hypothesize as follows:

Hypothesis 1: Inconsistency across Wave 1 and Wave 3 in *expressed* racial identifications as American Indian would predict increases in depressive symptoms, suicidal ideation, and use of psychological counseling.

Observed racial inconsistency could also predict poor mental health status. As noted, interviewer classification represents how the generalized other perceives the respondent (see Campbell and Troyer 2007; Herman 2010). For instance, Saperstein and Penner (2014) contend Add Health interviewers are representative of teachers, classmates, employers, and so on. These observers are privy to information about how the respondent looks and other racial cues (e.g., language, clothing style), all available in typical social interactions. Given variable dynamics of social interactions, observers' decisions about respondents' racial identifications could be inconsistent across observers or even over time. Furthermore, research has shown that individuals have a sense of how observers classify them (Campbell and Troyer 2011; Stepanikova 2010; Vargas 2013). Perceptions that vary across observers likewise influence the identity standard (Burke 1991, 2006). Inconsistency in observations may manifest an individual's failure to *signal* with sufficient strength, clarity, and consistency their desire to be perceived as a certain racial identification. Thus, we examine whether inconsistency *within* observed racial identifications matters for mental health status. Moreover, we argue discrepancy among racial identifications by observers could also result in distress and hypothesize as follows:

Hypothesis 2: Inconsistency across Wave 1 and Wave 3 in *observed* racial identifications as American Indian would predict increases in depressive symptoms, suicidal ideation, and use of psychological counseling.

Finally, we address whether skin color moderates inconsistency's mental health consequences. Although extant literature connects racial misclassification to mental health status and alternatively,

skin color to mental health status, no studies to date explore the interaction between racial identification inconsistency and skin color in predicting mental health status. For instance, Gerry Veenstra (2011) found that inconsistency between expressed and observed racial identifications (i.e., misclassification) predicted poor mental health *and* that dark skin predicted poor mental health. He did not, however, examine misclassification and skin color in the same model, or more important, skin color's potential moderating role.

Most literature that examines the relationship between skin color and mental health status reports findings consistent with Veenstra (2011): darker skin predicts poor mental health. Such findings are consistent with the concept of colorism, which defines skin color as a system of stratification with darker skin ranking the lowest. As a result, light skin is linked to higher economic status, preferences in dating, self-esteem, and mental health (see, for instance, Espino and Franz 2002; Hunter 2005, 2007; Russell, Wilson, and Hall 1992; Thompson and Keith 2001). However, within the racial identification literature, a colorism paradox emerges: light skin can be viewed as a disadvantage in terms of racial authenticity (Hunter 2007). Specifically, lighter skinned individuals are tasked with proving themselves to be an authentic member of a specific racial group.

Margaret Hunter (2005) illustrates the colorism paradox among Mexican Americans. On one hand, dark skin among Mexicans signals Indian or African ancestry and is therefore associated with low status. On the other hand, dark skin among Mexicans is taken for evidence of having some Indian or African ancestry, and is therefore associated with being authentically Mexican. In addition, Sara McDonough and David Brunnsma (2013:263) argue that, for multiracial individuals, "racial expectations are fundamentally tied to appearance." Moreover, if biracial individuals appear black but do not conform to expectations of what being black means, there might be negative repercussions for their experienced authenticity. Sara McDonough's (2005) interviews with biracial Americans revealed that disappointment and aggravation occurred when biracial individuals' authenticity was questioned. These processes are also at work among American Indians. Weaver (2013) agrees that light skin among American Indians can lead to preferential treatment, but refers to it as a double-edged sword. Moreover, Weaver (2013) argues that normative ideas about who is American Indian leads some people to discount authenticity of those whose appearance varies from expectations. She further argues discounted authenticity harms individuals' sense of self, especially when those individuals do not fit the American Indian identity standard. Thus, light skin would amplify potential deleterious mental health effects of both expressed and observed racial inconsistency. Here, we hypothesize as follows:

Hypothesis 3: The association between (expressed and observed) inconsistency and increased depressive symptoms, suicidal ideation, and use of psychological counseling would be more pronounced for American Indians with light skin color.

Method

Data

We analyzed Wave 1 and Wave 3 in-home interview data from Add Health. Add Health is a nationally representative sample of U.S. adolescents (Udry 1998, 2003). The first wave of Add Health was collected in 1994 by sampling 7th to 12th graders and included a subsample of 20,745 adolescents in their homes. The Wave 1 in-home sampling frame included a core sample and oversamples of racial groups. Wave 3 resampled 15,197 respondents, then young adults, from 2001–2002.¹ Wave 2 did not ask respondents their racial identification (i.e., it was "presumed" from Wave 1 data); therefore, we exclude Wave 2 data from our analyses. We rely on measures from Wave 3 unless an item was not included in the Wave 3 survey and temporal ordering

justifies using the Wave 1 item. Add Health's multiple measures of racial identification (e.g., across survey context, waves, and reporter) make it an appropriate data source for the present study.

Variables

Mental health status. Wave 3 depressive symptoms, suicidal ideation, and use of psychological counseling measured mental health status. A 10-item scale captured depressive symptoms ($\alpha = .82$). Items were adapted from the Center for Epidemiologic Studies Depression Scale (CES-D, Radloff 1977; see the appendix). Items were standardized and then averaged. Suicidal ideation was measured as follows: "During the past 12 months, have you ever seriously thought about committing suicide?" (1 = *yes*; 0 = *no*). Finally, use of psychological counseling was operationalized as follows: "In the past 12 months, have you received psychological or emotional counseling?" (1 = *yes*; 0 = *no*).

Inconsistent racial identifications. We used two measures of inconsistent racial identifications among American Indians: *expressed* and *observed*. *Expressed inconsistency* captured discrepancies in self-report as American Indian across Wave 1 and Wave 3 (1 = *yes*; 0 = *no*). For instance, if a respondent self-reported as "American Indian" at Wave 1 and Wave 3, then they received a "0" for expressed racial identification inconsistency. However, if a respondent self-reported "American Indian" at Wave 1 but "white" at Wave 3, then they received a "1" on expressed racial identification inconsistency.

Observed inconsistency captured across wave discrepancies in interviewers' perceptions that the respondent was American Indian (1 = *yes*; 0 = *no*). The only difference between expressed and observed inconsistency was that interviewers reported the latter. If an interviewer identified a respondent as "American Indian" at Wave 1 and Wave 3, then they received a "0" for observed racial identification inconsistency. However, if an interviewer identified a respondent as "American Indian" at Wave 1 but "white" at Wave 3, then they received a "1" on observed racial identification inconsistency. Altogether, this operationalization means that we restricted our sample to any respondent who was self- or other-identified as American Indian in either Wave 1 or Wave 3.

We included individuals who reported more than one race (i.e., multiple racial identifications) in our analyses. We agree with Saperstein and Penner (2014) that including multiple identifications better captures complexities of racial identifications. This is especially the case for American Indians who have high rates of multiple identifications. In one recent report from census data, nearly 44 percent of American Indians report more than one race (Liebler et al. 2014). Therefore, we operationalize racial inconsistency in this study as the absence of American Indian identification over time. This means that if a respondent checked "American Indian" and "white" at Wave 1 but only "American Indian" at Wave 3, then they had consistent racial identifications. This operationalization has implications only for expressed racial inconsistency because interviewers were not allowed to check more than one race when categorizing respondents. We ran separate supplementary analyses including only monoracial American Indian respondents to determine whether incorporation of respondents with multiple identifications biased our results. Doing so substantially decreased our sample size given the high rate of multiple racial identifications among American Indians; however, the substantive conclusions were unchanged (results available upon request). Therefore, we include and control for American Indians with multiple racial identifications (1 = *yes*; 0 = *no*).

We also note that Add Health does not race-match interviewers with respondents, and employed different interviewers across waves. We do not consider this a limitation because interviewers represent the generalized other (Roth 2010; Saperstein and Penner 2014). In addition,

placement of the race questions varied across the waves. In Wave 1, interviewers reported race immediately after respondents' reports. In Wave 3, interviewers reported race in a later portion of the interview. We also do not consider this a limitation because in both instances, interviewers were privy to the respondents' own racial identification, and decisively, we are not interested in mismatch between the two forms of racial identification (i.e., misclassification). We further note that response options for the self-reported and interviewer-reported racial identification questions changed between waves. Specifically, the "Other" category was removed as a response option from the Wave 3 race questions. Therefore, respondents who choose only "Other" at Wave 1 or who were observed as only "Other" could not have consistent expressed racial identifications. In addition, removing the "Other" category on the survey may have inflated the number of Hispanics identifying as American Indian in Wave 3 and could have increased inconsistency (Cheng and Powell 2011; Hitlin et al. 2006). For these reasons, we omitted respondents who were self- or interviewer-identified as Other.²

Skin color. Measurement of respondents' skin color was coded as 1 = *white*, 2 = *light brown*, 3 = *medium brown*, 4 = *dark brown*, and 5 = *black*. Skin color was observed and recorded by interviewers at Wave 3. The majority of the analytic sample (54 percent) was reported to have white skin color, 21 percent were reported to have light brown skin color, 13 percent were reported to have medium brown skin color, 7 percent were reported to have dark brown skin color, and 5 percent were reported to have black skin color.

Controls. Previous work by our interlocutors (e.g., Campbell and Troyer 2007; Cheng and Powell 2011) informed selection of control variables. We controlled for sex (1 = *male*; 0 = *female*) and age (continuous), both measured at Wave 3. Add Health uses separate questions to assess race and Hispanic ethnicity: respondents can identify as Hispanic and with any racial group. We therefore control for Hispanic ethnicity (1 = *yes*; 0 = *no*) as reported by respondents at Wave 3.³ As mentioned above, multiple identifications (1 = *yes*; 0 = *no*) capture whether a respondent has checked at least one additional racial identification besides American Indian. Parental education proxies socioeconomic standing and equals the highest educational attainment of either parent (ranging from *8th grade or less* to *advanced degree*) and was captured only at Wave 1.⁴ Social support and substance abuse are key correlates of mental health status for American Indians (Middlebrook et al. 2001); thus, we controlled for Wave 3 closeness to parents (ranging from 1 = *not close at all* to 10 = *extremely close*) and Wave 3 alcohol or marijuana use (1 = *yes*; 0 = *no*).

Analytic Strategies

Analyses were completed using Stata 12. The *-svy-* commands in Stata (see Chantala and Tabor 1999) adjusted for the Add Health's survey sampling design, including stratification and clustering, and sampling weights. We defined the American Indian subpopulation as respondents who self-identified *or* were interviewer-identified as American Indian in either wave ($n = 904$). This subpopulation was specified in *-svy-* commands for all analyses. We examined bivariate and multivariate relationships using survey-adjusted regression models appropriate to the level of measurement of the dependent variable. We ran lagged analyses controlling for each respective Wave 1 mental health status. Missing data were less than 1 percent for all variables in the analytical sample; therefore, we used listwise deletion.

Results

Table 1 presents a cross-tabulation, using sample weights, of *expressed* (self) identification as American Indian across waves. Rows represent self-identification at Wave 1, and columns represent

Table 1. Cross-tabulation of Expressed (Self) Racial Identifications among American Indian Respondents from Wave 1 to Wave 3, Add Health.

Racial Identification		Wave 3		
		American Indian	~American Indian	
Wave 1	American Indian	176 (20%)	296 (33%)	472
	~American Indian	401 (44%)	31 (3%)	432
		577	327	904

Note. Adjusted for the complex survey design. Design-based $\chi^2 = 276.5512^{***}$. Add Health = National Longitudinal Study of Adolescent to Adult Health; ~ = Not.

*** $p \leq .001$, two-tailed tests.

Table 2. Cross-tabulation of Observed (Interviewer) Racial Identifications of American Indian Respondents from Wave 1 to Wave 3, Add Health.

Racial Identification		Wave 3		
		American Indian	~American Indian	
Wave 1	American Indian	81 (9%)	68 (8%)	149
	~American Indian	93 (7%)	694 (76%)	755
		154	750	904

Note. Adjusted for the complex survey design. Design-based $\chi^2 = 119.973^{***}$. Add Health = National Longitudinal Study of Adolescent to Adult Health; ~ = Not.

*** $p \leq .001$, two-tailed tests.

self-identification at Wave 3. The tabulation shows that 176 respondents expressed consistent American Indian identifications across waves, 296 respondents self-identified as American Indian at Wave 1 but not at Wave 3, and 401 self-identified as not American Indian at Wave 1 but as American Indian at Wave 3. Also shown in Table 1 are the 31 respondents who did not self-identify as American Indian at either wave, and are thus not included in the expressed inconsistency analysis (these respondents are included in the full analytic sample total because they were observed as American Indian). To sum, 79 percent of the 873 respondents represented in this sample self-identified as American Indian expressed inconsistency in their racial identifications.

Table 2 presents a cross-tabulation of *observed* (interviewer) American Indian racial identifications across waves. Rows represent interviewer observations at Wave 1, and columns represent interviewer observations at Wave 3. The tabulations show that interviewers observed 81 respondents as American Indian at both waves; 68 as American Indian at Wave 1 but not at Wave 3; and 93 were identified as not American Indian at Wave 1 but as American Indian at Wave 3. Also shown in Table 2 are that 694 respondents were never observed as American Indian and are thus not included in the observed inconsistency analysis. To sum, 77 percent of the 242 respondents in this sample were inconsistently observed as American Indian.

Tables 1 and 2 represent independent samples in the analyses that follow. For instance, respondents could be included in the expressed inconsistency sample and not the observed inconsistency subsample if they were never identified as American Indian by an interviewer. Likewise, respondents could be included in the observed inconsistency sample and not the expressed inconsistency subsample if they were identified as American Indian by an interviewer. Indeed, 31 cases in the bottom right cell of Table 1 represent respondents who never self-identified as American Indian (and therefore were not included in the expressed racial inconsistency subsample) but were identified as American Indian by an interviewer and were included in the

observed racial inconsistency subsample. Given that those respondents never self-identified as American Indian, we ran supplementary analyses excluding them, and results were unchanged substantively (analyses available upon request). We therefore keep these respondents in our models, arguing that expressed and observed racial identification inconsistency are separate processes. Furthermore, we believe it important to consider multiple forms of racial identification as potentially valid identifications (Campbell and Troyer 2007; Harris and Sim 2002; Roth 2010; Saperstein 2006).

To sum, rates of expressed and observed inconsistency were high among American Indian respondents (see Tables 1 and 2). As a comparison point, rates for other racial groups in the Add Health data were remarkably lower: blacks = 2.8 percent expressed inconsistency, 2.9 percent observer inconsistency; whites = 5.7 percent expressed inconsistency, 3.8 percent observer inconsistency; Asians = 12.9 percent self-identified inconsistency, 16.8 percent observer-identified inconsistency.

Table 3 displays descriptive and bivariate statistics for study variables by type of racial identification inconsistency. American Indians with expressed inconsistency were significantly more likely to have multiple racial identifications, and were less likely to have used alcohol or marijuana, compared with those with consistent identifications. In addition, those with expressed inconsistency had marginally lighter skin color, although the average skin color reported for the entire analytic sample fell between white and light brown.

There were more differences between American Indians in the observed inconsistency sample (right panel of Table 3). Males were less likely to be inconsistently observed by interviewers as American Indian, and those inconsistently observed were also less likely to have used alcohol or marijuana. Compared with consistent American Indian identification, inconsistent observation as American Indian was also significantly associated with having Hispanic ethnicity, multiple racial identifications, and light skin color. Finally, American Indians with observed inconsistency were marginally older and rated themselves marginally closer to their parents, compared with those with observed consistency. Other differences across type of inconsistency were not statistically significant. At the bivariate level, evidence suggests that racial identification inconsistency was not related to mental health status.

Table 4 shows coefficients from three sets of regression models. All models control for sex, age, Hispanic ethnicity, multiple identifications, parental education, closeness to parents, alcohol or marijuana use, and Wave 1 mental health status (e.g., depressive symptomology at Wave 1 for the depression symptoms regression model, suicidal ideation at Wave 1 for the suicidal ideation regression model). In Model 1a, Wave 3 depressive symptoms were regressed on expressed inconsistency and the covariates; in Model 1b, skin color was introduced into the model; and in Model 1c, an interaction between expressed inconsistency and skin color was added. Models 2a to 2c repeat these analyses for suicidal ideation, whereas Models 3a to 3c present regressions where use of psychological counseling was the dependent variable. Linearized standard errors are reported in parentheses.

We found that expressed racial identification inconsistency had no association with depressive symptoms, suicidal ideation, or use of psychological counseling. Skin color also did not have a significant main effect. Similarly, an interaction between expressed inconsistency and skin color was statistically insignificant. Hence, we found little evidence to support Hypothesis 1 and Hypothesis 3 when considering expressed racial identification inconsistency.

In Table 5, we substituted observed racial identification inconsistency for expressed racial identification inconsistency and replicated the three sets of regression models. Again, Models 1a to 1c focus on depressive symptoms, Models 2a to 2c focus on suicidal ideation, and Models 3a to 3c focus on use of psychological counseling. Model 1a shows that there was a significant and positive effect of observed inconsistency on increased depressive symptoms, such that being inconsistently identified as American Indian was linked to more depressive symptoms. Model 1b

Table 3. Study Variables by Inconsistency in Expressed (Self) and Observed (Interviewer) Racial Identifications: American Indian Respondents in Add Health.

Variables	Expressed inconsistency			Observed inconsistency			Range
	Yes		No	Yes		No	
	M	or proportion	M or proportion	M	or proportion	M or proportion	
Depressive symptoms	0.030	(0.032)	0.048	(0.054)	0.051	(0.061)	[-0.962, 3.429]
Suicidal ideation (1 = yes; 0 = no)	0.085	(0.014)	0.130	(0.029)	0.103	(0.033)	[0, 1]
Use of psychological counseling (1 = yes; 0 = no)	0.089	(0.015)	0.077	(0.022)	0.113	(0.040)	[0, 1]
Male (1 = yes; 0 = no)	0.511	(0.027)	0.566	(0.044)	0.407**	(0.055)	[0, 1]
Age	21.697	(0.161)	21.383	(0.245)	21.722†	(0.291)	[18–28]
Hispanic identification (1 = yes; 0 = no)	0.221	(0.033)	0.255	(0.046)	0.563*	(0.072)	[0, 1]
Multiple identifications (1 = yes; 0 = no)	0.804**	(0.033)	0.574	(0.109)	0.330*	(0.062)	[0, 1]
Parental education	5.480	(0.164)	5.512	(0.220)	4.790	(0.439)	[1–9]
Closeness to parents	7.530	(0.117)	7.082	(0.262)	7.7981†	(0.218)	[1–10]
Alcohol or marijuana use (1 = yes; 0 = no)	0.781**	(0.024)	0.860	(0.043)	0.659***	(0.048)	[0, 1]
Skin color (white to black)	1.598†	(0.076)	2.027	(0.335)	1.923***	(0.157)	[1–5]
n	697		176		161		81

Note. Means and standard errors (in parentheses) adjusted for the complex survey design. Significant differences by inconsistency indicated with asterisks. Significance was obtained using survey-adjusted bivariate regression models, appropriate to the levels of measurement of each study variable. Add Health = National Longitudinal Study of Adolescent to Adult Health.

†p < .10. *p ≤ .05. **p ≤ .01, two-tailed tests.

Table 4. Coefficients from Regressions of Mental Health Status on Inconsistency in Expressed (Self) Racial Identification: American Indian Respondents in Add Health.

Variables	Depressive symptoms (n = 812)			Suicidal ideation (n = 787)			Use of psychological counseling (n = 813)		
	Model 1a	Model 1b	Model 1c	Model 2a	Model 2b	Model 2c	Model 3a	Model 3b	Model 3c
Expressed inconsistency (1 = yes; 0 = no)	0.045 (0.053)	0.037 (0.053)	0.080 (0.110)	-0.254 (0.363)	-0.262 (0.377)	-0.645 (0.848)	0.186 (0.375)	0.149 (0.362)	-0.004 (0.884)
Male (1 = yes; 0 = no)	-0.229*** (0.050)	-0.228*** (0.049)	-0.229*** (0.049)	-0.591† (0.329)	-0.589† (0.325)	-0.578† (0.318)	-1.676*** (0.353)	-1.655*** (0.344)	-1.652*** (0.345)
Age	-0.012 (0.013)	-0.011 (0.013)	-0.011 (0.013)	0.111 (0.104)	0.112 (0.105)	0.107 (0.104)	0.222 (0.139)	0.236† (0.138)	0.234† (0.137)
Hispanic identification (1 = yes; 0 = no)	-0.150 (0.096)	-0.152 (0.095)	-0.149 (0.097)	-0.409 (0.510)	-0.415 (0.511)	-0.462 (0.527)	-0.608 (0.467)	-0.600 (0.473)	-0.610 (0.466)
Multiple identifications (1 = yes; 0 = no)	-0.076 (0.097)	-0.093 (0.097)	-0.086 (0.101)	-0.674 (0.414)	-0.695 (0.436)	-0.783 (0.478)	0.158 (0.537)	0.025 (0.628)	-0.006 (0.597)
Parental education	-0.002 (0.011)	-0.002 (0.011)	-0.002 (0.011)	0.060 (0.065)	0.060 (0.065)	0.058 (0.064)	-0.082 (0.088)	-0.084 (0.088)	-0.084 (0.088)
Closeness to parents	-0.035** (0.011)	-0.036** (0.011)	-0.036** (0.011)	-0.100 (0.090)	-0.101 (0.091)	-0.100 (0.092)	-0.102 (0.079)	-0.113 (0.078)	-0.112 (0.077)
Alcohol or marijuana use (1 = yes; 0 = no)	0.090 (0.070)	0.083 (0.069)	0.080 (0.069)	0.835 (0.520)	0.829 (0.517)	0.866 (0.537)	1.335** (0.465)	1.290** (0.469)	1.296** (0.466)
Mental Health Status Wave 1 ^a	0.259*** (0.041)	0.258*** (0.041)	0.259*** (0.040)	1.037*** (0.391)	1.034** (0.396)	1.032*** (0.393)	0.181 (0.380)	0.122 (0.395)	0.118 (0.394)
Skin color (light to dark)	-0.026 (0.020)	-0.026 (0.020)	-0.008 (0.039)	-0.026 (0.140)	-0.026 (0.140)	-0.191 (0.335)	-0.026 (0.335)	-0.213 (0.175)	-0.295 (0.278)
Expressed inconsistency x Skin color			-0.023 (0.045)			0.219 (0.357)			0.098 (0.406)
Constant	0.662* (0.292)	0.726* (0.292)	0.680* (0.290)	-4.096† (2.310)	-4.032† (2.324)	-3.576 (2.302)	-6.505* (2.802)	-6.237* (2.921)	-6.047* (2.831)
F statistic	1.714	9.585	8.748	1.823	1.655	1.979	6.750	6.302	5.563

Note. Models adjusted for the complex survey design. Linearized standard errors presented in parentheses. Add Health = National Longitudinal Study of Adolescent to Adult Health.

^aModels 1a to 1c control for Wave 1 depressive symptoms, Models 2a to 2c control for Wave 1 suicidal ideation, whereas Models 3a to 3c control for Wave 1 use of psychological counseling.

†p < .10. *p ≤ .05. **p ≤ .01, two-tailed tests.

Table 5. Coefficients from Regressions of Mental Health Status on Inconsistency in Observed (Self) Racial Identification: American Indian Respondents in Add Health.

Variables	Depressive symptoms (n = 229)			Suicidal ideation (n = 221)			Use of psychological counseling (n = 228)		
	Model 1a	Model 1b	Model 1c	Model 2a	Model 2b	Model 2c	Model 3a	Model 3b	Model 3c
	Observed inconsistency (1 = yes; 0 = no)	0.169* (0.077)	0.146 (0.089)	0.528** (0.170)	1.431** (0.507)	1.842** (0.580)	5.392*** (1.590)	0.614 (0.424)	-0.035 (0.447)
Male (1 = yes; 0 = no)	-0.233* (0.106)	-0.223* (0.102)	-0.223* (0.099)	0.166 (0.802)	-0.009 (0.733)	0.006 (0.777)	-0.911 (0.762)	-0.778 (0.769)	-0.955 (0.818)
Age	-0.054* (0.026)	-0.056* (0.024)	-0.062** (0.023)	-0.113 (0.207)	-0.121 (0.184)	-0.128 (0.175)	0.304 (0.265)	0.331 (0.247)	0.329 (0.259)
Hispanic identification (1 = yes; 0 = no)	-0.200† (0.120)	-0.210† (0.118)	-0.182 (0.123)	0.146 (0.758)	0.339 (0.744)	0.567 (0.779)	-0.787 (0.909)	-0.608 (0.868)	-0.286 (0.806)
Multiple identifications (1 = yes; 0 = no)	-0.008 (0.118)	-0.008 (0.116)	0.013 (0.111)	-0.191 (0.669)	-0.071 (0.684)	0.010 (0.705)	1.190† (0.666)	0.909 (0.723)	1.141 (0.765)
Parental education	-0.011 (0.021)	-0.011 (0.021)	-0.009 (0.021)	0.153 (0.121)	0.180 (0.133)	0.173 (0.139)	-0.103 (0.197)	-0.108 (0.189)	-0.079 (0.178)
Closeness to parents	-0.045* (0.018)	-0.044* (0.018)	-0.043* (0.018)	-0.087 (0.128)	-0.139 (0.122)	-0.132 (0.121)	0.238 (0.156)	0.290 (0.208)	0.328 (0.208)
Alcohol or marijuana use (1 = yes; 0 = no)	0.067 (0.146)	0.061 (0.139)	0.052 (0.130)	3.959*** (1.012)	4.509*** (1.140)	4.399*** (1.032)	2.382* (1.197)	2.603* (1.261)	2.664† (1.397)
Mental Health Status Wave 1 ^a	0.172** (0.065)	0.176* (0.067)	0.174* (0.069)	1.054 (0.704)	0.879 (0.730)	1.148 (0.779)	0.198 (1.021)	0.511 (1.088)	0.421 (1.152)
Skin color (light to dark)		-0.032 (0.054)	0.075* (0.035)		0.511 (0.355)	1.482*** (0.389)		-0.798* (0.364)	0.244 (0.319)
Observed inconsistency x Skin color			-0.153* (0.074)			-1.176* (0.572)			-1.944* (0.809)
Constant	1.652** (0.522)	1.783*** (0.518)	1.583** (0.518)	-4.489 (4.769)	-6.049† (3.610)	-9.111* (4.143)	-12.462* (4.789)	-11.666* (4.580)	-14.925** (4.477)
F statistic	3.699	3.257	4.256	4.999	4.810	6.330	3.387	4.210	4.840

Note. Models adjusted for the complex survey design. Linearized standard errors presented in parentheses. Add Health = National Longitudinal Study of Adolescent to Adult Health. ^aModels 1a to 1c control for Wave 1 depressive symptoms, Models 2a to 2c control for Wave 1 suicidal ideation, whereas Models 3a to 3c control for Wave 1 use of psychological counseling.

†p < .10. *p ≤ .05. **p ≤ .01, two-tailed tests.

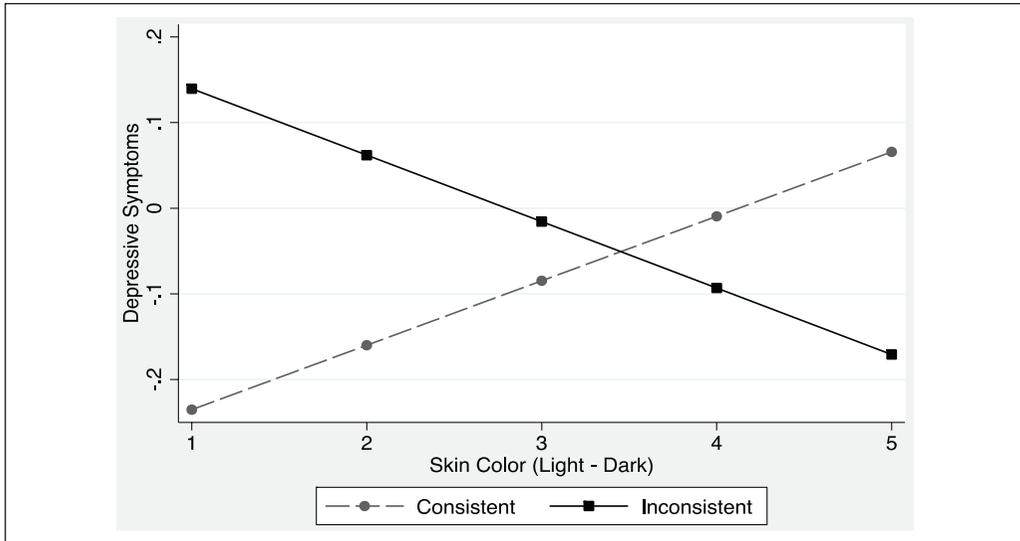


Figure 1. Depressive symptoms by observed inconsistency and skin color: American Indian respondents in Add Health.

Note. All skin color categories are represented in the figure, although the darkest skin tones have small sample sizes. Add Health = National Longitudinal Study of Adolescent to Adult Health.

shows that the effect of observed inconsistency was attenuated by skin color, which itself was not associated with depressive symptoms. However, an interaction between observed inconsistency and skin color was significant (Model 1c). Respondents inconsistently observed as American Indian and having light skin color reported higher levels of depressive symptoms than those inconsistently observed as American Indian and having dark skin color (the predicted value for depressive symptoms was .14 for those with a “white” skin color, whereas the predicted value was $-.17$ for those with “black” skin color). That is, the deleterious impact of observed inconsistency on mental health status was amplified by light skin. The converse was true for respondents observed consistently as American Indian (the predicted value for depressive symptoms was $-.24$ for those with “white” skin color, whereas the predicted value was .06 for those with “black” skin color). Although there were small cell counts at darker skin color ratings, for those respondents with the darkest shades of skin color, observed inconsistency was less psychologically damaging than being consistently classified by interviewers as American Indian. Figure 1 plots the interaction using survey-adjusted postestimation predicted values.

Model 2a shows that observed inconsistency was significantly associated with increased likelihood of suicidal ideation: odds of suicidal ideation were 4.18 times larger for those who were inconsistently observed as American Indian, compared with those with consistent observed identification. There was no main effect of skin color on suicidal ideation (Model 2b), however, the interaction between observed inconsistency and skin color was negative and significant (Model 2c). In this model, for light skinned respondents, the probability of suicidal ideation was .103 for those inconsistently observed, and only .002 for those consistently observed. However, even when respondents had darker skin color, being inconsistently observed was detrimental. That is, dark skin actually increased all American Indians’ likelihood of suicidal ideation. It is important to remember that there are small cell counts in the darker skin categories. Nonetheless, at “black” skin color, those consistently observed had the highest probability of suicidal ideation. Figure 2 plots this interaction.

Finally, Models 3a to 3c predict psychological counseling. We found no direct effect of observed inconsistency (Model 3a) or skin color on psychological counseling (Model 3b), but we

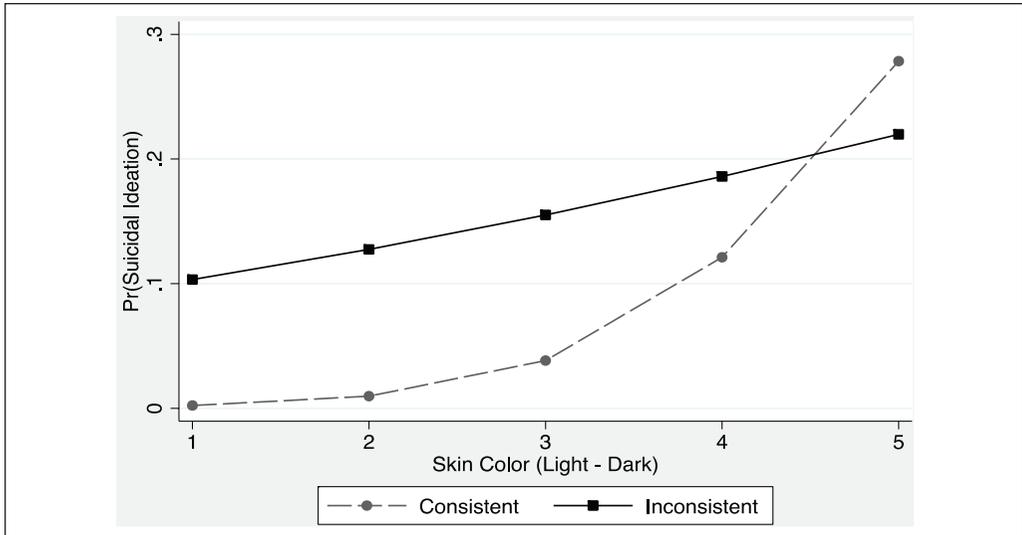


Figure 2. Suicidal ideation by observed inconsistency and skin color: American Indian respondents in Add Health.

Note. All skin color categories are represented in the figure, although the darkest skin tones have small sample sizes. Add Health = National Longitudinal Study of Adolescent to Adult Health.

found an interaction between observed inconsistency and skin color in Model 3c. The interaction reveals that American Indians who were observed inconsistently and observed as light skin had the highest probability of using psychological counseling (the probability was .15 for inconsistently observed American Indians with “white” skin color compared with .03 for consistently observed American Indians with “white” skin color). However, for respondents with dark skin color, being consistently observed was deleterious (see Figure 3).

Contrary to null results for expressed racial identification inconsistency shown in Table 4, Table 5 showed that observed racial identification inconsistency damaged mental health status. Specifically, a direct effect of observed inconsistency was supported for depressive symptoms and suicidal ideation. In addition, the interaction between observed inconsistency and skin color was consistent across the mental health measures such that those who were observed inconsistently and also observed as having light skin reported increased depressive symptoms and use of psychological counseling. To sum, these results provide support for Hypothesis 2 and Hypothesis 3 for observed inconsistency.

Discussion

We contribute to the literature by examining *within reporter* (i.e., self and interviewer) *over time* racial identification inconsistency and its mental health consequences, and by bringing skin color into the ongoing conversation about racial identifications. Overall, we found that *expressed* racial identification inconsistency across two waves of data did not have mental health consequences. However, we found that *observed* racial identification inconsistency harmed mental health, and this was especially true when respondents were reported having lightest skin color.

Why was only one type of racial identification inconsistency potent, and what are the implications of our results for identity theory? Cheng and Powell (2011) imply that variation within expressed racial identifications in the Add Health data may indicate confused or troubled respondents. Furthermore, identity theory proposes that a disjoint in the identity standard-feedback loop

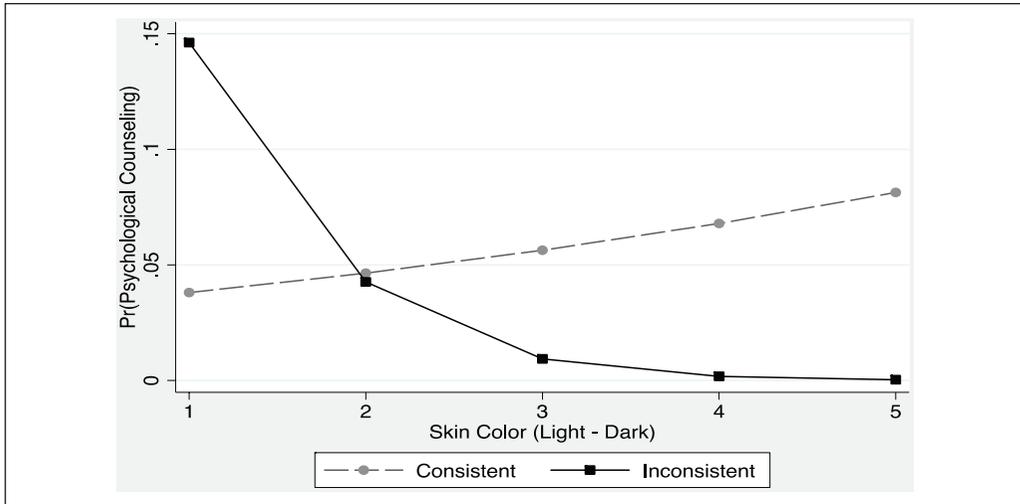


Figure 3. Use of psychological counseling by observed inconsistency and skin color: American Indian respondents in Add Health.

Note. All skin color categories are represented in the figure, although the darkest skin tones have small sample sizes. Add Health = National Longitudinal Study of Adolescent to Adult Health.

(i.e., inconsistent cues about the self) could result in cognitive dissonance and distress (Burke 1991, 2006). Our findings contradict this line of reasoning. Discrepancy in expressed racial identifications among American Indian respondents was not psychologically harmful. What then are plausible explanations for our (null) findings? Saperstein and Penner (2014) argue that most individuals who change their race (not just American Indians) do so for three main reasons: (1) to follow classification norms, (2) as a means to achieve higher prestige or move away from negative connotations, and/or (3) because they have a wide range of available classifications to choose from.

We offer two related explanations for American Indians. First, identifying inconsistently as American Indian could be a strategy in service of securing material rewards allotted to this under-represented group (Nagel 1995) or avoiding stigma associated with being a discriminated-against group (see Saperstein 2012). Or it might represent a newfound familial heritage (Liebler 2004). Second, the transition to adulthood is a time of experimentation. Trying on different racial identifications may be a normal process for American Indians and for other groups wearing ambiguous racial uniforms (Doyle and Kao 2007; Hitlin et al. 2006; Rockquemore and Brunsma 2008). We conclude that inconsistency in expressed racial identification as American Indian does not appear to represent a weak or troubled sense of self, but might be an exercise in agency.

In contrast, inconsistent observation as American Indian predicted elevated levels of poor mental health.⁵ Although prior research establishes the more obvious result that misclassification *between* self-reported race and other-reported race can be harmful (Campbell and Troyer 2007; Stepanikova 2010; Veenstra 2011), little work attends to inconsistency *within* observed racial identifications, or does so with longitudinal data. Still, we claim that identity theory provides plausible explanations for the deleterious impact of observed racial identification inconsistency. According to Peter Burke (1991, 2006), lack of control of one's identity can be detrimental. Inconsistency in observation as American Indian may manifest the respondent's failure to *signal* with sufficient strength, clarity, and consistency their desire to be perceived as American Indian.

Racial signaling is important. For instance, Otto H. MacLin and Roy S. Malpass (2001) found that changing a hairstyle from one that is stereotypically Latino to stereotypically black on a

racially ambiguous person meant observers were more likely to categorize the ambiguous person in the direction of the racial marker (the person would be identified as black, in this example). Without a clear signal, interviewers may have been confused about the authenticity of respondents' racial group membership. If respondents typically give off ambiguous racial cues, then it is possible that those respondents would be observed inconsistently as American Indian at some point, which might result in inevitable cases of 'misclassification'. Such may be the case for the nearly 90 percent of respondents who were included in the observed American Indian inconsistency subsample and who themselves reported a self-racial identification as American Indian. Similarly, Mary Campbell and Lisa Troyer (2011) said,

We hypothesize that young American Indians today experience added stress, not because they feel unclear about their identity, but because others routinely racially misclassify them. In other words, many young American Indians appear racially ambiguous to others, even if they do not have any internal conflict over their "true identity." (p. 752)

Importantly, however, we also contend that respondents (American Indian or not) may experience poor mental health because they are perceived ambiguously and identified inconsistently by those around them. Following this line of reasoning, previous research (e.g., Doyle and Kao 2007; Hitlin et al. 2006) demonstrates that inconsistency in racial identifications occurs often when an individual's phenotype is ambiguous. Indeed, significant interactions between inconsistency in observed racial identifications and skin color further support our conclusion. Specifically, respondents with light skin color who were inconsistently observed as American Indian reported higher levels of depressive symptoms, suicidal ideation, and use of psychological counseling than their consistently observed counterparts with light skin (see Figures 1–3). Furthermore, there were crossovers in two of the interactions such that observed racial identification inconsistency became less harmful when respondents' skin color became dark. However, caution is warranted when interpreting effects at the dark end of the skin color continuum because cell counts there were small—the majority of American Indians were observed to have "white" or "light brown" skin color.

We contend that individuals with light skin are more ambiguous and must signal their racial group membership and racial authenticity. Not only is failure to signal membership into a racial identification group problematic then, but the generalizable experience of inconsistent racial identifications by observers is problematic. We reason that respondents with light skin and related ambiguous racial cues likely encounter identity interruptions that require negotiation of others' perceptions. In other words, fielding queries about one's race—or even perceiving others to be confused about your race—causes distress. An example of a racial identity interruption could be the confrontation with the "what are you?" question. People with ambiguous racial features routinely report being asked this question (see Gaskins 1999; Williams 1996). For instance, multiracial respondents in Teresa K. Williams' (1996) study recall being asked this question by acquaintances and even strangers who are inquisitive about their expressed racial identification. Moreover, Derald W. Sue's (2010) research on multiracial populations asserts that this type of racial identity interruption is a *microaggression*, or mundane but psychologically harmful stressor. Moreover, we take it a step further and argue that *observed inconsistency acts as a marker for the stressful experiences associated with being not readily classifiable in a world obsessed with tidy racial classifications*.

In contrast, at the dark end of the skin color continuum, we observe a result consistent with main effects of skin color as reported in prior studies—relatively dark-skinned racial minorities report poor mental health outcomes (e.g., Thompson and Keith 2001; Veenstra 2011). We assert that when consistency in observation as American Indian is confirmed by darker skin color, then there is little escape from identification with a marginalized group. These results manifest the

“no-win” situation, produced by the pernicious nature of racism faced by some American Indians today. On one hand, when their phenotype dictates their observation by others as American Indian, they may be confronted with their assumed inferior placement in the racial hierarchy. On the other hand, when their phenotype allows them to be observed by others as racially ambiguous, they must work to signal their racial group membership and their authentic connection.

At this point, we must acknowledge several study limitations. First, interviewers may be atypical proxies for everyday observers because survey situations are unlike real-world interactions. Interviewers are trained to collect information about a respondent, and may think more carefully than everyday observers before making judgments. Furthermore, interviewers are exposed during the survey to respondents’ self-reported race and other information. It is reasonable to believe, consequently, that we report a conservative estimate of inconsistency in observed racial identifications (and its mental health consequences) as experienced by American Indians.

Second, we cannot determine whether a respondent knows how an interviewer perceives them—we do not have access to this underlying mechanism. Previous research (Campbell and Troyer 2011; Roth 2010; Stepanikova 2010) suggests that individuals are indeed aware of how others perceive them. For example, Irena Stepanikova (2010) used the Behavioral Risk Factor Surveillance System (BRFSS) for her research on misclassification. The BRFSS asks respondents to report their own race and the race they think others perceive them to be—a measure that better captures perceptions of inconsistency—and Stepanikova finds incongruence between the two measures. Campbell and Troyer (2011) replicated their 2007 findings on misclassification also using the BRFSS and found that American Indians have high rates of misclassification, and it is detrimental for health. Veenstra (2011) constructed his own survey instrument to capture perceived misclassification in Canada and found deleterious psychological implications for misclassification. We recommend that future research focus on signaling in regard to racial group membership to specify further the transmission of consistent racial identifications.

Third, we only examine racial identification inconsistency for American Indians. Although remarkably less prevalent, *within reporter inconsistency* may have mental health consequences for other racial groups. For instance, Hispanics are also found to have high rates of inconsistency in racial identifications (Hitlin et al. 2006). Because Add Health, and most surveys that follow the standard of the U.S. government, treat Hispanic as an ethnic identification, research on Hispanic inconsistency is limited (but see Wilkinson 2010 for an example of Hispanic inconsistency and educational outcomes). Future research might explore inconsistency between Hispanics’ ethnic identifications and mental health status.

Fourth, whereas we included alcohol or marijuana use as a control variable, future research could examine them as outcome variables (see Table 3). Finally, our analyses do not consider how social context affects the relationship between racial identification inconsistency and mental health status. For example, Campbell and Troyer (2007) hypothesize that connectedness to peers and the racial context of school and/or neighborhood may influence misclassification. The same may be true for expressed and observed inconsistency. In addition, religion, residence on a reserve, tribal affiliation, urbanicity, and parental ancestry are related to American Indian racial identifications (see Liebler 2004) and should be examined in future research.

Our results suggest that racial identifications are socially constructed, yet have critical consequence for outcomes such as mental health status. We agree with Roth’s (2010) recommendation that scholars develop a *language of race* that communicates the multiplicity of social processes involved in its construction. Moreover, we must avoid the assumption that either racial self-identifications or others’ observations are valid indicators (Cheng and Powell 2011; Saperstein and Penner 2012). We speculate that resurgent interest in the salience, centrality, meaning, and significance of race and racial identifications begs the return of sociologists to consideration of racial identity as a factor impacting social interactions. Psychologists have taken the lead over the past three decades in measuring racial identity and specifying its consequence for groups and

individuals (see, for example, Sellers et al. 2003; Sellers et al. 1998). It seems that now is a good time for that trend to change if we hope to apprehend sociological factors that explain the lived fluidity and authenticity of racial group membership.

Appendix

In the past seven days, how often was each of the following things true . . . ?

1. You were bothered by things that do not usually bother you (4 categories)
2. You could not shake off the blues (4 categories)
3. You had trouble keeping your mind on what you were doing (4 categories)
4. You were depressed (4 categories)
5. You were too tired to do things (4 categories)
6. You were sad (4 categories)
7. You felt that people disliked you (4 categories)
8. You felt that you were just as good as other people (4 categories, reverse coded)
9. You enjoyed life (4 categories, reverse coded)

In the past 12 months, how often have you . . . ?

1. Cried a lot (5 categories)

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Notes

1. According to the National Longitudinal Study of Adolescent to Adult Health (Add Health) documentation (Chantala, Kalsbeek, and Andraca 2005), the response rate was 75.6 percent in Wave 3. Add Health researchers investigated the effect of nonresponse on study estimates and concluded Wave 3 represents the same population surveyed at Wave 1 when sampling estimates are used.
2. Although we removed respondents with an “Other” identification, we included respondents who were self- or interviewer-identified as Other in supplementary analyses, and results were consistent with what is presented here.
3. Previous research shows that Hispanics were more likely to check “Other” in Wave 1 and then a different race in Wave 3 when the “Other” option was removed (see Hitlin et al. 2006). Because we excluded

respondents with an “Other” identification, this problem was resolved. Nonetheless, we also excluded Hispanics as a robustness check, and results remained consistent.

4. We informed the proxy for socioeconomic status from the work of our interlocutors (Campbell and Troyer 2007). However, we ran additional sensitivity analyses for respondents’ education attainment in Wave 3. We found that educational attainment in Wave 3 did not impact our results. Analyses are available upon request.
5. In additional analyses (not shown), we explored the mental health significance across waves of first being observed as American Indian and then being observed as not American Indian, and vice versa. Results were virtually identical to those presented above. Observed inconsistency was detrimental regardless of the sequence across waves that produced it.

References

- Brebner, Joanne L., Olav Krigolson, Todd C. Handy, Susanne Quadflieg, and David J. Turk. 2011. “The Importance of Skin Color and Facial Structure in Perceiving and Remembering Others: An Electrophysiological Study.” *Brain Research* 1388:123–33.
- Brown, Terry D. Jr., Francis C. Dane, and Marcus D. Durham. 1998. “Perception of Race and Ethnicity.” *Journal of Social Behavior and Personality* 13:295–307.
- Brown, Tony N. 1999. “Predictors of Racial Label Preference in Detroit: Examining Trends from 1971 to 1992.” *Sociological Spectrum* 19(4):421–42.
- Burke, Peter. 1991. “Identity and Social Stress.” *American Sociological Review* 56(6):836–49.
- Burke, Peter. 2006. “Identity Change.” *Social Psychology Quarterly* 69(1):81–96.
- Campbell, Mary and Lisa Troyer. 2007. “The Implication of Racial Misclassification by Observers.” *American Sociological Review* 72(5):750–76.
- Campbell, Mary and Lisa Troyer. 2011. “Further Data on Misclassification: A Reply to Cheng and Powell.” *American Sociological Review* 76(2):356–64.
- Chantala, Kim, William D. Kalsbeek, and Eugenio Andraca. 2005. “Non-response in Wave III of the Add Health Study.” Add Health Working Paper, Carolina Population Center, Chapel Hill, NC.
- Chantala, Kim and Joyce Tabor. 1999. “Strategies to Perform a Design-based Analysis Using Add Health Data.” Add Health Working Paper, Carolina Population Center, Chapel Hill, NC.
- Cheng, Simon and Brian Powell. 2011. “Misclassification by Whom? A Comment on Campbell and Troyer.” *American Sociological Review* 76(2):347–55.
- Cooley, Charles H. 1902. *Human Nature and Social Order*. New York: Charles Scribner’s Sons.
- Cross, William. 1991. *Shades of Black*. Philadelphia, PA: Temple University Press.
- Demo, David and Michael Hughes. 1990. “Socialization and Racial Identity among Black Americans.” *Social Psychology Quarterly* 53(4):364–74.
- Doyle, Jamie M. and Grace Kao. 2007. “Are Racial Identities of Multiracials Stable: Changing Racial Self-identification among Single and Multiple Race Individuals.” *Social Psychology Quarterly* 70(4):405–23.
- Eschbach, Karl. 1993. “Changing Identifications among American-Indians and Alaska Natives.” *Demography* 30(4):635–52.
- Espino, Rodolfo and Michael M. Franz. 2002. “Latino Phenotypical Discrimination Revisited: The Impact of Skin Color on Occupational Status.” *Social Science Quarterly* 83(2):613–23.
- Gaskins, Pearl. 1999. *What Are You? Voices of Mixed-race Young People*. New York: Henry Holt.
- Gecas, Viktor and Peter Burke. 1995. “Social Identities.” Pp. 41–67 in *Sociological Perspectives on Social Psychology*, edited by K. Cook, G. Fine, and J. House. Needham Heights, MA: Allyn & Bacon.
- Harris, David R. and Jeremiah Sim. 2002. “Who Is Multiracial? Assessing the Complexity of Lived Race.” *American Sociological Review* 67(4):624–27.
- Herman, Melissa. 2010. “Do You See What I Am? How Observers’ Backgrounds Affect Their Perceptions of Multiracial Faces.” *Social Psychology Quarterly* 73(1):58–78.
- Hitlin, Steven J. Scott Brown, and Glenn H. Elder, Jr. 2006. “Racial Self-categorization in Adolescence: Multiracial Development and Social Pathways.” *Child Development* 77(5):1298–308.
- Hogg, Michael A. and Dominic Abrams. 1988. *Social Identifications: A Social Psychology of Intergroup Relations and Group Processes*. London, England: Routledge.

- Hunter, Margaret. 2005. *Race, Gender, and the Politics of Skin Tone*. New York: Routledge.
- Hunter, Margaret. 2007. "The Persistent Problem of Colorism: Skin Tone, Status, and Inequality." *Sociology Compass* 1(1):237–54.
- Liebler, Carolyn A. 2004. "Ties of the Fringes of Identity." *Social Science Research* 33:702–23.
- Liebler, Carolyn A., Sonya Rastogi, Leticia E. Fernandez, James M. Noon, and Sharon R. Ennis. 2014. "America's Churning Races: Race and Ethnic Response Changes between Census 2000 and the 2010 Census." Working Paper No. 2014-09, Center for Administrative Records Research and Applications U.S. Census Bureau, Washington, DC.
- MacLin, Otto H. and Roy S. Malpass. 2001. "Racial Categorization of Faces: The Ambiguous Race Effect." *Psychology, Public Policy, and Law* 7(1):98–118.
- McDonough, Sara. 2005. *What Are You? A Sociological Study on the Racial Identity Development in Multiracial Individuals*. Undergraduate thesis, Department of Sociology, College of William and Mary, Williamsburg, VA.
- McDonough, Sara and David Brunnsma. 2013. "Navigating the Color Complex: How Multiracial Individuals Narrate the Elements of Appearance and Dynamics of Color in Twenty-first-century America." Pp. 257–72 in *The Melanin Millennium Skin Color as 21st Century International Discourse*, edited by J. Hall. New York: Springer.
- Middlebrook, Denise L., Pamela L. LeMaster, Janette Beals, Douglas K. Novins, and Spero M. Manson. 2001. "Suicide Prevention in American Indian and Alaska Native Communities: A Critical Review of Programs." *Suicide and Life-Threatening Behavior* 31:132–65.
- Nagel, Joane. 1995. "American Indian Ethnic Renewal: Politics and the Resurgence of Identity." *American Sociological Review* 60(6):947–65.
- Radloff, Lenore S. 1977. "The CES-D Scale: A Self-report Depression Scale for Research in the General Population." *Applied Psychological Measurement* 1(3):385–401.
- Rockquemore, Kerry Ann and Patricia Arend. 2003. "Opting for White: Choice, Fluidity and Racial Identity Construction in Post Civil-rights America." *Race & Society* 5(1):49–64.
- Rockquemore, Kerry Ann and David L. Brunnsma. 2008. *Beyond Black: Biracial Identity in America*. 2nd ed. New York: Rowman & Littlefield.
- Rosenberg, Morris. 1979. *Conceiving the Self*. New York: Basic Books.
- Roth, Wendy. 2010. "Racial Mismatch: The Divergence between Form and Function in Data for Monitoring Racial Discrimination of Hispanics." *Social Science Quarterly* 91(5):1288–311.
- Russell, Kathy, Midge Wilson, and Ronald E. Hall. 1992. *The Color Complex: The Politics of Skin Color among African Americans*. New York: Random House.
- Saperstein, Aliya. 2006. "Double-checking the Race Box: Examining Inconsistency between Survey Measures of Observed and Self-reported Race." *Social Forces* 85(1):57–74.
- Saperstein, Aliya. 2012. "Capturing Complexity in the United States: Which Aspects of Race Matter and When?" *Ethnic and Racial Studies* 35(8):1484–502.
- Saperstein, Aliya and Andrew M. Penner. 2012. "Racial Fluidity and Inequality in the United States." *American Journal of Sociology* 118(3):676–727.
- Saperstein, Aliya and Andrew M. Penner. 2014. "Beyond the Looking Glass: Exploring Fluidity in Racial Self-identification and Interviewer Classification." *Sociological Perspectives* 57(2):86–207.
- Sellers, Robert M., Cleopatra Caldwell, Karen Scheelk-Cone, and Marc Zimmerman. 2003. "Racial Identity, Racial Discrimination, Perceived Stress, and Psychological Distress among African American Young Adults." *Journal of Health and Social Behavior* 44(3):302–17.
- Sellers, Robert M., Mia A. Smith, J. Nicole Shelton, Stephanie A. J. Rowley, and Tabbye M. Chavous. 1998. "Multidimensional Model of Racial Identity: A Reconceptualization of African American Racial Identity." *Personality and Social Psychology Review* 2(1):18–39.
- Snipp, Matthew. 1992. "Sociological Perspectives on American Indians." *Annual Review of Sociology* 18:351–71.
- Stepanikova, Irena. 2010. "Applying a Status Perspective to Racial/Ethnic Misclassification: Implications for Health." Pp. 159–83 in *Advances in Group Processes*. Vol. 27, edited by S. R. Thye and E. Lawler. Bingley, England: Emerald.
- Sue, Derald W. 2010. *Microaggressions and Marginality: Manifestation, Dynamics and Impact*. Hoboken, NJ: John Wiley & Sons.

- Thompson, Maxine S. and Verna M. Keith. 2001. "The Blacker the Berry: Gender, Skin Tone, Self-esteem, and Self-efficacy." *Gender & Society* 15(3):336–57.
- Thornton, Michael C., Robert J. Taylor, and Tony N. Brown. 2000. "Correlates of Racial Label Use among Americans of African Descent: Colored, Negro, Black and African American." *Race & Society* 2(2):149–64.
- Udry, J. Richard. 1998. *National Longitudinal Study of Adolescent [to Adult] Health (Add Health), Waves I & II, 1994–1996*. Chapel Hill, NC: Carolina Population Center.
- Udry, J. Richard. 2003. *The National Longitudinal Study of Adolescent [to Adult] Health (Add Health), Wave III, 2001–2002*. Chapel Hill, NC: Carolina Population Center.
- Vargas, Nicholas. 2013. "Off White: Color-blind Ideology at the Margins of Whiteness." *Ethnic and Racial Studies* 37(13):2281–302.
- Vaughan, Alden T. 1982. "From White Man to Redskin: Changing Anglo-American Perceptions of the American Indian." *The American Historical Review* 87(4):917–53.
- Veenstra, Gerry. 2011. "Mismatched Racial Identities, Colourism, and Health in Toronto and Vancouver." *Social Science & Medicine* 73: 1152–62.
- Weaver, Hilary N. 2013. "What Color Is Red? Exploring the Implications of Phenotype for Native Americans." Pp. 287–300 in *The Melanin Millennium Skin Color as 21st Century International Discourse*, edited by J. Hall. New York: Springer.
- Wilkinson, Lindsay. 2010. "Inconsistent Latino Self-identification in Adolescence and Academic Performance." *Race and Social Problems* 2(3):179–94.
- Williams, Teresa K. 1996. "Race as a Process: Reassessing the 'What Are You?' Encounters of Biracial Individuals." Pp. 191–210 in *The Multiracial Experience: Racial Borders as the New Frontier*, edited by M. P. P. Root. Thousand Oaks, CA: Sage Publications.

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