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## A QUALITATIVE EXPLORATION OF ALCOHOL AND OTHER DRUG USE AMONG MULTIRACIAL YOUNG ADULTS

Tessa Nalven  
*University of Rhode Island, tessa\_nalven@uri.edu*

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A QUALITATIVE EXPLORATION OF ALCOHOL AND OTHER DRUG USE  
AMONG MULTIRACIAL YOUNG ADULTS

BY  
TESSA NALVEN

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY  
IN  
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2022

DOCTOR OF PHILOSOPHY DISSERTATION

OF

TESSA NALVEN

APPROVED:

Dissertation Committee:

Major Professor      Nichea Spillane

Joseph Rossi

Ginette Ferszt

Brenton DeBoef

DEAN OF THE GRADUATE SCHOOL

UNIVERSITY OF RHODE ISLAND

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## ABSTRACT

The United States' Multiracial population (i.e., two or more races) increased by 276% between the 2010 and 2020 censuses, making it one of the fastest growing racial/ethnic demographic groups in the country. Research suggests that Multiracial young adults (i.e., 18–25 years old) report higher alcohol and other drug (AOD) use and are at a higher risk for AOD-related consequences than nearly all their monoracial counterparts. The present study conducted focus groups and utilized descriptive qualitative methodology to uncover factors associated with AOD use in Multiracial young adults. 22 participants (77.3% women,  $M_{age} = 20.8$  years,  $SD = 2.6$ ) were included and were eligible if they were Multiracial, 18–25 years old, and reported any past six-month AOD use. In fall 2021, semi-structured interviews were conducted with four online focus groups of 4–7 participants each; these groups were audio/video recorded via Zoom. Following transcription of recordings, content and thematic analysis was completed with two independent coders using Atlas. Five major categories emerged in participants' responses regarding risk or protective factors related to their AOD use: (1) racial discrimination and microaggressions, (2) mental health, (3) environment, (4) fitting in and belonging, and (5) racial identity. In addition, two themes were extracted from data: (1) no one understands my life and (2) being Multiracial is always present. For the five categories, experiences of racial discrimination and microaggressions included discrimination within the family, racism directed at individuals for a racial group with which they do not belong, stereotype threat, intergenerational trauma, internalized racism, and privilege. Mental health-related factors included mood/anxiety, self-esteem, social support, and coping. Environmental influences were comprised of availability of AODs,

neighborhood factors (e.g., socioeconomic status), and social environmental influences. Participants discussed challenges and advantages they had with fitting in and belonging among their families and communities, including seeking acceptance, being socially isolated, and social flexibility. Finally, racial identity concerns included delayed racial identity development, identity confusion, emotional exhaustion related to identity (and the need to be constantly attentive to race), but also pride in racial identity and increased emotional intelligence. The two themes were comprised of common threads across the majority of participants' lived experiences including their reported constant sense of isolation, loneliness, and being misunderstood, which resulted in feeling a lack of support and community. They also felt that being Multiracial was impactful in all aspects of their lives, and while that created stress and exhaustion, it also enhanced their social and emotional resilience. These findings suggest that there are unique factors associated with AOD use in Multiracial young adults. Interventions to ameliorate the disproportionate rates of AOD use among Multiracial young adults should leverage the unique risk and protective factors experienced by Multiracial young adults and consider the complex interactions between racial discrimination, individuals' identity, their way of fitting in, their environment, and mental health. Such interventions may particularly benefit by addressing healthy ways of coping with such concerns and educating society about ways to foster Multiracial individuals' healthy growth.

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## PREFACE

Entering into graduate school, I always knew I wanted to do research on substance use and marginalized racial/ethnic populations. I knew I had a passion for learning more about alcohol and other drug (AOD) use, its correlates and harmful effects, and ways to prevent or intervene with problematic use. I also had a passion for social justice and supporting any marginalized populations, but particularly racial/ethnic minoritized groups. However, I had no narrow focus until I started to dive deeper into the literature. While doing so, I came across tables that presented the rates of substance use across racial/ethnic groups from nationally representative data. These results, much to my surprise, suggested that Multiracial young adults have higher rates of AOD use than their monoracial counterparts. This finding was true across almost all substances, and I was in disbelief. After taking time to process this information, I realized that it made sense that Multiracial individuals may have a lot of unique challenges that contribute to these disparities. However, what continues to shock me to this day is the vast lack of attention drawn to this information; I wondered how I had never heard this before, and I knew I wanted to learn more.

Since that time, I have envisioned a whole line of research I plan to pursue for my career going forward. As an individual who is Multiracial myself, I was struck by the fact that few people know that Multiracial individuals report such high levels of AOD use and even fewer researchers have begun to examine correlates of this AOD use. Moreover, I have yet to see any interventions designed or adapted to address AOD use specifically among Multiracial individuals.



I find myself noticing that, of the scant literature focusing on Multiracial AOD use, a majority takes a deficit focus. Research often focuses on risk factors, and I believe it is for a good reason: because AOD use rates are higher among Multiracial young adults. However, it is important to also keep in mind that there is some literature suggesting that there are also unique advantages and positive aspects of being Multiracial, and these factors might confer protection from AOD use.

Another important factor that I often find myself considering and discussing with others is the extent to which “Multiracial” is actually a meaningful group. While I am constantly aware that combining many diverse people into one group is reductionist and cannot account for the vast heterogeneity across all the different combinations of individuals, I believe that “Multiracial” represents an important and unique social group with notable and salient characteristics that are worthy of exploration. As with other racial groups, I take into account that race is a social construct that is largely based off of how society perceives and, therefore, treats a group of people and that all racial groups are comprised of diverse peoples with varied experiences coming from different nations and cultures. Similarly, I believe that Multiracial people are members of a group that is defined largely by the way society perceives and treats them. Thus, in the proceeding dissertation, I study Multiracial people as a cohesive group, without parsing out their separate identities, to examine the similarities – both strength and struggle – that Multiracial young adults experience as a result of their similar lived experiences in the context of a racialized, monoracist (Harris, 2016), White supremacist society.

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## CHAPTER 1.

### INTRODUCTION

The United States' Multiracial population (i.e., two or more races) comprise approximately 2.9% of the population and are expected to triple in number by the year 2050 (Goings et al., 2018). As a quickly growing population, they have disproportionately high rates of alcohol and other drug (AOD) use compared to monoracial counterparts (Chavez & Sanchez, 2010; Choi et al., 2006b; Jackson & LeCroy, 2009; Sakai et al., 2010; Udry et al., 2003), particularly among Multiracial young adults (i.e., between ages 18–25; SAMHSA, 2021). Specifically, the 2020 National Study on Drug Use and Health (NSDUH), found that Multiracial young adults have a higher prevalence of lifetime and past year illicit substance use (64.6% and 44.3%, respectively) than Black (49.3% and 36.9%, respectively), White (59.0% and 42.3%, respectively), Asian (33.8% and 19.9%, respectively), and Hispanic/Latinx (46.0% and 28.1%, respectively) counterparts (See Table 1 for a breakdown of past year rates by substance among different racial groups as reported in NSDUH). Moreover, Multiracial young adults reported higher prevalence rates of past year alcohol use disorder (17.4%) than Black (9.7%), Asian (9.1%), and Hispanic/Latinx (13.0%) counterparts, but lower rates than White (18.8%) counterparts (SAMHSA, 2021). These heightened rates of AOD use among Multiracial young adults are particularly problematic because early initiation of AOD use is related to later AOD-related consequences and disorders (Chavez & Sanchez, 2010) and because high rates of AOD use in young adulthood persist throughout the lifespan among Multiracial people (SAMHSA, 2020). There is a dearth of

research on AOD-related consequences in Multiracial individuals, but the existing research indicates that Multiracial youth (ages 10–20) are more likely to experience AOD-related consequences than other racial groups, such as White, Black, or Asian youth (Heaton, 2018; Nalven & Spillane, 2019). Yet, the social and environmental mechanisms associated with AOD use among Multiracial young adults remain underexplored.

While Multiracial young adults comprise a highly heterogeneous group, these alarming rates may suggest that there are common factors experienced by those within the Multiracial group that warrant further exploration. Some concepts and risk factors may be particularly relevant as they relate to social determinants of health. Given that race is defined as a social construct (Schaefer, 2008), Multiracial individuals may experience unique social and environmental dynamics, as outlined below, that are worth exploring further in their potential relations with AOD use. There may also be factors that are known to predict substance use among minoritized monoracial individuals that are worthy of exploration or adaptation in the study of factors associated with Multiracial AOD use.

### **Racial Discrimination**

High levels of racial discrimination have a robust relationship with increased AOD use in monoracial populations (Metzger et al., 2018; Salas-Wright et al., 2018). Among Multiracial individuals, discrimination has been found to be related to heavy alcohol use in adults (Nalven et al., 2021) and AOD use in adolescents (Choi et al., 2006b). These findings underscore the importance of studies suggesting that Multiracial people report experiencing equal or greater racial discrimination than their monoracial

White and minoritized peers (Brackett et al., 2006; Greig, 2014; Nalven et al., 2021). Moreover, Multiracial individuals may experience unique forms of discrimination, such as discrimination from within their own families (Franco & Carter, 2019) or racial identity invalidation, defined as the discrimination or exclusion from others due to misalignment between the way an individual appears or is perceived by others and their own self-identified racial identity (Franco & O'Brien, 2018). Such forms of racial discrimination have been found to cause significant distress (Franco & O'Brien, 2018) and be harmful to one's mental health and well-being (Franco & Carter, 2019; Sanchez, 2010; Townsend et al., 2009), but they may not be well captured in commonly accepted and widely used assessments of discrimination that are designed for other populations. Therefore, we expect that experiences of discrimination may be an important factor in Multiracial AOD use that is worthy of further exploration.

### **Racial Identity**

Multiracial individuals tend to relate to their racial background less strongly than monoracial people (Nalven et al., 2021). Because Multiracial individuals, by definition, have two or more racial backgrounds, they may have more difficulty developing a strong sense of racial identity. Most literature on the relationship between racial identity affiliation and AOD use has focused on monoracial people and suggests that a strong affiliation with one's race is protective against AOD use (Chao & Otsuki & Clutter, 2011; Fisher et al., 2017; Smith & Silva, 2011; Zapolski et al., 2017). The few studies that have explored this relationship among Multiracial young adults resulted in mixed findings but may suggest that strong racial identity affiliation is associated with less frequent AOD use (Choi et al., 2006b; Fisher et al., 2017; Zapolski et al., 2017). However, further

research is necessary to address the gap in knowledge by specifically examining the relations of racial identity and AOD use among Multiracial young adults, who are at an age when identity may be particularly relevant (Phinney & Kohatsu, 1997). Moreover, assessment tools aiming to capture racial identity that are typically used in quantitative research may not be accurately capturing what they intend to among Multiracial people; for example, if they only ask about one's "race," it may be hard for Multiracial people to answer because they do not know which race the question refers to (Zapolski et al., 2017). Thus, a more in-depth exploration of how racial identity is formed and its relation to AOD use in Multiracial individuals is needed.

### **Belonging and Social Support**

Multiracial individuals may lack a sense of belonging and may feel as though they do not "fit" into any of their separate racial groups; this lack of belonging may be particularly harmful for psychological well-being during young adulthood (Coleman & Carter, 2007; Franco & O'Brien, 2018; Hud-Aleem & Countryman, 2008). Furthermore, they may be perceived by others as "colder" and feel that they are more susceptible to negative feedback from peers (Sanchez & Bonam, 2009). A lack of belonging is also associated with lack of perceived social support (Choi et al., 2006a; Sanchez & Bonam, 2009; Shih & Sanchez, 2009). In a very limited number of studies, perceived lack of belonging and a dearth of social support have been found to be associated with elevated AOD use among Multiracial individuals (Choi et al., 2006a; Fisher et al., 2019). However, research in this area is limited and additional work is needed to further explore, confirm, and extend previous findings.

### **Self-Esteem**



Research suggests that self-esteem may be lower in Multiracial individuals than their monoracial counterparts (Fisher et al., 2014). Higher self-esteem has been found to have protective effects against AOD use in Multiracial adolescents (Fisher et al., 2017) and has a robust relationship with AOD use among monoracial individuals (Arsandaux et al., 2020; Schick et al., 2020; Szinay et al., 2019; Zeigler-Hill et al., 2017). Yet, there are few studies examining self-esteem among Multiracial individuals, and in particular, no studies, to date, have examined the relations of self-esteem and AOD use in Multiracial young adults.

### **Depression**

Some studies have found that depressive symptoms and suicidal thoughts and behaviors are higher among Multiracial, compared to monoracial, individuals (Subica & Wu, 2018; Udry et al., 2003). Moreover, Multiracial individuals are more likely to report having had serious thoughts about suicide (19.7%) or made a plan for suicide (8.0%) in the past year than their counterparts who are Black (9.5% and 3.6%, respectively), White (12.4% and 3.6%, respectively), American Indian/Alaska Native (15.1% and 6.7%, respectively), Asian (8.4% and 2.2%, respectively), and Hispanic/Latinx (8.6% and 3.0%, respectively; SAMHSA, 2021). Depression has a robust relationship with AOD use among monoracial people (Aneshensel & Huba, 1983; Hanna et al., 2001; Kotov et al., 2010; Paton et al., 1977; Schmidt et al., 2001; Swendsen & Merikangas, 2000) and one study among Multiracial adolescents found that suicidal thoughts were related to alcohol use (Subica & Wu, 2018).

### **Limitations of the Current Literature**

While there is a scant amount of literature exploring the associations of social and environmental factors such as identity, discrimination, mental health, and social support with AOD use in Multiracial individuals (Dillworth, 2009; Franco & Carter, 2019; Gale, 2018; Joseph, 2017; Nalven et al., 2021; Urbaeva et al., 2017; Zapolski et al., 2017), the existing literature often has mixed results and needs further confirmation and expansion. Moreover, the existing research has relied on an etic approach, an outside perspective that applies frameworks designed among monoracial populations to understand AOD use among Multiracial individuals (Gale, 2018; Joseph, 2017). Given that emic approaches provide an emergent and situated understanding of a problem (e.g., AOD use) that is embedded in its social and environmental context (Morey & Luthans, 1984), the lack of emic theories regarding Multiracial young adults is problematic, because it provides an incomplete understanding of their AOD use. Furthermore, the majority of studies examining factors associated with AOD use in Multiracial individuals have examined racial discrimination, racial identity, social support/belonging, self-esteem, and depression in isolation or only with one other factor. No study, to date, has used community knowledge to ascertain a comprehensive and in-depth understanding of AOD use for Multiracial individuals. This dearth of research, combined with high rates of AOD use, highlight the need for in-depth methodology to uncover unique factors related to AOD use based on the perspectives of individuals who are members of the Multiracial community. Allowing Multiracial individuals to provide input on the factors associated with their AOD use is likely to lead to a more precise and thorough understanding of AOD use that will have great potential to identify malleable targets for intervention that are specific to this high-risk population of interest.

## **Current Study**

Risk and protective factors associated with AOD use among Multiracial young adults are vastly understudied; however, understanding them is critically important because it will inform treatment and prevention efforts by identifying factors that may be malleable and able to be utilized to protect against or treat AOD use. To date, no published study has undertaken a qualitative analysis among Multiracial individuals to understand AOD use. The proposed study builds off of previous research and extends it by capitalizing on community knowledge and by narrowing the population to young adults, who are most at risk for AOD use and related consequences (SAMHSA; 2021). We used in-depth qualitative descriptive design to explore factors related to AOD use from the perspectives of Multiracial young adults without an a priori commitment to a theoretical view (Sandelowski, 2000). First, we conducted a series of focus groups ( $n = 4$ ; 4–7 individuals per group) to explore risk and protective factors associated with AOD use in Multiracial young adults. Then, using a combination of manifest content and thematic analysis (Bengtsson, 2016; Braun & Clarke, 2006; Kleinheksel et al., 2020; Vaismoradi et al., 2013), we uncovered factors associated with AOD use in Multiracial young adults that is informed by the community's input. By applying qualitative analyses, we believe this research optimizes and enriches the understanding of AOD use in Multiracial young adults (Creswell & Poth, 2016; Sandelowski, 2000; Sullivan-Bolyai et al., 2005). Moreover, results will be instrumental in creating and adapting future intervention studies to specifically address disparities in AOD use in this quickly growing, high-risk population.

## CHAPTER 2.

### METHODOLOGY

A descriptive qualitative design was used for this research study. The research questions that guided this study were: 1) what factors confer protection against AOD use among Multiracial young adults? 2) what factors contribute towards risk for AOD use among Multiracial young adults? and 3) how are racial discrimination, racial identity, belonging, social support, self-esteem, and depression associated with AOD use among Multiracial young adults?

#### **Participants**

Participants were eligible if they: (1) were between 18–25 years old, (2) currently lived in the U.S., (3) could speak and understand English, (4) identified as Multiracial, biracial, mixed-race or as having parents from two or more racial backgrounds, (5) reported past month AOD use (i.e., use of alcohol, marijuana, illicit substances, or misuse of prescription substances), (6) were willing to participate in a group interview that would be audio and video recorded, and (7) had access to a private space with internet to participate in the virtual focus group. Participants were recruited across the United States by: (1) emails sent to university listservs, (2) social media posts and other internet advertisements (e.g., Craigslist), (3) posting flyers throughout the local community (e.g., at community health centers, coffee shops, libraries), and (4) using snowball sampling by asking people interested in the study if they have acquaintances that may also be interested in participating.

Given that there are no definitive standards for a mandatory sample size in qualitative research (Lincoln & Guba, 1985; Morse, 2015; Seidman, 2006; Shaheen & Pradhan, 2019), participants were recruited on a continuous basis, simultaneous to data collection, until saturation was achieved and no new concepts arose (Boyatzis, 1998; Braun & Clarke, 2006; Vasileiou et al., 2018). In total, four focus groups were held with 4-7 participants per group, for a total of 22 participants; see Table 2 for a full description of their demographic characteristics. The average age of participants was 20.8 years ( $SD = 2.6$ ), and 81.8% identified their sex assigned at birth as female ( $n = 18$ ), while the remaining 18.2% identified their sex assigned at birth as male ( $n = 4$ ). For gender, 77.3% of participants identified as women ( $n = 17$ ), 18.2% identified as men ( $n = 4$ ), and 4.5% identified as non-binary/agender ( $n = 1$ ). For ethnicity, 40.9% of participants ( $n = 9$ ) reported that they were Hispanic or Latino/a while the remaining 59.1% ( $n = 13$ ) identified as non-Hispanic or Latino/a. While all participants met the criteria for Multiracial by our working definition (see eligibility criteria number four above), 90.9% ( $n = 20$ ) reported that they primarily identify with Multiracial/biracial/mixed race, while 4.5% ( $n = 1$ ) reported that they identify primarily with Black race and 4.5% ( $n = 1$ ) identify primarily with White race. Of note, all individuals, including the ones that identified as primarily Black or White will be referred to as “Multiracial” hereafter given that they reported having parents from two or more racial backgrounds (i.e., out of the categories: White, Black/African American, Hispanic/Latino/a, Native American/Alaska Native, Native Hawaiian/Other Pacific Islander, or Asian). Regarding AOD use, 95.5% ( $n = 21$ ) of participants reported past month alcohol use, 63.6% ( $n = 14$ ) reported past month cannabis use, 18.2% ( $n = 4$ ) reported past month amphetamine or other stimulant

misuse, 13.6% ( $n = 3$ ) reported past month hallucinogen use, 4.5% ( $n = 1$ ) reported past month cocaine use, and 4.5% ( $n = 1$ ) reported past month methamphetamine use.

Moreover, 68.2% ( $n = 15$ ) reported that they had used two or more different kinds of AODs in the past month.

### **Informed Consent**

Prior to beginning data collection, participants were emailed and instructed to read a consent form, which outlined a basic description of the study, confidentiality, potential for harm, and potential benefits of participating. The study team then reviewed relevant consent information over the phone with potential participants, and they were encouraged to ask questions and clarify any procedures throughout the consent process. The consent form included the contact information for the student investigator (Nalven), the student's major professor (Dr. Spillane), and the University of Rhode Island Institutional Review Board, in case the potential participants had questions or concerns. Potential participants were made aware that they can discontinue participation in the study at any time by informing the study staff that they wish to cease their participation and that they could choose to not answer questions. Potential participants were then required to document that they had read the consent form, that any questions had been answered, and that they agreed to participate by signing the electronic consent form that was emailed to them via a REDCap survey link. Moreover, a separate signature was obtained to ensure participants consented to being audio and video recorded during the focus groups. All procedures were approved by the University of Rhode Island Institutional Review Board before data collection began.

### **Procedures**

Interested participants' that reached out to the study team were scheduled for a brief phone call to tell them about the study and assess interest, availability, and eligibility. During the phone calls, screener questions assessed eligibility by collecting demographic information and confirming past month AOD use. After confirming eligibility, participants were given additional information about the study, consented, and were scheduled for a focus group. They were also emailed a Zoom link for them to join during their scheduled focus group online, given information about signing in for the focus group, and assigned a participant number. A REDCap survey link was (separately) emailed to participants for them to sign consent online during the phone meeting. They also completed a brief sociodemographic and AOD use questionnaire on REDCap (with no identifying information connected to this data; see Measures for more details on questions that were asked).

### ***Focus Groups***

The present study utilized focus groups, given that they confer several benefits. Specifically, more sensitive and personal information is more likely to be disclosed during focus groups (Guest et al., 2017), synergy may be achieved such that people's contributions may build off one another's and a broader depth may be attained when individuals consider topics in a new way based on what others have said (Acocella, 2012), and groups can result in participant interaction that may enhance understanding of co-constructed meanings (Wilkinson, 1998). However, it is worth also noting that focus groups may have some weaknesses. For example, in a randomized study comparing results from both focus group and individual interviews for the same study objective, Guest and colleagues (2017) found that both formats resulted in a similar number of

unique ideas but that individual interviews were more likely to produce a broad range of results. Moreover, focus groups can account for more participants in less time and may potentially save research costs, but they require additional preparation, such as for the consideration of the homogeneity of a group (Acocella, 2012). In a focus group, the researcher must be attentive to group dynamics and social phenomena, such as some individuals speaking over others and conformity to group views where minority opinions may not be as likely to be shared (Acocella, 2012). Thus, during focus groups for the present study, the moderator made attempts to ameliorate some of these concerns by encouraging people with differing opinions to speak up and offering sufficient time for silent reflection; however, it is likely that the aforementioned problems persisted to some extent (Acocella, 2012).

Focus groups occurred during the fall of 2021. Following screening, participants selected which of four pre-scheduled timeslots they were available to join a focus group. During the focus groups, consent information was reviewed and all participant questions were answered prior to starting the recording and beginning data collection. The study investigator confirmed that all consent forms had been signed prior to continuing with the focus group. Next, after collectively establishing ground rules (e.g., protecting others' confidentiality, keeping camera on when able, being respectful of others), a semi-structured interview was conducted, inquiring about reasons for use of AODs among Multiracial people (see Measures below). The study investigator (Nalven) debriefed with other investigators following each group, and behavioral observations and reflective memos about noteworthy categories and themes were typed into a password protected file (see Data Analyses below for more details). Focus groups were audio and video recorded



on two separate devices (i.e., phone recorder and Zoom, for backup) so that they could be transcribed at a later time. Transcripts were then de-identified and transcribed verbatim by a professional third-party transcribing service. Next, transcriptions and memos were entered into a qualitative software program, Atlas, for coding. Of note, recording interviews confers many benefits including the ability to record data verbatim and to use in an audit trail (Seidman, 2006). Focus groups each took approximately two hours or less ( $M = 104.25$  minutes; Range: 94–113 minutes). Following the focus groups, participants were thanked and given \$30 for their participation, which is based on recommended participant payment guidelines (Grady, 2005), and they were asked to select between a Venmo transfer or Amazon gift card payment.

### ***COVID-19 Considerations***

While in person focus groups would have been the preferred method of data collection, in-person focus groups were deemed unsafe due to COVID-19 restrictions at the time of data collection (fall 2021); therefore, the focus groups were conducted via online video sessions through a HIPAA compliant video conferencing platform (i.e., Zoom). Research suggests that online focus groups are feasible and may offer some benefits (e.g., ease of use, data storage, potential increased disclosure due to a sense of anonymity; Fox et al., 2007; Gaiser, 2008). Moreover, these groups allowed the study team to recruit beyond the local communities to obtain a more nationally diverse sample. Participants were also informed that they should ensure they have access to a quiet, private space during the focus group and that computers with internet access, a microphone, and a camera would be the preferable connection method, while smart

phones that are capable of video conferencing were also an acceptable means to join the focus group (and allow for access to a broader range of participants).

## **Measures**

### ***Demographics (Appendix A)***

Sociodemographic information was collected to describe the sample through a self-report questionnaire. Questions assessed age, sex, gender, race, and parental race. The following were also collected to characterize the sample:

**Socioeconomic Status** was assessed using the MacArthur Scale of Subjective Social Status (MSSSS), a measure of participants' sense of social status across income, education, and occupation (Adler et al., 2000). Participants respond by indicating how they perceive their social status to be compared to others in the United States on a scale from 1–10, with higher scores indicating higher social status. The MSSSS has been used in research with diverse racial and ethnic groups (Franzini & Fernandez-Esquer, 2006; Ostrove et al., 2000). We also assessed for self-reported education level, income, and employment status.

**Racial/Ethnic Identity Affiliation** (Appendix B) was assessed using the Multigroup Ethnic Identity Measure-Revised (MEIM-R), a six-item measure of affiliation with one's racial/ethnic group. Each item was rated with a Likert-type scale ranging from 1 = "strongly disagree" to 5 = "strongly agree." A total score was then calculated, with higher scores indicating stronger racial/ethnic identity affiliation. The MEIM-R has been validated and demonstrates good reliability and invariance among Multiracial individuals (Brown et al., 2014). Reliability in the present sample was acceptable, Cronbach's  $\alpha = .65$ .

### ***AOD Use (Appendix C)***

The Drug History Questionnaire (DHQ) is a self-report questionnaire that collects information on history and frequency of use of alcohol, cannabis, hallucinogens, depressants, inhalants, narcotics, stimulants, tranquilizers, and other drugs. For each substance, participants reported on their past month frequency of use with a scale ranging from 0 = “no use” to 7 = “daily.” The DHQ has demonstrated good test-retest reliability (Sobell et al., 1995).

### ***Data Collection Methodology***

Semi-structured interviews were utilized to guide the conversation during focus groups, as they are the most commonly used methodology in qualitative descriptive design (Kim et al., 2017). See Appendix D for an outline of the full semi-structured interview guide. During focus groups, the investigators ensured that questions were aligned with research aims but also allowed for flexibility in addressing and following up with participant responses (Jacob & Furgerson, 2012; Legard et al., 2003; Wilkinson et al., 2004). Before implementing an interview protocol, the student investigator received feedback on interview questions from experienced researchers and experts on substance use research among Multiracial young adults to refine questions and ensure they are systematic and comprehensive, although the questions were allowed to evolve as new topics arose during focus groups (Yeong et al., 2018). Specifically, questions started out by broadly assessing participants’ views on their race and how it has impacted their life. Then, participants were asked about their beliefs regarding their use of AODs. Open-ended questions assessed for community strengths and protective factors as well as potential areas of concern for vulnerability to use of AODs. Although we were interested

in participants guiding the conversation to topics that they believe are relevant to their use of AODs, in order to maintain a moderate level of structure and to facilitate conversation, we also asked specific questions that are guided by the literature about the roles of discrimination, racial identity, belonging/social support, self-esteem, and depression.

Finally, it is important to note in qualitative research that the researcher is an instrument in the data collection, such that their preconceived notions and biases cannot be separated from the individual during data analyses and interpretation (Lincoln & Guba, 1985). Therefore, the researchers considered their assumptions beforehand and discussed them with the study supervisor (Spillane), primary investigator (Nalven), and other research assistants involved in data collection. This process ensured continuous monitoring of assumptions in order to minimize their effect and was undertaken with the goal of enhancing trustworthiness of results (Bengtsson, 2016; Lincoln & Guba, 1985); see the Preface for the student investigators' (Nalven's) reflective journal that outlines her previously held beliefs.

### **Data Analytic Strategy**

A qualitative descriptive design using focus groups was used to conduct this research study (Artinian, 1988; Sandelowski, 2000; Willis et al., 2016). Qualitative descriptive design consists of the collection and presentation of in-depth information about a phenomenon without an a priori commitment to a theoretical view (i.e., exploratory analysis; Sandelowski, 2000). It is considered to be particularly preferable and amenable to health disparity research among marginalized groups (Sullivan-Bolyai et al., 2005) and for attaining direct, fundamental information that is highly accurate (Sandelowski, 2000). Therefore, qualitative descriptive research lends itself well to the

study of AOD use among Multiracial people for which no known theory has been created. Furthermore, the data was analyzed using a combination of both manifest content (which is more systematic and remains close to the data) and thematic (which involves some interpretation) analysis to ensure an in-depth analysis procedure was followed that relies on minimal interpretation and optimizes trustworthiness (including rigor and credibility; Bengtsson, 2016; Braun & Clarke, 2006; Kleinheksel et al., 2020; Vaismoradi et al., 2013).

As qualitative analyses are an iterative process, the student investigator conducted interview questions while the other researcher (i.e., a graduate research assistant and/or mentor, Dr. Spillane) recorded behavioral observations and memos during and after each group on concepts as they arose. Specifically, reflective memos included the researchers' response to the interviews and notes on what they heard and observed including noteworthy concepts that arose, as well as notes on changes needed for the next focus group, as appropriate (Birks et al., 2008). This process allows for parallel data analysis and collection, as consistent with qualitative descriptive design (Artinian, 1988; Sandelowski, 2000). The study investigators also discussed emerging processes and concepts after each focus group. While participants were instructed to refrain from using their own name during focus groups to help protect their confidentiality (they were asked to pick a pseudonym to be used throughout the group), transcripts were reviewed for accuracy and to ensure no identifying information was available prior to data coding. A qualitative software program, Atlas, was then used to assign codes to the focus group transcripts and memos. This process involved further coding and comparing transcripts, breaking data down into smaller components, labelling them, and comparing them with

other data and codes (Levitt et al., 2017; O'Brien et al., 2014; Vaismoradi et al., 2013). Along with the main student investigator, a second graduate student researcher was trained in coding and cross-checked analyses so that consistency of coding and triangulation could be assessed to increase study trustworthiness. Regular team meetings were utilized to assess and re-define code books as necessary, including combining overlapping or redundant codes, eliminating extraneous codes, and ensuring that codes were exhaustive and mutually exclusive for data. During team meetings, codes that were related were placed into categories. In the case of new emerging categories, transcripts were re-coded, as necessary, from the beginning to include new categories (Boyatzis, 1998; Braun & Clarke, 2006; Vaismoradi et al., 2013). Through ongoing mapping of codes and refinement of concepts, emergent categories were derived directly from the data until saturation was achieved and no new concepts arose (Boyatzis, 1998; Braun & Clarke, 2006). Following completion of summarizing categories, researchers then examined these categories and extracted overlapping themes that ran across categories. These themes are latent and abstract areas that capture the essence and underlying meaning running across data and require a small level of interpretation (Morse, 2015; Vaismoradi et al., 2016). The emergent themes were also discussed during a team meeting to reach agreement across all those involved in the analyses. Finally, the themes and categories were summarized, along with the frequency with which they occurred and, prior to summarizing results for dissemination, findings were reviewed with an expert in Multiracial young adult substance use, the study mentor, and other professionals in qualitative analysis among marginalized populations.

The following results are reported according to standards set forth for qualitative research by the American Psychological Association in the Journal Article Reporting Standards (Levitt et al., 2018). Moreover, to increase trustworthiness, rigor, and fidelity, several strategies were used. First, we ensured that at least two researchers were present for each focus group and that two coders had at least 80% agreement before proceeding to further analysis; we achieved a reliability of 85.3% agreement. Moreover, we measured the frequency with which different categories arose in transcripts, as is consistent with content analysis (Bengtsson, 2016; Vaismoradi et al., 2013). An audit trail containing all interview transcriptions, memos, and data analysis codes and categories has been maintained so that the path from raw data to results can be followed and confirmed by an experienced researcher (e.g., Dr. Spillane) to further enhance and optimize trustworthiness (Carcary, 2009). Debriefing sessions were also used following each focus group among the researcher and individuals from the study team who were present in the focus groups to discuss ideas, interpretations, and perceptions, as well as potential researcher biases and preferences (Shenton, 2004).

## CHAPTER 3.

### RESULTS

Participants discussed many topics related to the challenges and advantages they faced as Multiracial individuals, including the risk and protective factors related to their AOD use. Through the focus groups, five categories and two themes emerged that participants identified as being intrinsically related to AOD use among Multiracial young adults; see Figure 1 for a visual depiction of results. The five categories include: (1) racial discrimination and microaggressions, (2) mental health, (3) environment, (4) fitting in and belonging, and (5) racial identity. See Table 3 for the frequency with which each category and its sub-categories occurred during coding. In addition, the two themes that were extracted and cut across categories include: (1) no one understands my life and (2) being Multiracial is always present.

#### **Categories**

##### ***Racial Discrimination and Microaggressions***

Racial discrimination and microaggressions and their relation to AOD use were the most frequently discussed category during focus groups. Given that, by definition, all Multiracial people come from at least one non-White family, participants in all four focus groups discussed racial discrimination they experienced because of their racially minoritized status. For example, participants in two of the focus groups discussed being called racial slurs. Moreover, participants in all focus groups noted that, due to their Multiracial identity, there was discrimination within one or both sides of their family



either towards themselves or their immediate family members that were a different race.

As one participant described it:

“I always describe my family as like the Romeo and Juliet situation. Two houses, two sides, and it’s like, they hate each other. So, my nuclear family is basically who I have. Sure, I have extended family, but because I’m the other [race], that is not a good thing.”

Participants in all focus groups also noted that there have been many instances when someone miscoded their race and discriminated against them while falsely assuming they were from a racial group that they are not a part of. For instance, one non-Mexican participant said, “I’ve never been racially profiled or discriminated against at least to my knowledge for races or groups that I actually belong to. I’ve been called slurs for, specifically Mexicans.” Moreover, participants in all focus groups discussed having their racial identity invalidated, often in instances where they try to join a community group for their race (e.g., Asian club) and were not allowed to join or felt they had to show proof of their racial identity to be believed. For example, a participant said, “I kind of have to prove myself or have knowledge of certain things or culture. And if I, you know, say the wrong thing, I feel like I’ll be discovered as a fraud.”

Participants in all four focus groups discussed how, when other people knew their racial combination, they were then subject to stereotype threat and pressured with expectations on how they should behave. Participants described responding to this pressure in different ways. Some reported that they believed they “might as well” use AODs because people already expected it. Others said they did not want to make the stereotypes correct, so they refrained more often from AOD use. Still another part-Asian

participant described how she felt the expectations for Asians were to use less substances and in response she "was abusing drugs and alcohol to prove the fact that...this is what an Asian person looks and acts like on *me*."

Participants in three focus groups described the systemic racism, historical trauma, and discrimination their parents and family faced and how those problems had an influence on their own AOD use. Finally, participants in all focus groups mentioned thoughts consistent with internalized racism, given the impact of living in a White-supremacist society. For example, participants in three focus groups discussed their non-White features being a source of dislike of themselves and one participant talked about how she believed many people were attracted to others of a certain race (e.g., Black or White, etc.), but she felt left out from romantic attraction: "It sucks. I always didn't feel...pretty 'cause I wasn't White. I wasn't blonde. I wasn't Black. I wasn't the typical person like people wanted." Overall, participants described discrimination as a factor related to their AOD use but perhaps indirectly through emotions and coping; for instance, one participant said, "I would say that also, the feelings that come from being discriminated against like maybe anger, frustration, helplessness, people might use drugs or alcohol to cope with those feelings."

While many noted that these discrimination experiences were harmful, participants in all focus groups also acknowledged and addressed their privileges within the context of facing hardships such as discrimination, and how this may have served a protective role against AOD use for them. In particular, many participants identified as being part White, and participants in three groups noted there were advantages to their phenotype such as having lighter skin tone or the ability to "pass" as White in some

contexts; thus their “proximity to Whiteness” offered them some advantages over others who were 100% minoritized racial status. For example, one participant said, “we probably benefit again, depending on our proximity to Whiteness, in access to healthcare resources.”

### ***Mental Health***

Mental health was another category that was frequently discussed in relation to AOD use among Multiracial young adults. Participants in all four focus groups talked broadly about having difficulties with depression, anxiety, and other mental health diagnoses. Moreover, participants in three groups discussed challenges with self-esteem (which often overlapped with internalized racism as it relates to not liking their own appearance as a non-White person). One participant connected this with AOD use, stating, “I think that that's a big part of it, is the lower self-esteem that can come with being mixed [race] and then drinking to not think about it.” In addition to mental health struggles, these issues were discussed in all focus groups as being made worse by lack of support from friends and family; as one participant described it:

“I think that is probably pretty common in the mixed [race] community where you are not necessarily getting the support that you need, either because of your identity or because you might have undiagnosed mental illnesses, because it's just not talked about in your family.”

Participants in two focus groups specifically reported that, while friends and family might have wanted to be supportive, they did not know how to support participants adequately. Moreover, participants in all focus groups described stigma, often learned from families, about accessing mental health resources in the context of mental illness. For example,

one participant said, “I think most people of color can safely say that at some point a relative has told them that therapy is a White person thing.” For the people who did seek help for their mental health, they struggled to find appropriate care for their needs. One participant drew the link between not having appropriate mental health care and “self-medication” through AOD use:

“It's very, very difficult to find a counselor of mixed identity...Being mixed [race] in itself is a large stressor for many individuals, feeling like there's not the appropriate or adequate resources to take care of it or that you can't talk to other individuals about your experiences, without them judging you or not understanding, lends itself to self-medication [through AOD use].”

Thus, participants in all focus groups agreed that coping with emotions and a need to escape reality or self-medicate by using AODs are important risk factors for AOD use among Multiracial young adults. As one participant worded it, “anyone who's struggling with an identity or struggling with mental health or whatever; a logical kind of escape way is [through] drugs and alcohol.”

### ***Environment***

Another important category related to Multiracial young adult AOD use identified in focus groups was participants' environment. Specifically, participants in three focus groups discussed the importance of access and availability of AODs. However, participants in one focus group described not having access as protective against use. Others talked about AOD use being common in their families and that granted them easier access to AODs. In addition, participants in three focus groups talked about their neighborhood socioeconomic status (SES) and how Multiracial people are more likely to

be living in lower income communities. Participants in all groups specifically talked about the availability of liquor stores being much higher in their lower SES neighborhoods, compared to neighborhoods of higher SES.

Moreover, participants in all focus groups identified risk factors related to their AOD use in their social environment; such as peer and/or family pressure to use AODs or cultural or family norms of frequent AOD use. Participants in three focus groups also talked about their parents' lack of racial/ethnic socialization efforts for them, such as one participant who said:

“My dad's not super in touch with his Black culture. And, I also think my gender probably relates to that. I identified more with my mom, and she is White. So, I kinda grew up as the ‘White’ Black-girl, because I didn't know how to do my hair.”

Participants in all focus groups also talked about a lack of representation in media or their immediate environment and how that was problematic for them. For example, one participant stated, “there wasn't anybody else who looked like me...watching TV or something... There just wasn't anybody who I felt like I could relate to 'cause there wasn't...anybody, Asian on screen except for maybe Jackie Chan, much less somebody of a mixed [race] background.”

In addition to potential risks from social environment, participants in all focus groups discussed aspects of their social environment that were protective from AOD use, such as when they went to a school with a strong record of academic success, which was inconsistent with AOD use. Further, while a lot of people did not have access to Multiracial clubs or community groups, those who did found them to be protective

against AOD use. One participant described several aspects of their environment that were protective against AOD use:

“I was lucky enough to grow up in an environment where there were a lot of mixed [race] people, including my family. So, I knew where I belonged, if not with anyone else, with them. And that definitely helped me also because drinking was never allowed at family functions. We weren't allowed to have alcohol in the house.”

### ***Fitting In and Belonging***

Participants discussed the challenges and advantages they had with fitting in and belonging socially and how this category related to their AOD use. In particular, participants in all focus groups noted that there were many situations where they felt marginalized and as though they had no place to fit in, socially. One Filipino and White person summarized it well, “you’re either too White for the Filipino kids or too Filipino for the White kids.” Others noted that even among groups meant for minoritized racial people, they still felt left out, as if they were marginalized among minoritized groups with which they should belong. One participant described their worries and difficulties related to this:

“If I go up to this group of people that like, look like my family, will they accept me? Or will they think, ‘What are you doing here?’ Cause that's happened and it's just a very uncomfortable experience, to feel like you're a fraud in a place where you feel like should be home.”

Thus, participants in all focus groups reported they would use AODs “to fit in” as they were seeking a community. For example, one participant said, “you’re just trying to fit in

to whatever group you're in, and if that means you got to drink more, smoke weed, or, I don't know, be [designated driver], that's how you do it." Participants in two focus groups also mentioned not "liking" the taste or effects of using AODs but that they choose to use anyway when others around them were using AODs. As one participant said, "you're already the outlier, so why...are you going to make yourself stand out more and belong less by not doing...what everyone else is doing?" Participants in all focus groups also talked about how they have to "code-switch" the ways in which they present themselves (e.g., how they talk), to fit in with others better. For example, one participant said, "when I'm out with my White dad...I put on a different persona...and then when I'm out with my Filipino mother, then I feel like people definitely look at [me] differently."

However, as a protective factor against AOD use, participants in one focus group also found that being Multiracial allowed them more social flexibility and to fit in, at least partially, with more groups than others and that this was advantageous for them. One participant referred to himself as a social chameleon and stated:

"Because of growing up as an outsider to both of these [racial groups], I kinda had to figure out how to be a social chameleon at some point. And so, because of that...I don't find it terribly hard to fit into a lot of different social situations."

### ***Racial Identity***

The final category that emerged from focus groups related to AOD use among Multiracial young adults was about the protective and risk factors associated with their racial identity. Participants in all four focus groups discussed feeling that their racial identity development was delayed because of difficulties with belonging or not having

others around that were also Multiracial. As one participant said, “I feel like my, identity as someone who is Multiracial was definitely delayed, 'cause I feel like growing up, I didn't really ever see or interact with other people that were Multiracial.” Participants in three focus groups also described their families being from different cultures, religions, or nationalities and that this created a lot of conflict and stress that resulted in a struggle with their identity development. For instance, one participant said, “because my parents came from two different backgrounds and religions as well, I wasn't really raised on [either] religion at all.” Participants in all focus groups also described general confusion and stress with their identities and some reported having an “identity crisis.” As one participant described:

“going to college and going to a [primarily-White institution]...I think that probably contributed to an identity crisis and then, because it was college and drinking was rampant anyway, while I was having an identity crisis, there was alcohol readily available to numb that crisis.”

Moreover, participants in three focus groups described Multiracial identity as “exhausting” because they have to constantly tune in to and adjust who they were and how they present themselves in different contexts in order to figure out how they will be perceived and treated by others. As stated by one participant, “there's so many factors about, like, my experience in my life that I don't really want to explain to people, but sometimes have to, and that gets exhausting.”

However, not all participants reported difficulty or confusion with their identities (at any point, past or present); several protective factors against AOD use arose from focus groups that were related to identity. Participants in three focus groups noted that



they had an established identity as a Multiracial person and that this was protective for them; they reported liking themselves and a sense of pride in being Multiracial. They also discussed how being Multiracial caused them to want to learn more and talk about race and identity and that they are “more passionate about social justice issues dealing with race” because of being Multiracial. Finally, participants in two focus groups also noted that they thought they had a better than average sense of emotional intelligence, or as one participant stated “Multiracial is a strength because you’re able to see the world in different perspectives.”

## **Themes**

### ***No One Understands My Life***

One common thread across a majority of participants’ discussion related to their AOD use is that “no one understands my life.” This theme ran across categories where people discussed a sense of general isolation and loneliness when participants might have sought support or understanding, but found that family and professionals who were not Multiracial were not able to understand participants’ needs. This thought was summarized well by one participant who said, “it’s also kinda hard when I feel like I want to confide in someone about something, but they wouldn’t understand...So I think part of that does have to do with being mixed [race] just because, like, no one gets it.” The theme also ran across experiences of racial discrimination, including racist remarks that participants faced that were directed towards a race with which they didn’t belong. Participants in all four focus groups discussed experiencing unique forms of discrimination. For instance, they simultaneously wanted to acknowledge their privileges associated with having lighter skin, but also described instances of experiencing racial

discrimination (e.g., being called racial slurs) and then immediately discounting those experiences, reporting that their experience wasn't as bad as if they were "fully a person of color." This dilemma contributed towards them feeling misunderstood by other groups with which they identified, who didn't understand that even while acknowledging their privileges, Multiracial people still experience racial discrimination. For example, one participant said:

"Both my mother and my grandma passed due to medical malpractice...and I'm aware that there is in the medical community, there's bias and such and like racism. And I'm kinda worried that I might go to the hospital and they might just screw me over. And also, there's a thought of, 'am I allowed to have thoughts like that because I'm not *that* black?'"

However, participants summarized it well when discussing the difficult dynamic between acknowledging their privileges but also noting their further marginalization when others tell them that the discrimination they experience is not real. For example, one participant said:

"I also tried to join some diversity, education group. And we had a conversation about discrimination and all of these other Black girls had these stories to tell about discrimination. And I've never felt any of that. So that was my privilege kind of like rearing its head. But at the same time...the same Black girls who didn't want me in their club, I also felt excluded from them while they were also feeling societal discrimination...and it's brought back to people not understanding diverse experiences of being a person of color, being Black and having also White mom. And it was, it was a struggle and it's really hard...It's a hard dynamic."

This dynamic might be made further complex by the fact that in response, Multiracial individuals are not always taught to cope with discrimination or given the social support needed in the face of discrimination, therefore making its effects even more deleterious.

Interestingly, participants in two focus groups identified that, because they felt they were constantly at the margins of social groups and because no one understood them, identifying as Multiracial was their strongest affiliation. For example, one participant said:

“I definitely identify a lot more with other mixed [race] people than I do, either one or the other of my ethnicities and it’s not just the White and Asian people, but just mixed folks across the board. I feel like there’s more common ground, or that I’ve got [more in common] with other mixed people.”

Moreover, in one focus group participants reported benefits and feeling understood from engaging in the focus groups themselves; for example, one participant, in the context of reflecting on the focus group discussion, stated, “I feel very seen by this conversation.”

### ***Being Multiracial is Always Present***

Another theme that emerged consistently across different categories as it related to AOD use was that “being Multiracial is always present.” This theme included the general experience of being Multiracial as having an important role across all aspects of their lives and that all the categories are linked together, including racism, lack of representation or support in their environments, difficulties with fitting in and resulting mental health struggles, and racial identity challenges. For example, one participant stated that, “I think Multiracial people just have lots of stressors” and a separate participant stated “I think when we live in a country that is so heavily focused on a

monoracial perspective, everything about being mixed race lends to hypothetical damage.” Participants in three focus groups noted that they use AODs to cope with these numerous stressors because they must constantly be attentive to their racial background and how that interacts with their surroundings; this process resulted in general mental exhaustion. For example, one participant described “wanting to not feel anything because then you're constantly feeling all these types of ways from being a mixed-race person. So then, the only way to like shut those feelings off for a second is to use alcohol and drugs and...escape.”

However, participants in three focus groups also described how their Multiracial status always being present created strong resilience and general strength within them. While discussing some of the negative risk factors Multiracial people face, one participant noted that it “doesn't mean that being mixed race is a bad thing. I'm grateful for my mixed ethnicity. I'm grateful for the experiences I have.” Participants in one group also noted that their negative experiences from being Multiracial helped them grow as individuals and gain social and emotional skills. For example, one participant stated, “I feel like the being an outsider thing...is always present. Like it's always in the...back of my mind...And because of that, I felt like I've had to overcompensate...to being [more] social.” Moreover, participants described how they gained many skills across their lives, including the ability to be socially flexible and more attentive to others’ emotions and social justice issues. One participant stated that as a result of being Multiracial and having to behave as “a social chameleon... I think I've gained this type of, like, social resilience.”

## CHAPTER 4.

### DISCUSSION

The present study is among the first qualitative explorations of AOD use among Multiracial young adults to date. Results of the focus groups highlighted five categories and two themes that are related to Multiracial young adults' disproportionate rates of AOD use. The five categories are (1) racial discrimination and microaggressions, (2) mental health, (3) environment, (4) fitting in and belonging, and (5) racial identity. While participants discussed these categories that are related to their AOD use, many people also noted that these categories cannot be separated from each other and that they are all interconnected. Thus, two themes that ran across categories and captured the essence of what participants discussed holistically included: (1) no one understands my life and (2) being Multiracial is always present. Altogether, these findings suggest that, along with factors that relate to AOD use among all young adults, there are factors that are uniquely and specifically experienced by Multiracial young adults that are worthy of further exploration to understand how they can be leveraged in the design or adaptation of interventions for AOD use.

Participants reported experiencing frequent racial discrimination related to the minoritized racial groups to which they belong; this finding is consistent with literature suggesting Multiracial individuals are subject to racial discrimination at rates equal or greater than monoracial peers (Brackett et al., 2006; Greig, 2014; Nalven et al., 2021). Also consistent with literature (Franco & O'Brien, 2018), participants discussed experiencing microaggressions such as racial identity invalidation, where others refused

to believe or discounted their racial identity. However, a few topics of discussion regarding discrimination are novel or not clearly discussed in previous literature regarding Multiracial AOD use. For example, participants reported that others often falsely assume them to be a part of a racial group with which they do not belong; they reported being subject to racist remarks for groups they don't belong to or experiences where others assumed they were not related to their family members. These experiences resulted in responses of confusion, and are a potential area for intervention in that discussions on how to respond to racism and microaggressions could include methods of replying to this miscoded racism. Education in this area may assist in the development of appropriate ways of coping for Multiracial young adults as an alternate to using AODs to cope.

Regarding mental health, our findings are consistent with literature suggesting that Multiracial individuals experience difficulties related to mental health disorders (Subica & Wu, 2018; Udry et al., 2003). Moreover, social support was discussed as a risk factor for AOD use when it is lacking and protective when it is present and adequate, as is consistent with existing literature (Hong et al., 2022). We also found that participants had some struggles with self-esteem. While many experiences of self-esteem may be related to being a young adult, rather than their Multiracial identity, specifically (i.e., many young adults struggle with self-esteem; Orth et al., 2018), a few aspects of self-esteem arose that seemed unique to being Multiracial. These factors may help to explain why literature is mixed regarding whether or not Multiracial individuals struggle more with self-esteem than other racial groups (Shih & Sanchez, 2005). For instance, several participants talked about how their race and gender interacted, such that if their

phenotype was different than their same-gendered parent, they were not always taught how to behave or style themselves (e.g., how to groom their hair properly); this process negatively impacted their self-esteem. Thus, if parents were educated on addressing issues such as physical appearance and proper grooming for their Multiracial children's phenotype, it is possible that they could help improve their Multiracial youth's self-esteem, and subsequently, protect against AOD use.

Participants identified their environmental factors such as access/availability of AODs, SES, family/cultural norms, and peer/family pressure to use AODs as important factors related to their personal AOD use. While we had not anticipated this finding because we were focused on specifically identifying unique factors associated with AOD use in Multiracial young adults, it is unsurprising that they were identified as relevant, given extensive theory and research that suggests environment is an important factor in AOD use among most young adults, across many racial groups (Marlatt et al., 1988; Spillane et al., 2020a; Spillane et al., 2020b; Spillane et al., 2021). However, one environmental factor that is unique to communities of color, and even further problematic for Multiracial young adults, is the lack of racial representation, either in one's surroundings or in popular media. As discussed by Shih and Sanchez (2005), not seeing people who look like you (e.g., because they are not Multiracial or do not represent the same racial combination) in the media or one's surroundings, including even within one's own family, is problematic because young adults may lack role models that set positive examples of abstaining from AOD use.

As we anticipated and consistent with existing literature (i.e., Choi et al., 2006a; Fisher et al., 2019), fitting in and lack of belonging within participants' families and

communities or social groups was an important category discussed regarding use of AODs. Participants discussed the need to change the way they identify and present themselves (i.e., “code-switch”) in order to fit in for different contexts, which is consistent with the concept of “malleable racial identification” that Shih and colleagues (2009) studied in Multiracial individuals and found it was related to lower psychological well-being. As described in Harris’s Multicrit theory (2016), Multiracial individuals are in a marginalized racial position in society, often even among other racially minoritized groups, which perpetually “others” Multiracial people and benefits White supremacy. Multiracial participants in this study talked frequently about how this positioning affects them and leads them to use AODs. Interestingly, some participants also noted they may benefit from social flexibility and the ability to fit in to multiple social groups; thus, they have become adept at social skills because of being Multiracial. This finding is consistent with literature suggesting Multiracial people may benefit from enhanced social functioning (Salahuddin & O'Brien, 2011). Thus, it is possible that leveraging the utility of these enhanced social skills may be beneficial for interventions protecting against AOD use.

Regarding racial identity, previous literature has resulted in mixed findings for the relations of AOD use and racial identity among Multiracial individuals, such that some research finds racial identity is related to AOD use and other research does not support this relation (Choi et al., 2006b; Fisher et al., 2017; Nalven et al., 2021; Zapolski et al., 2017). Moreover, consistent with literature (Shih & Sanchez, 2009), some participants reported resiliency associated with being Multiracial, such as having pride in their identity and increased emotional intelligence, which are protective against AOD use.



However, a few aspects that participants identified as related to their AOD use and identity were unexpected. For example, numerous participants described Multiracial identity as being “exhausting” because of the many stressors they experience related to identity and having to constantly be aware of their own and others’ racial identity. Another unexpected finding was the stress participants reported they face given conflicting values from parents or families from different races; this finding is consistent with some literature suggesting that Multiracial youth may receive conflicting messages and values passed down from their parents (Shih & Sanchez, 2005). It is possible that if parents educate themselves and their children more often on racial/ethnic socialization, Multiracial individuals may have even more resiliency against AOD use. This socialization may be particularly helpful if parents foster an identity among their children, not just for their separate races, but also specifically fostering Multiracial identity (Atkin & Yoo, 2019).

Two themes also emerged from the data that offer unique, underexplored, and highly important implications, given that they capture the essence of what is related to AOD use among Multiracial young adults but have not yet been explored in literature. One theme, “no one understands my life” suggests that Multiracial people feel misunderstood and lonely in many contexts in their lives (e.g., when facing discrimination or seeking support). Of note, while it may be common across many young adults to feel misunderstood, the depth and frequency with which Multiracial people reported this feeling extended beyond what is likely typical. While not specifically discussing this general sense of isolation, a recent qualitative study reported that Multiracial people experience “categorical invisibility” (i.e., that society lacks attention

to the fact that people can be more than one race; Bratter et al., 2022); this invisibility likely contributes to the sense of being misunderstood that Multiracial people reported in our present study. Bratter and colleagues (2022) also highlight the importance of Multiracial people needing a safe space where they can build community and advocate for Multiracial visibility in society. Thus, it may be beneficial to build a network of support groups and professional therapists specifically trained and specializing in issues regarding being Multiracial. For example, national support of communities for Multiracial individuals (i.e., clubs, social groups, etc.) would be beneficial in supporting a sense of belonging for Multiracial young adults. In fact, one participant hinted that this is something that should be addressed at a systemic level by major institutions:

“Are higher education institutions doing enough to promote Multiracial as a group of students?...What initiatives are being done to help Multiracial students? In my opinion, if...communities did that, that might help increase the sense of belonging and then help snowball positive effects later down the road.”

Regarding the theme “being Multiracial is always present,” participants reported general stressors across all aspects of their lives because they are Multiracial; these stressors resulted in a general sense of exhaustion. Thus, participants identified that a lot of the categories discussed during focus groups were intertwined and connected with each other (e.g., racial discrimination relating to depressed mood). This finding is novel and not explored often in literature, but it is worthy of exploration. Given that participants also identified that they have enhanced social and emotional resilience due to experiencing a multitude of stressors, intervention efforts may benefit by celebrating the resilience of

Multiracial people and using that resilience to effectively manage the high level of stress and exhaustion they face.

### **Limitations and Future Directions**

While the present study benefited by using qualitative methodology to gather in-depth information directly from Multiracial young adults that use AODs to uncover factors related to their use, results must be considered within the context of their limitations. First, as with all qualitative research with (relatively) small sample sizes, there are limits to the scope of transferability of results, such as to Multiracial individuals that live in other countries that may have differing experiences. A majority of the participants identified as women and on average, they reported higher educational attainment than average across the U.S. (U.S. Census Bureau, 2020), which may limit transferability of findings to Multiracial men or people of lower educational status. It is also possible that people who signed up for this study were already interested in discussing identity and being Multiracial and, thus, they may be more connected with their race than people who did not volunteer to participate. In addition, given that our eligibility included participants who had used AODs in the past six months, our sample may have missed important protective factors against AOD use that people who have not used AODs recently could more readily identify. Finally, as discussed in detail by Goings and colleagues (2020), the combination of races that Multiracial people belong to may be influential in their AOD use.

In the future, it would be advantageous if these results were integrated with quantitative results to create a model and verify the validity of the present findings among larger samples. Moreover, interventions that make use of the numerous unique factors

associated with AOD use among Multiracial young adults identified in this study and other literature (e.g., identity invalidation, struggles with support or belonging, etc.) should be designed/adapted and tested through randomized clinical trials to prevent or treat the disproportionate rates of AOD use among Multiracial individuals.

## **Conclusions**

Through direct community voice and input, the present study found that racial discrimination and microaggressions, mental health, environment, fitting in and belonging, and racial identity are important risk and protective factors related to AOD use among Multiracial young adults. Moreover, Multiracial participants felt that no one understood them, and that being Multiracial was always present and impactful in their lives. These findings suggest that, along with factors associated with AOD use among all young adults, there are unique factors Multiracial young adults face that are specific to their race. These factors could be useful in targeting prevention or treatment efforts to ameliorate the disproportionate rates of AOD use among Multiracial young adults. Thus, studies creating or adapting interventions should use approaches that consider the complex interactions between racial discrimination, individuals' racial identity, their way of fitting in, their environment, and mental health. Such interventions may particularly benefit by addressing healthy ways of coping with such concerns and educating society about ways to foster Multiracial individuals' healthy growth.

**Table 1**

Past Year Alcohol and Other Drug Use Among Different Racial Groups aged 18–25 years, as Reported in SAMHSA (2020) Detailed Tables

Racial group	Alcohol use disorder	Illicit substance use	Marijuana use	Cocaine use	Inhalant use	Opioid misuse*	Prescription sedative or tranquilizer misuse*
41 <b>Multiracial</b>	17.4%	<b>44.3%</b>	<b>40.0%</b>	<b>6.5%</b>	<b>4.7%</b>	<b>6.5%</b>	<b>5.5%</b>
<b>Asian</b>	9.1%	19.9%	18.8%	0.2%	0.1%	3.2%	2.6%
<b>White</b>	<b>18.8%</b>	42.3%	39.4%	5.6%	1.6%	5.5%	5.0%
<b>Black</b>	9.7%	36.9%	34.9%	1.7%	0.5%	3.8%	2.8%

<b>Hispanic/ Latinx</b>	13.0%	28.1%	26.3%	3.7%	1.7%	5.7%	3.3%
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Note. Bold typeface indicates highest racial group for the given substance.

\* indicates low precision of data available from 2020 as reported in the original source; results presented from 2019 data

**Table 2**

## Sample Characteristics

	<i>N (%)</i>	<i>M (SD)</i>
		Range
<b>Age</b>		20.8 (2.6)
		18–25
<b>Sex assigned at birth</b>		
Male	4 (18.2%)	
Female	18 (81.8)	
<b>Gender</b>		
Man	4 (18.2%)	
Woman	17 (77.3%)	
Non-binary/agender	1 (4.5%)	
<b>Hispanic or Latino/a</b>		
No	13 (59.1%)	
Yes	9 (40.9%)	
<b>Subjective social status</b>		6.5 (1.3)
		1–10
<b>Highest education level completed</b>		
High school/GED/equivalent	3 (13.6%)	
Some college	12 (54.5%)	
College graduate	4 (18.2%)	
Some graduate school	1 (4.5%)	

Masters	2 (9.1%)	
<b>Current employment status<sup>1</sup></b>		
Full-time	4 (18.2%)	
Part-time	9 (40.9%)	
Unemployed	5 (22.7%)	
Student	14 (63.6%)	
<b>MEIM total score</b>		23.3 (3.7)
		6–30
<b>Past month AOD use<sup>2</sup></b>		
Alcohol	21 (95.5%)	
Cannabis	14 (63.6%)	
Amphetamines/other stimulants <sup>3</sup>	4 (18.2%)	
Hallucinogens	3 (13.6%)	
Cocaine	1 (4.5%)	
Methamphetamine	1 (4.5%)	

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<sup>1</sup> Participants were instructed to check all that apply for employment status (e.g., so that they could indicate it they are both a student and employed); thus, the total percentages total more than 100%. No participants indicated that their employment status was on disability (SSI/SSDI) or retired.

<sup>2</sup> Numbers for each substance reflect the number and percentage of participants who indicated any use of that substance in the past month (i.e., a score of 1 or higher on the Drug History Questionnaire). No participants reported past month use of benzodiazepines/tranquilizers, sedatives/hypnotics/barbiturates, heroin,



fentanyl/carfentanyl, street or illicit methadone/suboxone, other opioids, inhalants, steroids, or illegal use of prescription drugs.

<sup>3</sup> Amphetamine/other stimulant use was reported if misused (i.e., non-prescription use or use other than prescribed). Prescription use, if done as intended on the label and prescribed by a doctor, was not reported for these substances.

**Table 3**

Frequency of Categories and Sub-Categories as Rated by Two Coders and Across All Four Transcripts (Out of 628 Total Codes)

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Categories and Sub-Categories	Number of Codes
<u>Racial Discrimination and Microaggressions</u>	<u>176</u>
Experienced discrimination/racism	54
Privilege	23
Miscoded race or racism	22
Racial identity invalidation	16
Stereotype threat/expectations	20
Historical/intergenerational trauma	21
Internalized racism	20
<u>Mental Health</u>	<u>154</u>
Mental illness	27
Self-esteem	19
Lack of support/social isolation or loneliness	35
Stigma or lack of access to appropriate mental healthcare	33
Coping with emotions/escaping reality/self-medicating	40
<u>Environment</u>	<u>115</u>
Access and availability of AODs	13

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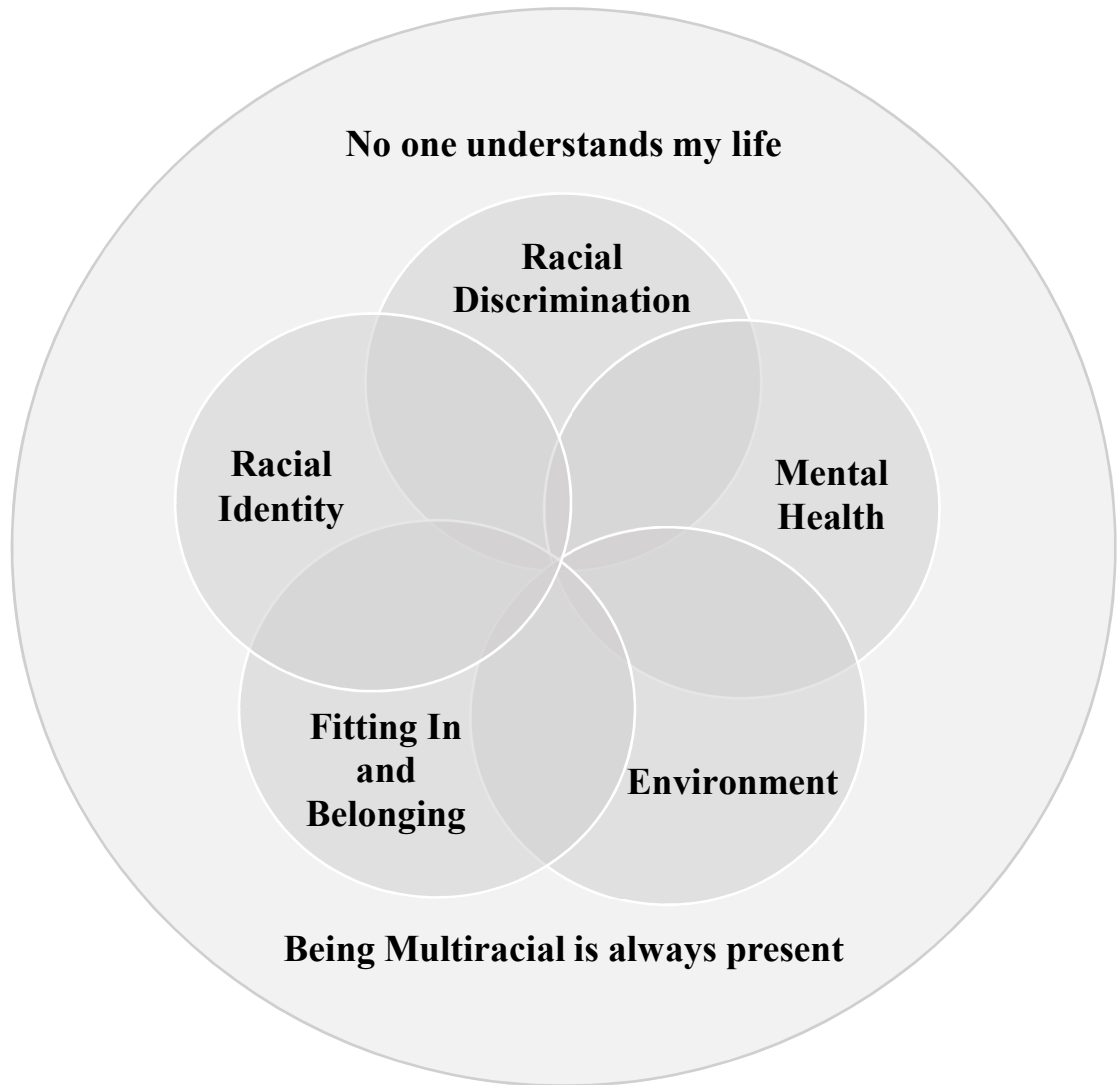
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Neighborhood/socioeconomic status	9
Protective social context (positive support)	28
Risky social context (cultural norms/family or peer pressure)	39
Lack of racial representation in environment/media	26
<u>Fitting in/Belonging</u>	<u>104</u>
Social marginalization	44
Seeking acceptance or community fit	41
Racial code-switching	10
Social flexibility/social chameleon	9
<u>Racial Identity</u>	<u>79</u>
Delayed racial identity development	11
Conflicting cultural values	17
Identity confusion or crisis	19
Identity exhaustion (resulting from having to tune in to or change racial identity constantly)	10
Established/pride in racial identity	14
Emotional intelligence	8

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**Figure 1**

A Visual Depiction of Results with Two Overarching Themes Encircling Five Categories that Emerged



## APPENDICES

### APPENDIX A

#### *Demographic Questions*

**1. Age:** \_\_\_\_\_

**2. Sex Assigned at Birth (biological sex):**

- Male (0)
- Female (1)
- Intersex (2)
- Other (Please specify): \_\_\_\_\_

**3. Gender (e.g., woman, man, transgender, etc.):** \_\_\_\_\_

**4. Ethnic Background: Are you Hispanic or Latino(a)?**

- No (0)
- Yes (1)

**5. Racial Background (check all that apply):**

- Black/African American (1)
- American Indian /Alaska Native (2)
- Asian (3)
- Native Hawaiian or Pacific Islander (4)
- White/European American (5)

**6. Do you identify as Multiracial/biracial/mixed-race?**

- No (0)
  - If no, which race do you primarily identify with? \_\_\_\_\_

- Yes (1)

**7. Biological Mother's Racial Background (check all that apply):**

- Black/African American (1)
- American Indian /Alaska Native (2)
- Asian (3)
- Native Hawaiian or Pacific Islander (4)
- White/European American (5)
- Unknown (6)

**8. Biological Father's Racial Background (check all that apply):**

- Black/African American (1)
- American Indian /Alaska Native (2)
- Asian (3)
- Native Hawaiian or Pacific Islander (4)
- White/European American (5)
- Unknown (6)

**9. Think of this ladder as representing where people stand in the United States.** At the **top** of the ladder are the people who are the best off – those who have the most money, the most education, and the most respected jobs. At the **bottom** are the people who are the worst off – those who have the least money, least education, the least respected jobs, or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.



**Where would you place yourself on this ladder?**

Please select a number 1-10 where you think you stand at this time in your life relative to other people in the United States. (1-10)

**10. Instructions: Think of this ladder as representing where people stand in their communities.** People define community in different ways; please define it in whatever way is most meaningful to you. At the **top** of the ladder are people who have the highest standing in their community. At the **bottom** are the people who have the lowest standing in their community.



**Where would you place yourself on this ladder?**

Please select a number 1-10 where you think you stand at this time in your life relative to other people in your community.

**11. What is the highest level of education you have completed (please check one)?**

- Less than high school (1)
- High school/GED/equivalent (2)
- Vocational (3)
- Some college (4)
- College graduate (5)
- Some graduate school (6)
- Masters (7)
- Doctoral (8)

**12. Are you currently enrolled in (please check one):**

- High school/GED/equivalent (1)
- Vocational (2)
- Community college (3)
- Four-year college/university (4)
- Graduate school (5)
- Not in school (6)

**13. What is the highest level of education your mother has completed (please check one)?**

- Less than high school (1)
- High school/GED/equivalent (2)
- Vocational (3)
- Some college (4)
- College graduate (5)
- Some graduate school (6)
- Masters (7)
- Doctoral (8)
- Unsure (9)

**14. What is the highest level of education your father has completed (please check one)?**

- Less than high school (1)
- High school/GED/equivalent (2)
- Vocational (3)
- Some college (4)



- College graduate (5)
- Some graduate school (6)
- Masters (7)
- Doctoral (8)
- Unsure (9)

**15. What is your current employment status? (check all that apply)**

- Full-time employment (1)
- Part-time employment (2)
- Student (3)
- Disability (SSI/SSDI) (4)
- Unemployed (5)
- Retired (6)
- Other (please specify): \_\_\_\_\_ (7)

**16. With whom do you live (please check one)?**

- Alone (1)
- Roommates (2)
- Parents (3)
- Other Family (4)
- Homeless (5)
- No stable living arrangement (6)
- Other (please specify): \_\_\_\_\_ (7)

**17. What is your current individual income each year? \_\_\_\_\_**

**18.** A “household” for the following questions refers to anyone financially tied to you, including those who help you pay bills or for whom you are financially responsible (e.g., parents, other family, significant other, children, other dependents).

**18a. What is your total household income each year?** \_\_\_\_\_

**18b. How many people (including yourself) are currently in your household?**

\_\_\_\_\_

## APPENDIX B

### *Multigroup Ethnic Identity Measure - Revised (MEIM-R)*

National Mentoring Resource Center (NMRC)

*In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Mexican-American, Hispanic, Black, Asian-American, American Indian, Anglo- American, and White. Every person is born into an ethnic group, or sometimes two groups, but people differ on how important their ethnicity is to them, how they feel about it, and how much their behaviors are affected by it. These questions are about your ethnicity group and how you feel about it or react to it.*

#### **Response Options**

1 = Strongly disagree

2 = Disagree

3 = Neutral

4 = Agree

5 = Strongly agree

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.

2- I have a strong sense of belonging to my own ethnic group.

3- I understand pretty well what my ethnic group membership means to me.

4- I have often done things that will help me understand my ethnic background better.

5- I have often talked to other people in order to learn more about my ethnic group.

6- I feel a strong attachment towards my own ethnic group.

## APPENDIX C

### *Drug History Questionnaire*

Sobell & Sobell, 2007

#### **Response Options:**

0 = No use

1 = Less than once a month

2 = Once a month

3 = 2-3 times a month

4 = Once a week

5 = 2-3 times a week

6 = 4-6 times a week

7 = Daily

#### **In the past 30 days, how frequently have you used....**

1. Alcohol?

2. Cannabis (marijuana, hash oil, pot, weed, edibles, wax, THC)?

3. Cocaine (coke, crack, blow)?

4. Methamphetamine (meth, ice, crank)?

5. Amphetamines/Other Stimulants (Ritalin, Adderall, Benzedrine, Dexedrine, speed, bennies, uppers)?

6. Benzodiazepines/Tranquilizers (Ativan, Valium, Librium, Xanax, Diazepam, roofies, downers)?

7. Sedatives/Hypnotics/Barbiturates (Amytal, Seconal, Dalmane, Quaalude, Phenobarbital)?
8. Heroin (smack, scat, brown sugar, dope)?
9. Fentanyl/Carfentanyl?
10. Street or Illicit Methadone/Suboxone (Buprenorphine)?
11. Other Opioids (Tylenol #2 & #3, Percodan, Percocet, OxyContin, Opium, Morphine, Demerol, Dilaudid)?
12. Hallucinogens (LSD, acid, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy, MDMA)?
13. Inhalants (glue, gasoline, aerosols, paint thinner, poppers, rush, whippets)?
14. Steroids (Deca-Durabolin, Durabolin, Equipoise, Winstrol, Anadrol, Oxandrin, roids, juice)?
15. Illegal Use of Prescription Drugs (describe: \_\_\_\_\_)?

## APPENDIX D

### *Focus Group Semi-Structured Interview Guide*

Thank you for your willingness to participate in this focus group.

1. Brief interviewer introduction and reviewing ground rules.
  - What does it mean to you to be Multiracial/Biracial/Mixed race or from more than one racial background?
2. Ask if I can share my definition of Multiracial and refer to that term going forward: “those who identify as having more than one race from the categories specified by the U.S. Census Bureau (i.e., Asian, Native Hawaiian/Other Pacific Islander, African American/Black, Native American/Alaska Native, or White), including individuals who self-identify as biracial, Multiracial, or mixed-race, or as having parents from two or more different racial backgrounds.”
  - What are your thoughts about this definition?
3. Describe investigator research interest in the assessment of racial background for people who are Multiracial. Refer back to demographics questions asking about race. Mention researcher process of picking questions.
  - In the demographic questionnaire, you answered a question about whether or not you identify as “Multiracial/Biracial/Mixed-race.” Tell me more about why you chose the answer that you selected? What or who has influenced that choice?
  - Do you identify with one racial background more than another? Who or what influenced that choice?
  - In what ways do you think your appearance influences your racial identity?

4. Describe that investigator research seeks to understand the ways that race and identity may influence health behaviors, as research has shown it is can have positive and negative effects among other groups.
  - As a Multiracial person, in what ways has your life has been different than people who are only from one racial background?
5. Review that large national datasets find that alcohol and other drug use, in particular past year alcohol use disorder and illicit substance use prevalence among Multiracial young adults is higher than it is among all monoracial groups.
  - Do you have any ideas as to what, specifically, is related to the high rates of alcohol and substance use seen in Multiracial young adults? What unique experiences does this group have?
6. Researcher will provide rationale for asking about the following and inquire specifically about the roles of each and to what extent they relate to alcohol and other drug use (one at a time):
  - What role do you think [*sense of belonging, racial identity development, depression, self-esteem, discrimination*] has in Multiracial young adults' use of alcohol and other drugs? (*Note: it's possible there is no relation.*)
7. Inquire about any other related factors or thoughts. Summarize main points and keywords discussed.
  - What else do you think is important to mention or related to your own or other Multiracial individuals' alcohol and other drug use?



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