The Role of Multiracial Identity on Chronic Health Conditions in the U. S.: Evidence From the Behavioral Risk Factor Surveillance Survey

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The Role of Multiracial Identity on Chronic Health Conditions in the U. S.: Evidence From the Behavioral Risk Factor Surveillance Survey

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Sociology

by

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University of Arkansas
Bachelor of Arts in Psychology, 2018

May 2023
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This thesis is approved for recommendation to the Graduate Council.

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Abstract

Racial identity as it informs health disparities has largely been examined using monoracial groups and a binary framework. This study, informed by critical race theory and stress process theory, investigates the relationship between multiracial identity and health. Data from the 2021 Behavioral Risk Factor Surveillance Survey, a national telephone survey that collects health data on adult aged respondents, will be analyzed using a set of regression techniques. Specifically, the number of chronic health conditions reported by those identifying with more than one race will be compared to the number of conditions reported by monoracial individuals.
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The Role of Multiracial Identity on Chronic Health Conditions in the U. S.: Evidence From the Behavioral Risk Factor Surveillance Survey

Over the last decade, the multiracial population has grown dramatically. From 2010 to 2020, the multiracial population grew 276 percent from 9 million to 33.8 million people (U.S. Census Bureau, 2021). Current demographic trends indicate that compared to historically marginalized racial and ethnic groups, the number of people identifying as White alone has decreased by 8.6% since 2010. The growth of the multiracial population has led to new questions about the health patterning among this group. In general, most racial health disparities research has focused on differences between and within traditional U.S. monoracial groups, leaving questions about whether and how multiracial identity shapes health patterning differently when compared to traditional monoracial groups.

To date, the majority of scholarship in this area has focused on adolescents and young adults (see exceptions [Migone et al., 1991; Setia et al., 2002]). Additionally, scholars have heavily examined mental health consequences (Bracey et al., 2004; Fisher et al., 2014; Gibbs, 1987; Sanchez, 2010; Sanchez et al., 2009), overlooking potential physical health patterning (Charmaraman et al., 2014). Existing work in the field has produced inconsistent findings. For example, scholars have found that multiracial adolescents are at a higher health risk than single race groups (Udry et al., 2003). On the other hand, there is evidence of psychological benefits for high school aged individuals identifying with more than one racial group (Binning et al., 2009). Furthermore, Campbell and Eggerling-Boeck (2006) found little to no difference when comparing the psychosocial well-being of multiracial adolescents to other racial groups. Due to current data limitations and inconsistencies in theoretical frameworks (Jackson, 2009; Poston, 1990; Rockquemore et al., 2009; Woo et al., 2011), scholars have yet to develop a unified
measure of racial and ethnic identity that includes those that identify with more than one racial and ethnic group (Shih & Sanchez, 2009; Millville et al., 2005). As a result, more research is needed to better understand potential linkages between multiracial identity and physical health.

Provided these considerations, the purpose of the current study is to examine whether multiracial identity differently shapes the increased risk of chronic conditions when compared to those that identify as a single race. Data for this study will be drawn from the Behavioral Risk Factor Surveillance System, which is a nationally representative sample. The phone survey allowed adult respondents to self-identify with one or more races and information about chronic health conditions was also obtained. Due to the methods of data collection, racial identity can be broken down into specific component groups and also reflects individuals preferred racial status.

**Literature Review**

**Racial formation**

In order to understand multiracial identity, it is important to first understand how and why race has been historically constructed in the U.S. Omi and Winant (2015) use racial formation to describe the process of race making, more specifically, as “the sociohistorical process by which racial identities are created, lived out, transformed, and destroyed” (p.109). They argue that the historical treatment of indigenous persons and African people in the U.S. serve as a master frame by which other subordinated groups have been treated (Omi & Winant, 2015). Additionally, racialization is the process by which racial meaning is attributed to previously unmarked groups and racial projects serve as the connections between assigned racial meaning and structures. Related processes have been echoed by other scholars.

For example, earlier conceptualizations of race with origins rooted in slavery and colonialism posited race as an immutable inherited trait linking darker skin tone to inferior and
inhuman character. This understanding proliferated and served to justify White dominion over African slaves. It was endorsed by politicians, accepted by community members, and validated by scientists who conducted dehumanizing medical experiments on black individuals (Washington, 2006). For instance, during colonial times, the “one-drop rule” dictated that persons with any Black ancestry were automatically Black and therefore subordinate to Whites within Black-White racial framework.

Whiteness evolved from a person’s phenotype, to race, then status and ultimately property (Harris, 1993). During chattel slavery, being White served as the basis of racialized privilege and was legitimated in law through the slave codes. These seventeenth century laws prohibited Blacks from traveling freely, owning property, and becoming educated amongst other basic rights (Nelson & Williams, 2019). Essentially, being Black deemed a person likely of enslavement and being White guaranteed freedom. Such processes of oppression were also extended to Native Americans through the seizure and appropriation of their land, as opposed to labor, by way of the Doctrine of Discovery. After the legal institutions of the Black Codes and Jim Crow fell, they were replaced with colorblind policies. Some scholars argue that like Jim Crow, the present incarceration system maintains social control of Black and Brown bodies with some dissimilarities (Alexander, 2011; Forman Jr., 2012).

Exclusionary practices were not limited to Black Americans and grew to affect Asians and Latinxs as the nomenclature of these groups solidified their marginalization from Whiteness. For example, The Naturalization Act of 1790 limited citizenship to persons considered White, once again enforcing the nature of Whiteness as a claimable property. Moreover, the Chinese Exclusion Act of 1882 federally prohibited Chinese laborers from immigrating to the U.S. for 10 years. Similarly, anti-Latinx prejudice resulted in the community’s disbarment from voting to the
extremity of lynchings or *linchamientos* post-World War II (Delgado, 2009). Though this treatment was spurred from immigration trends based in labor needs, Hispanic identity was racialized and punished. Scholars like Delgado (2009) considered English-Only movements to be reminiscent of Latino lynchings through their historical erasure.

Additionally, Kim (1999) demonstrates that via racial triangulation, Asian Americans have been positioned vis-a-vis Whites and Blacks. By being ostracized, Asian Americans were unassimilable for purposes of citizenship and were categorized distinctly from Blacks due to relative valorization. Even the “model minority myth”, which aggregates Asian ethnic sub-groups into a cultural homogeneity is used as evidence of overcoming disadvantage against other minority groups (Yi & Museus, 2015). Regarding federal classification, the 1860 Census was the first to include the “Chinese” group within its race and ethnicity measures, but the pan-ethnic Asian label was not introduced until the late 1960s (Bashi, 1998). Legal cases, such as Takao Ozawa v. United States (1922) and United States v. Bhagat Singh Thind (1923) reinforced the boundary between Asian and White categories as well. Furthermore, contemporary work investigates racial and ethnic nuances such as distinguishing Filipinos as Asian or Latinx (Ocampo, 2016).

Another example of racial formation applies to the construction of Hispanic and Latino categories resulting from extensive negotiation between Census officials and Hispanic community leaders (Mora, 2014). Such debates reflect the internal and external pressures under which racialization occurs (Bashi, 1998). Despite being classified as a race in the 1930s, “Mexican” as a labeled group was ultimately replaced with a pan-ethnic identity inclusive to multiple Hispanic and Latino communities. This transition was affected by the fact that Latino ethnicities were racialized differently (Mora, 2014). For example, Mexicans became racialized as
Brown while Cubans racialized themselves as White, counter to societal ascriptions (López, 1997). The racial or ethnic status of Hispanic/Latino has been debated since but, to date, is typically considered an ethnicity. This complexity is further demonstrated by communities like Afro-Cubans who may be racialized as Black or Hispanic depending on context and salience (Newby & Dowling, 2007). Despite within group contention over racial and ethnic identity labels, Asian along with Hispanic and Latino panethnic labels contribute to challenging the binary model of race.

Over time, the dominant paradigm proposing race as a mostly biological concept was challenged by social scientists who have shown theoretically and empirically that race is a social construction. Still, biological qualities are associated with race and imposed through the use of ancestry tools, such as 23andMe. Unfortunately, as multiracial groups are recognized, Whiteness continues to shape and dominate the hierarchy. Collectively, marginalized and minoritized identities remain excluded from the social and legal benefits conferred by white status.

**Role of the Census**

Race categories have shifted in and out of established boundaries throughout the history of the Census. Reliance on rigid categories representing a fluid identity construct begs the present validity of their use. Historically, Census groups have been influenced and controlled by those with the most power, namely the White majority, and classification has “separated those entitled to full participation in society from those whose race was cause for exclusion.” (Hochschild and Powell, 2008, p. 63). Regardless, federal classifications of race have remained the normative reference. The first Census in 1790 only distinguished between free Whites and slaves. Whereas, in 1850, categories shifted to just Whites and Black or Mulatto persons. Ten years later, the first Asian category, Chinese, was introduced, and it was not until 1930 that
residents had the option to report Mexican instead of being absorbed into the White category. Throughout many iterations, the Asian and Hispanic/Latino groups were subsumed under pan-ethnic identities, and today scholars point out the multiple ways the Census defines, shapes, and informs the structure of society.

As a constitutional requirement, the Census was initially used to determine the number of Congressional members allowed and war payments owed by each state. Contemporarily, enumerations produced from the survey help inform implementation of revenue sharing programs, affirmative action programs, and planning for new services and facilities (U.S. Census Bureau, 2000). Therefore, the structure of the Census and how people are counted is of vital importance. Other previous uses have included the tracking of “sundown towns”, or towns with no Black households due to overt racial exclusion (Loewen, 2009).

Additionally, political and public policy impacts are made possible by the interaction between state and non-state actors’ utilization of federal classifications. Moreover, the relationship between race and socioeconomic status helps explain existing inequalities. For example, wealth accumulation is greatest for non-Hispanic Whites (Campbell & Kaufman, 2006). Additionally, differential education attainment impacts occupational outlook, subsequently affecting earnings and health later in life (Yeung & Conley, 2008). As intergenerational disadvantage accumulates, social mobility is limited (Pfeffer & Killewald, 2019). Therefore, by reifying Census categories, race shapes and dictates life outcomes for different racial and ethnic communities.

Race has long been codified into policies affecting housing, employment, immigration, and other facets of living. Yet, racial and ethnic self-identification options remain required on forms and surveys such as the Census. To date, the Census provides racial categories inclusive to
White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. It was not until 2000 that individuals could select more than one racial group. Despite having more contemporary categories, minority members endure various forms of disadvantage through inequitable access to resources and political significance (Literte, 2010). While living conditions are stratified along social status, race, gender, and other factors, scholars acknowledge the prominent role race plays independently of all others (Omi & Winant, 2015; Link & Phelan, 2015).

**Racial Mixing**

The concept of racial mixture, or persons of white and black ancestry was federally introduced in the 1850 Census by the term “mulatto”. However, intermixing began much earlier in colonial times when mulatto was synonymous with Black. Oftentimes, mixed race children were the result of White men raping Black slaves and leaving their offspring to join the laboring enslaved (Hickman, 1997). Race scientists sought to establish that mixed race persons were degenerate, and the mulatto label remained in use until the 1930s (Hochschild & Powell, 2008). Additionally, the process of marrying outside of one’s race was unlawful through the implementation of anti-miscegenation policies. For example, interracial marriage was punishable by banishment, fines, and even enslavement (Hickman, 1997). Thus, participating in intermarriage or being of mixed race was socially marked as undesirable.

Throughout the processes of migration, other groups have intermarried, however, racial construction has remained socially and politically relevant. Global scholarship has attended to racial classification challenges relevant to U.S. scholars. As an example, in Latin America, the mestizo myth and process of mestizaje address other factors of racial admixture. The first is a conflation of admixture, or racial mixing, with equality and the Whitening of distinct experiences
of indigenous and Afro-descendants (Blackwell et al., 2017). The second concern is regarding the creation of a unified identity used to reduce the idea of inferiority associated with “hybridity” of racial mixing (Rodríguez Mega, 2021). In regard to Native American/American Indians, blood quantum is used to establish tribal association and indigeneity although federal legal definitions still vary (Garroutte, 2001). In contrast to the automatic assignment of Black with the “one-drop rule”, American Indians require greater amounts of “blood” percentage or ancestry to prove inclusion. Relatedly, scholars like Paradies (2006) are presented with the struggle of being Indigenous while maintaining a racial multiplicity, even in the Australian context (Russell, 2002 as cited in Paradies, 2006). Researchers trying to classify multiracial within the current U.S. racial structure must attend to these considerations. Especially since they lead to questions regarding the usefulness of the multiracial category itself and how it may be measured without reverting to ancestry quantifications. Other concerns include the deployment of multiracial identity as providing support for a post-racial or multicultural society.

Nonetheless, monoracism is defined as “systemic social oppression that targets individuals who do not fit into monoracial categories, groups, or phenomena” (Harris, 2016; Johnston & Nadal, 2010). According to this form of discrimination, multiracial individuals may be at risk for a unique kind of stress exposure since monoracial conceptualizations of race have dominated history. Additionally, scholars warn against employing monoracial frameworks in multiracial studies, such as applying social identity theory to persons who may have more than one in-group (Gaither, 2015). Nonetheless, the multiracial group has been positioned less visibly within a structure that has dictated group membership from racist practices.

Amidst burgeoning studies, multiracial identity has begun to receive more attention, especially within identity scholarship. “Multiracial”, “mixed race”, and “biracial” are all terms
that have been used to describe individuals who identify with more than one racial group typically drawn from the Census racial and ethnic classifications. The multiracial population has grown drastically and requires analysis as the U.S. becomes increasingly more racially integrated. Despite a lack of work in this area, the extant literature on multiracial health falls into the following areas: (1) women and infant health, (2) physical health, (3) mental health, and (4) patient-centered care.

**Women and Infant Health**

Research on pre-term birthweight and gestational factors provides evidence of negative impacts on multiracial women’s pregnancies. Specifically, studies have shown that biracial babies born to couples identifying as Black and White have lower birthweights than babies born to monoracial couples (Gold et al., 2010). Pre-term birth risk is also found to be higher amongst mothers of multiracial children than mothers of monoracial White children, and Black/White mixed-race parentage appears to be associated with an increased risk of stillbirth (Blebu et al., 2022; Migone et al., 1991). Relatedly, women socially assigned as White are less likely to have a child with a low birth rate, which supports the health advantage associated with being identified by others as White (Abuelezam et al., 2022; Jones et al., 2008). However, women reporting a contested racial identity seek prenatal care less often in early pregnancy and have higher odds of smoking compared to those who do not experience incongruency with their racial identity (Abuelezam et al., 2022). The issue of contested racial identity is likened to the consequences of identity incongruent discrimination, or a form of discrimination experienced by multiracial persons when their self-identification differs from their perceived identity (Franco & O’Brien, 2018 as cited in Franco et al., 2021). Lastly, regarding prenatal care, Setia et al. (2002) observed that neonatal jaundice is diagnosed more for East Asian and East Asian/White mixed parentage
compared to infants born to White parents. These outcomes demonstrate problems affecting both maternal health and child health that are present from the beginning stages of life.

**Physical Health**

Self-reported health and other physical health measures such as cardiovascular reactivity and obesity display mixed results for those with multiracial identities (Bratter & Gorman, 2011; Franco & O’Brien, 2020; Subica et al., 2017). One possibility for these mixed results may be due to the use of small, cross-sectional samples. For example, Malhotra et al. (2021) observe that biracial adolescent males present T-wave inversions at rates greater than White adolescents and less than Black adolescents, which places their medical outcomes between the privileged majority and one of the most disadvantaged minority groups. Additional work supports multiracial individuals reporting a higher prevalence of poor physical health than component ethnic groups. For example, Hawaiian/Latino men and Black/Latina women have the highest prevalence of being overweight compared to other groups (Albright et al., 2008).

Health behaviors also appear to be impacted by multiracial status. For example, multiracial Hispanic adolescents are at a higher risk for smoking and substance abuse than monoracial peers (Whaley & Francis, 2006). Furthermore, research examining self-rated health provides evidence of significant disadvantages for Hispanic and Mexican Black individuals within health patterning, reemphasizing the role of Hispanic ethnicity itself in racial health disparities (Borrell & Crawford, 2006; Marquez-Velarde et al., 2020). Additionally, scholars studying respiratory conditions observe deleterious effects amongst American Indian/Alaska Native (AI/AN) multiracial adults. Those who identify as both AI/AN and White exhibit higher rates of asthma, hay fever, sinusitis, and COPD than monoracial individuals (Pleis & Barnes, 2008). Similarly, data from the Behavioral Risk Factor Surveillance System reveals that
multiracial AI/AN individuals report a higher prevalence of lifetime and current asthma than single race AI/AN adults (Stern et al., 2022). It is also suggested that AI/AN multiracial adults suffer from poorer mental health outcomes when compared to single race groups (Asdigian et al., 2018). Contrary to the aforementioned findings on women’s health, poorer mental health is reported by adults with a partial White racial identity while multiracial individuals who identify with non-White racial groups report higher self-esteem and self-rated health (Miller et al., 2019). These contrasting results demonstrate the need for further investigation into how health scientists construct and measure multiracial status.

While most of the physical health literature reported thus far shows harmful relationships between multiracial identity and health, a few studies have uncovered positive outcomes with some inconsistencies. For example, amongst the Hawaiian population, Zhang (2013) finds that multi-ethnic Asian Americans report better physical and mental health than mono-ethnic Asian Americans. Yet, data from the California Health Interview Survey (CHIS) displays differences across measures of diabetes and heart disease amongst Asian, multiracial, and Latinx Filipinxs (Adia et al., 2022). Specifically, when compared to non-Hispanic Whites, Asian Filipinxs are more likely to report fair or poor health, high blood pressure, and diabetes while multiracial Filipinxs are more likely to be obese or overweight. Such findings challenge both the model minority myth and practice of aggregating health data for diverse groups.

**Mental Health**

Within mental health research, malleable racial identification or “the tendency to identify with different racial identities across different social contexts” has been associated with lower psychological well-being (Sanchez et al., 2009, p. 2). However, the ability to engage identity flexibility and adapt identities may serve as advantageous for multiracial people in certain
situations (Gaither, 2015). Furthermore, Austin (2018) finds that multiracial girls experience lower self-esteem and perceive lower peer support than monoracial peers. Additionally, multiracial persons forced to pick one race as opposed to being allowed to choose from multiple races on demographic questionnaires demonstrate poorer mental health (Townsend et al., 2009). Despite this evidence, researchers have also determined that mental health outcomes need to be evaluated across clinical and non-clinical populations (Shih & Sanchez, 2005).

**Patient-Centered Care**

The role of racialization as it affects physician-patient dynamics is important when evaluating factors affecting medical outcomes, especially since nonconscious biases contribute to health trends (Stone & Moskowitz, 2011). Previous work on medical biases illuminates the potential risks that misidentification may pose to multiracial patients in healthcare settings. For example, research suggests that doctors do not reliably identify multiracial patients as multiracial while health services utilization is also impacted (Herman, 2022). Black-White multiracial and Black-Native American multiracial young adults are less likely to report using primary care services than monoracial White young adults (Tabb et al., 2016). This hesitancy is significant because it indicates that potential barriers may exist for individuals who identify outside of monoracial terms and are in need of medical care.

Even research into Latinx health uncovers differences between self-perceived, street, and ascribed race (López et al., 2018). Self-reporting White race compared to non-White increases the odds of an individual reporting very good/excellent physical health by 52% whereas White street race versus non-White street race increases the odds of reporting very good or excellent mental health by 41%. There are also disparities amongst those reporting as White amongst the three types of categories available, ranging from 14 to 45%. Deriving from the origin of passing
as White in the U.S., multiracial persons may inhabit multiple spaces acting as boundary crossers (Nishime, 2005). Regardless of such flexible characteristics, these abilities do not preclude a multiracial individual from choosing to identify with a single race.

Arguments for the use of race and ethnicity within health data include the identification of racial disparities, and proponents argue that by identifying demographic shifts and patterns, appropriate interventions can be deployed (Sondik et al., 2000). However, by recognizing health disparities, the maintenance and reliance on race as a construction is reinforced (Tashiro, 2005). With multiracial health studies producing such inconsistent results, continued scholarship is necessitated.

**Theory**

This study is informed by critical race theory and Pearlin’s (1981) stress process theory. The scope of racism’s effects on health must move beyond personal experiences of discrimination and broadened to include structural forces. Indeed, work by David Williams and others have long admonished equity initiatives reliant on single factors. While the exact mechanisms leading to poorer or improved health are still debated, the dismantling of institutionalized racism remains evident to critical health scholars. Within this vein of approach, the present study seeks to connect pillars of critical race theory and social stress theory. The impetus for integrating multiple racial and ethnic measures into regular use is limited by the historical reliance on single race terms and practices. In contrast, critical race theory informs health research by providing visibility to structural forces and racial stratification as major factors contributing to disparities which is imperative for understanding health inequity (Mannor & Malcoe, 2022).
For these reasons I argue that many tenets of critical race theory (CRT) are inherent to the study of multiracial health experiences. Though CRT originated in the legal field under scholars like Derrick Bell, Alan Freeman, Richard Delgado, Kimberlé Crenshaw, and others, organizations like the American Heart Association have already publicly denounced structural racism and pledged to identify new ways forward (Churchwell et al., 2020). More specifically, critical race theory is defined as a movement focused on uncovering and transforming the relationships between race, racism, and power (Delgado & Stefancic, 2010). It critiques the incremental approach of previous civil rights and serves as a renewed call for social justice based in several main principles. Such principles include: a criticism of liberalism, structural determinism, and anti-essentialism as well as a reliance on elevating marginalized voices and engaging intersectionality (Delgado & Stefancic, 1993).

Graham et al. (2011) proposes a set of CRT tenets for use in population health research among ethnic minorities. The first explains how dominant cultural customs are written into institutions leading to the neglect and exclusion of other “non-normative” cultural orientations. Within health studies, this is observed by the reuse of race and specific categories despite inconsistent operationalization (Williams, 1994; Schulman, 1995). This also leads to the prevention of creating novel or complex categories such as multiracial for meaningful comparison. Another central tenet is the contextualized or historicized emphasis of data. This component emphasizes the lived experience of research participants. As multiracial individuals may identify with more than one marginalized community, mixed methods and qualitative accounts will aid in the production of their narratives.

Public health has adapted its own form of critical studies known as the Public Health Critical Race praxis (PHCR). The PHCR provides a CRT informed application for public health
initiatives (Ford & Airhihenbuwa, 2010). Its main elements include racialization, race consciousness, social position, and the elimination of inequity thereby enabling racialized risk factors to be examined under the conditions of CRT in health equity research. Since most health scholarship has focused on the Black-White binary, race and racism’s effects need to be understood through the perspective of someone identifying with more than one race. Understanding the racialization of multiracial individuals draws from the practice of interrogating race meaning making from a critical perspective. Not only do multiracial individuals access a fluid identity, but their experience of race is also remade across various environments (Sanchez et al., 2009). On top of these complications, intersectionality requires scholars to evaluate other aspects of identity, such as gender and class (Crenshaw, 1989). The consideration of additional factors further complicates research seeking direct relationships yet excluding such variables would lead to reductionist interpretations in health outcomes for this population.

According to Pearlin’s stress process theory sources, mediators, and manifestations of stress interact to impose stress upon an individual (Pearlin et al., 1981). Stressors impact the lives of all members via chronic and acute channels while psychosocial resources and mediators provide support. Additionally, stressful life experiences tied to race are recognized as not being randomly distributed but instead linked to social institutions. Although evidence suggests that stress exposure and appraisal vary (Brown et al., 2020), it is unclear how these protections are engaged by novel groups. In line with the study of race-related stress, I argue that multiracial identity operates as a form of stress due to its association with multiple marginalized identities. Abuelezam et al. (2022) also posits that “contested racial identity can operate as a stressor in multiple ways”. Even though multiracial is represented by varying racial and ethnic
combinations, the commonality amongst them is the absence of being recognized as uniquely multiracial within monoracial structures. Moreover, issues related to identity validation and identity incongruent discrimination are taxing factors for those identifying accordingly. For example, through the historical classification of component groups, someone with mixed parentage is offered entry into various social settings and access to resources. Unfortunately, assumptions enforced by traditional racial categories inhibit accurate and authentic representation for people with less traditional backgrounds. These limitations are reliant on the overuse of perceived race based on physical traits. Moreover, as mentioned in the previous section, parsing out disparate effects is reliant upon the inclusion of multiracial operationalization in studies.

**Current Study**

Although previous literature on health disparities has examined the impacts of race and racism on monoracial groups, this study explicitly calls upon the pillars of social stress process theory and critical race theory to help explain such impacts on multiracial health. This investigation is informed by the role of racism, in the form of racial construction, as a stressor and effects of racialization on communities and systems leading to the argument that multiracial identity itself serves as a unique stressor. Additionally, data drawn from the Behavioral Risk Factor Surveillance System (BRFSS) will provide a nationally representative sample from which to analyze chronic health outcomes. Therefore, my specific research question is:

1. Does multiracial identity function as a meaningful category that produces health outcomes dissimilar from single race component groups and if so, what are the observed trends?
Guided by critical race theory and stress process theory, I expect to observe that multiracial outcomes will experience worse physical health outcomes than single race groups.

**Methods**

**Sample**

This study uses data from the Behavioral Risk Factor Surveillance System (BRFSS), which partners with the CDC to deliver an annual national telephone survey. Based on a disproportionate stratified sampling design, adult-aged respondents are surveyed regarding their health diagnoses, risk factors, and utilization of preventative services. We draw on the most recent survey collection from 2021. Although previous studies have omitted measuring Hispanics as an independent ethnic group, we have chosen to include them in our sample due to significant representation.

The present study includes a sample of 78,649 adults whose survey responses from the 2021 BRFSS were used to evaluate the relationship between self-reported multiracial identity and physical health outcomes relative to self-reported monoracial identity.

**Measures**

**Dependent Variable**

Chronic conditions is a count-based measure that includes the total number of chronic health conditions respondents have ever been diagnosed with. The list presented to respondents included: heart attack, angina or coronary heart disease, stroke, asthma, skin cancer, other types of cancer, chronic obstructive pulmonary disease (C.O.P.D.) or emphysema or chronic bronchitis, arthritis, kidney disease, and diabetes.

**Independent Variable**
The key independent variable for this study is self-reported racial identity, which includes responses for multiracial identity. The racial categories reported by respondents included single race categories such as Black only, non-Hispanic, White, non-Hispanic, American Indian or Alaskan Native, non-Hispanic, Asian, non-Hispanic, Native Hawaiian or other Pacific Islander, non-Hispanic, Other race non-Hispanic, Multiracial non-Hispanic, and Hispanic. Unfortunately, due to small sub-sample sizes, respondents who self-identified as American Indian or Alaskan Native and Other race were removed from the final analytic sample.

**Controls**

I also included a number of covariates that have been shown to shape chronic conditions. These covariates include education, income, sex, number of children or adults in household, reported age, marital status, smoking status, and alcohol consumption. Additional controls included language, urban or rural living, physical activity (as leisure time), and exercise. *Education* was measured by the highest level of education completed and was comprised of did not graduate high school, graduated high school, attended college or technical school, and graduated from college or technical school. *Income level* was represented as annual household income from all sources and included the following categories: < $15,000, $15,000 to < $25,000, $25,000 to < $35,000, $35,000 to < $50,000, $50,000 to < $100,000, $100,000 to < $200,000, $200,000 or more. *Sex* was a dichotomous variable where Male=1 and Female=2. *Number of children or adults* per household were continuous variables. Six *age* groups were collapsed into two categories: Age 18 to 64 and Age 65 or older. *Marital status* was reported as Married=1, Divorced=2, Widowed=3, Separated=4, Never married=5, or A member of an unmarried couple=6. *Smoking* was inclusive to categories of Current smoker-now smokes every day=1, Current smoker-now smokes some days=2, Former smoker=3, and Never smoked=4. *Alcohol*
consumption was measured by volume reported within the past 30 days or total number of alcoholic beverages consumed per week. The language identifier was a two category variable where English=1 or Spanish=2. Urban or rural status were broken into Urban counties=1 and Rural counties=2 as well as Metropolitan counties=1 and Nonmetropolitan counties=2. Physical activity was considered the amount of leisure time respondents reported doing during the past 30 days outside of their regular job where Had physical activity or exercise=1 or No physical activity or exercise in last 30 days=2. Lastly, exercise represented participating in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise during the past month where Yes=1 and No=2.

Analytic strategy

I first provide descriptive statistics for all measures included the study. In order to assess whether multiracial identify differently shapes chronic conditions when compared to monoracial groups, I used a series of regression techniques. Specifically, since the dependent variable was operationalized as a count measure, a Poisson regression technique was originally employed to evaluate the relationship between racial identity and physical health. However, due to overdispersion within the distribution of chronic conditions a negative binomial regression was executed to account for overestimations of significance amongst the variables of interest. Evidence from a study conducted by the CDC in 2019 found that about half of adults aged 18 to 34 reported having at least one chronic condition so a second negative binomial model was used to parse out differences in risk across the six age groups (Watson et al., 2022). Only results derived from negative binomial regressions are reported.
Results

Table 1 presents weighted descriptive statistics for the overall sample of adults from the BRFSS. The average number of chronic conditions experienced was about 1.5. The total sample consisted of 78,649 respondents from the 2021 BRFSS. Regarding race and ethnicity, the majority of the sample identified as White (78%), followed by Black (11%), Latinx (7%), Asian/Pacific Islander (3%), and Multiracial (1%). About sixty percent of respondents were female. Senior aged individuals (65 or older) comprised half of the sample and young adults (18 to 24) represented a very small percentage (2%). Moreover, most individuals (83%) resided in a household with no children and over half graduated from high school. Almost one-third attended college and another third completed post-graduate studies. Income level was split between those who made more or less than $50,000 annually. Regarding health behaviors, the bulk of respondents (71%) had been physically active within the last 30 days and only about five percent reported heavy alcohol use. A little under half (44%) had ever smoked. Nine out of ten respondents resided in an urban area. Lastly, most respondents (97%) had a form of health insurance.

Table 1. Descriptive Statistics for Overall Sample
N= 78,649

<table>
<thead>
<tr>
<th></th>
<th>Mean(S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic conditions</td>
<td>1.50(.01)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>.78(.00)</td>
</tr>
<tr>
<td>Black</td>
<td>.11(.00)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>.03(.00)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>.01(.00)</td>
</tr>
<tr>
<td>Latinx</td>
<td>.07(.00)</td>
</tr>
<tr>
<td>Covariates</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>.41(.00)</td>
</tr>
</tbody>
</table>
Female .59(.00)

**Level of Education**
- Did not graduate high school .10(.00)
- Graduated high school .28(.00)
- Attended college or technical school .31(.00)
- Graduated from college or technical school .31(.00)

**Income Level**
- Less than $15,000 .07(.00)
- $15,000 to < $25,000 .12(.00)
- $25,000 to < $35,000 .14(.00)
- $35,000 to < $50,000 .15(.00)
- $50,000 to < $100,000 .29(.00)
- $100,000 to < $200,000 .18(.00)
- $200,000 or more .05(.00)

**Number of children in household**
- No children .83(.00)
- One child .08(.00)
- Two children .06(.00)
- Three children or more .05(.00)

**Number of adults in household**
- One adult .26(.00)
- Two adults .50(.00)
- Three adults .15(.00)
- Four adults .06(.00)
- Five adults or more .01(.00)

**Marital status**
- Married .60(.00)
- Divorced .10(.00)
- Widowed .16(.00)
- Separated .01(.00)
- Never Married .11(.00)
- A member of an unmarried couple .02(.00)

**Age**
- 18 to 24 .02(.00)
- 25 to 34 .03(.00)
- 35 to 44 .06(.00)
- 45 to 54 .12(.00)
- 55 to 64 .22(.00)
- 65 or older .54(.00)

**Urban** .90(.00)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural</strong></td>
<td>0.10</td>
</tr>
<tr>
<td><strong>Physical activity in the last 30 days</strong></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td>0.71</td>
</tr>
<tr>
<td>No physical activity</td>
<td>0.29</td>
</tr>
<tr>
<td><strong>Has a form of health insurance</strong></td>
<td>0.97</td>
</tr>
<tr>
<td><strong>Smoking status</strong></td>
<td></td>
</tr>
<tr>
<td>Every day smoker</td>
<td>0.09</td>
</tr>
<tr>
<td>Someday smoker</td>
<td>0.03</td>
</tr>
<tr>
<td>Former Smoker</td>
<td>0.32</td>
</tr>
<tr>
<td>Never Smoked</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>English dominant language</strong></td>
<td>1.02</td>
</tr>
</tbody>
</table>
The regression results analyzing the relationship between the racial and ethnic identity and chronic conditions are presented in Table 2. Aside from the Multiracial group, all other racial and ethnic groups were at a decreased risk for chronic health conditions compared to Whites. Specifically, Black individuals reported about an 8% reduced risk (IRR=.92 p<.01) while Asian and Pacific Islanders (IRR=.71 p<.01) and Latinx (IRR=.81 p<.001) reported 29% and 19% less, respectively. Comparatively, the Multiracial group had about a 21% increased risk relative to White Americans (IRR=1.21 p<.05).

Amongst the covariates, some significant relationships emerged. Females reported a slight decrease in risk compared to males. Likewise, living in an urban area and being physically active were associated with a decreased risk of chronic conditions. In contrast, making less than $100,000 per year and an incomplete high school or college degree were associated with poorer outcomes. Older age was also strongly related to reporting more conditions. Lastly, having health insurance increased risk by about 34% whereas smokers had about a 26% greater risk than non-smokers.

Table 2. Relationship Between Racial Identity and Health
N=78,649
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Unstandardized coefficient(SE)</th>
<th>IRR(SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>-.08(.03)**</td>
<td>.92(.03)**</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>-.34(.12)**</td>
<td>.71(.09)**</td>
</tr>
<tr>
<td>Multiracial</td>
<td>.19(.09)**</td>
<td>1.21(.11)**</td>
</tr>
<tr>
<td>Latinx</td>
<td>-.21(.06)***</td>
<td>.81(.05)***</td>
</tr>
</tbody>
</table>

**Covariates**

**Female**

**Education Level**

Did not graduate high school

Graduated high school

Attended college or technical school

**Income Level**

Less than $15,000

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Coefficient</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000 to &lt; $25,000</td>
<td>.48(.06)***</td>
<td>1.62(.10)***</td>
</tr>
<tr>
<td>$25,000 to &lt; $35,000</td>
<td>.32(.06)***</td>
<td>1.38(.08)***</td>
</tr>
<tr>
<td>$35,000 to &lt; $50,000</td>
<td>.25(.06)***</td>
<td>1.29(.07)***</td>
</tr>
<tr>
<td>$50,000 to &lt; $100,000</td>
<td>.18(.05)***</td>
<td>1.19(.06)***</td>
</tr>
<tr>
<td>$100,000 to &lt; $200,000</td>
<td>.04(.05)</td>
<td>1.04(.05)</td>
</tr>
</tbody>
</table>

**Number of children in household**
- One child in household: -.08(.05)  .93(.05)
- Two children in household: -.09(.05)  .92(.05)
- Three children or more in household: -.12(.11)  .89(.10)

**Number of adults in household**
- 2 adult: .10(.03)***  1.11(.03)***
- 3 adults: .11(.04)**  1.12(.04)**
- 4 adults: .16(.06)**  1.18(.07)**
- 5 adults: -.09(.12)  .91(.10)
- 6 adults or more: .04(.18)  1.04(.19)

**Marital status**
- Divorced: .07(.03)*  1.07(.04)*
- Widowed: .09(.03)***  1.10(.03)***
- Separated: .26(.09)**  1.29(.12)**
- Never Married: -.03(.04)  .97(.04)
- A member of an unmarried couple: .01(.09)  1.01(.09)

**Age**
- 25 to 34: .52(.21)*  1.69(.35)*
- 35 to 44: .81(.17)***  2.25(.39)***
- 45 to 54: 1.24(.16)***  3.45(.57)***
- 55 to 64: 1.54(.16)***  4.68(.75)***
- 65 or older: 1.86(.16)***  6.41(1.03)***

**Urban**
- -.05(.03)*  .95(.02)*

**Physical activity**
- -.25(.02)***  .78(.02)***

**Health insurance**
- .29(.11)**  1.34(.15)**

**Smoking status**
- Every day smoker: .22(.03)***  1.25(.04)***
- Someday smoker: .23(.06)***  1.26(.08)***
- Former Smoker: .24(.02)***  1.27(.02)***
- Constant: -1.72(.20)***  .18(.04)***

*<=.05, **<=.01, ***<=.001
Table 3 presents the incidence rate ratios for chronic health conditions by age group. Findings demonstrate inconsistent health patterns across racial and ethnic groups relative to Whites. For example, the risk for chronic conditions decreased with age for Latinx individuals. Similarly, 65 years of age and older was associated with fewer conditions for Black Americans, however, Asian and Pacific Islanders closer to middle age (35 and 44 years) displayed a lower risk of chronic conditions relative to White Americans. Interestingly, Multiracial individuals in the second youngest (25 to 34 years) and oldest (65 years or older) groups demonstrated about 4.5 times and 1.24 times risk, respectively, compared to Whites. Additional observations were made although they lacked statistical significance. About half of the age groups for Multiracial and Latinx respondents reported increased risks for chronic conditions. The majority of Black and Asian and Pacific Islander respondents reported decreased risk relative to White Americans, except for Black adults in the 55 to 64 year old group. Again, these rate ratios overwhelmingly lacked significance.

Amongst the covariates, lower income rates were associated with poorer health for those over the age of 45 while incomplete education only slightly increased the risk for adults in the oldest age groups. Moreover, physical activity was protective while health insurance had the opposite impact. Smoking increased the risk of conditions for nearly all groups aside for two (25 to 34 years and 45 to 54 years). A greater number of adults per household appeared to impact the number of conditions reported, however, most of the values were not significant. Of note was that having six or more adults per household was significantly associated with a 7 times higher risk of conditions for the 35 to 44 age group. Like the number of adults per household, the number of children per household was not statistically relevant across ages. Gendered differences were absent apart from the most senior females (65 years or older) who reported
fewer conditions than their male counterparts.
### Table 3: Age Disaggregation

<table>
<thead>
<tr>
<th>Age Group</th>
<th>N</th>
<th>IRR (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 TO 24 YEARS</td>
<td>386</td>
<td></td>
</tr>
<tr>
<td>25 TO 34 YEARS</td>
<td>823</td>
<td></td>
</tr>
<tr>
<td>35 TO 44 YEARS</td>
<td>2,689</td>
<td></td>
</tr>
<tr>
<td>45 TO 54 YEARS</td>
<td>6,507</td>
<td></td>
</tr>
<tr>
<td>55 TO 64 YEARS</td>
<td>15,105</td>
<td></td>
</tr>
<tr>
<td>65 YEARS OR OLDER</td>
<td>53,139</td>
<td></td>
</tr>
</tbody>
</table>

#### Race/Ethnicity
- **Black**: 0.48(.35)  
- **Asian/Pacific Islander**: 0.52(.32)  
- **Multiracial**: 1.21(2.38)**  
- **Latinx**: 2.17(8.4)**

#### Covariates
- **Female**: 0.75(.19)  
- **Graduated high school**: 1.18(.51)  
- **Attended college/technical school**: 0.90(3.6)

#### Income Level
- **Less than $15,000**: 2.24(1.56)  
- **$15,000 to < $25,000**: 1.08(.77)  
- **$25,000 to < $35,000**: 1.36(.82)  
- **$35,000 to < $50,000**: 0.30(.24)  
- **$50,000 to < $100,000**: 0.88(.54)  
- **$100,000 to < $200,000**: 0.45(.29)

#### Number of children in household
- **One child**: 0.59(.30)  
- **Two children**: 0.37(.20)  
- **Three children or more**: 0.27(.24)

#### Number of adults in household
- **Two adults**: 1.39(.88)  
- **Three adults**: 1.95(1.19)  
- **Four adults**: 0.97(.65)  
- **Five adults**: 0.29(.39)  
- **Six adults or more**: 1.98(1.85)

#### Marital status
- **Divorced**: 0.54(.60)  
- **Widowed**: 1.74e-10(2.40e-10)***
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>Error</td>
<td>Coef</td>
<td>Error</td>
<td>Coef</td>
</tr>
<tr>
<td>Separated</td>
<td>1.12(60)</td>
<td>.99(18)</td>
<td>1.32(15)*</td>
<td></td>
<td>1.36(23)</td>
</tr>
<tr>
<td>Never Married</td>
<td>.36(20)</td>
<td>.78(09)*</td>
<td>.86(06)*</td>
<td></td>
<td>1.01(05)</td>
</tr>
<tr>
<td>A member of an unmarried couple</td>
<td>.26(27)</td>
<td>.79(18)</td>
<td>.98(11)</td>
<td></td>
<td>.96(07)</td>
</tr>
<tr>
<td>Urban</td>
<td>.79(25)</td>
<td>.83(10)</td>
<td>.94(05)</td>
<td></td>
<td>.97(03)</td>
</tr>
<tr>
<td>Physical activity</td>
<td>.75(24)</td>
<td>.84(11)</td>
<td>.87(07)</td>
<td>.75(03)***</td>
<td>.78(02)***</td>
</tr>
<tr>
<td>Health insurance</td>
<td>1.02(55)</td>
<td>1.21(45)</td>
<td>1.25(24)</td>
<td>1.65(17)***</td>
<td>1.51(30)*</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day smoker</td>
<td>3.12(149)*</td>
<td>1.78(57)</td>
<td>1.83(31)***</td>
<td>1.16(13)</td>
<td>1.26(07)***</td>
</tr>
<tr>
<td>Someday smoker</td>
<td>5.49(90)***</td>
<td>1.63(67)</td>
<td>1.75(43)*</td>
<td>.97(15)</td>
<td>1.21(10)*</td>
</tr>
<tr>
<td>Former Smoker</td>
<td>1.39(86)</td>
<td>1.31(31)</td>
<td>1.62(22)***</td>
<td>1.18(11)</td>
<td>1.35(06)***</td>
</tr>
<tr>
<td>Constant</td>
<td>.86(97)</td>
<td>1.14(82)</td>
<td>.32(12)***</td>
<td>.45(12)***</td>
<td>.65(10)***</td>
</tr>
</tbody>
</table>

P<.05* P<.01** P<.001***
Discussion

Emerging literature has begun to examine the health status of individuals reporting a multiracial identity. However, inconsistent operationalization and survey response limitations complicate the aims of such research. Moreover, recent scholarship on this understudied population’s experience of chronic conditions is lacking. Therefore, this study relied on a critical framework and theory-based approach to examine the position of multiracial individuals within traditional health disparities.

The findings suggest that multiracial individuals experience worse outcomes than monoracial Whites. Although comparing the breakdown of component racial identities was not feasible for the present study due to its small sub-sample sizes, the results still support the hypothesized outcome. Not only were multiracial adults at an almost 25% increased risk of chronic health conditions, but all other monoracial groups displayed less risk relative to monoracial Whites. Moreover, this finding strengthens the argument that identifying as multiracial may act as a stressor or disadvantageous social position. Previous work has already suggested that multiracial individuals fare worse than monoracial Whites (Malhotra et al., 2021; Pleis & Barnes, 2008). Additionally, recent scholarship provides evidence of stressors related to multiracial stigmatization such as single forced choice reporting options, dual-faceted discrimination, perceptions of social isolation, group invisibility, and even exoticization (Bratter et al., 2022; Sanchez et al., 2020). However, in the absence of an operationalized stress measure, race as a proxy for racism was used and supported by critical race theory and stress process theory.

The results from the minority monoracial groups implied that relative risk for chronic conditions amongst other racial and ethnic groups may be reduced compared to Whites.
Although these findings challenge the benefit of proximity to Whiteness, additional contributing factors should be included in future analyses. For example, Asian Americans demonstrated a lower risk for chronic conditions relative to Whites, however, scholars reiterate the need for disaggregation of the pan-ethnic label in health research (Hastings et al., 2015). Furthermore, socioeconomic factors, differential diagnoses, and cultural perceptions of healthcare by Asian Americans may be related to the observed reduced risk (Lee et al., 2021). Comparatively, Black Americans have repeatedly been associated with poorer outcomes across a multitude of health measures (Thorpe, Jr. et al., 2016), however, this data demonstrated the opposite. Factors leading to such observed decreased risk, compared to White Americans, could include medical mistrust and issues related to residential segregation, such as quality of care and access. Although neither were measured in this study, scholars link both to Black Americans’ reduced reliance on the healthcare system. Furthermore, historical segregation adds inaccessibility to the already decreased use of preventative screenings and primary care physicians by Blacks (Arnett et al., 2016; Powell et al., 2019). Both Asian Americans and Black Americans demonstrated lower incidences of risk for chronic conditions across age groups, however, most did not reach statistical significance.

Latinx adults indicated less risk for chronic conditions in the primary regression compared to White counterparts, and a unique trend emerged from disaggregating the sample sub-group across ages. Specifically, risk for chronic conditions decreased as age increased for Latinx adults. These findings across age mimic characteristics of the Latino health paradox, which suggests that older members of the Latinx community may present preferable health outcomes similar to Whites. Unfortunately, nativity, which has been strongly related to such
benefits was not included in this study (Boen & Hummer, 2019), and the heterogeneity of Latinx health outcomes may have been masked by the racial and ethnic aggregation of this population. Regardless, the disaggregation of age allowed for age-specific patterns to emerge that might not have been visible from standard cross-sectional data analyses.

The present study has several limitations, such as the small multiracial subgroup despite the relatively large sample size. Subsequently, further analysis based on the age characteristic led to reduced certainty in our findings across all racial groups. Incorporating additional years of data from the BRFSS may yield more robust results. Additionally, the data lacks a longitudinal design, which removes potential analysis related to the life course. Including variables such as health behaviors and mental health would also create a more holistic measure of health. Moreover, these findings only represent the self-reported number of conditions so differences in diagnoses, onset, and treatments are not captured. Another limitation of the present study is its aggregation of racial groups. Future work should incorporate nuanced groups or include combination descriptions.

This study aimed to evaluate the relationship between multiracial identity and physical health outcomes. The findings contribute to existing research on multiracial health as well as provide query into existing minority health patterns especially since proximity to Whiteness did not afford the historically observed health advantage. Moreover, the results informed by stress process theory support the possibility that multiracial status or the unique stressors related to multiracial stigmatization impact health outcomes for this population. Additionally, critical race theory enables us to understand how existing racial groups have emerged from racism and how the present exclusion and absence of recognizing multiracial identity produces disadvantage related to living within a structure that discounts such experience. Therefore, these results
demonstrate the need to further operationalize and investigate how structural and systemic racism impacts the health and lives of those identifying outside of traditional monoracial categories.
References


Austin, S. J. (2018). A mixed methods exploration of the role of friends and identity in multiracial adolescent girls' mental health (Doctoral dissertation, UCL (University College London)).


