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Determinants of Drinking Trajectories Among Minority Youth and Young Adults: The Interaction of Risk and Resilience

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Abstract

Adolescent drinking research has focused heavily on risks for alcohol-related consequences and on personality traits associated with adverse alcohol-related outcomes. A risk-based paradigm may inadvertently overemphasize risk when measures are applied to communities that experience discrimination and socioeconomic disadvantage. In this study we use qualitative methods to examine drinking motives and the relationship between motives and patterns of risk and resilience among a diverse group of 60 youth and young adults enrolled in an independent trial of brief intervention for alcohol use at an inner-city pediatric emergency department and report on their own understandings of their experiences, particularly their reasons for drinking. We found a clear distinction between drinking to "chill" and drinking to "cope" with very different projected life course trajectories despite similarities between groups in neighborhood and interpersonal stressors. Strategies to

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motivate "copers" to alter drinking behavior may need to be shored up with a network of support services.

Keywords

adolescent drinking, drinking motives, risk and resilience

Introduction

Early onset of drinking has been shown to be associated with a host of high-risk behaviors and serious consequences, from fights to serious injury to dependence as an adult (Hingson, Heeren, & Winter, 2006; Hingson, Heeren, Zakocs, & Winter, 2002). Recent studies suggest that binge drinking at the age of 16 is also associated with adult dependence and adverse events (Viner & Taylor, 2007)

Research about adolescent drinking has focused heavily on personality traits associated with adverse alcohol-related outcomes, primarily temperament, negative affectivity (Pardini, White, & Stouthamer-Loeber, 2007), values (Donovan, 2004), cognitive processing (Nigg et al., 2006), and environmental risk factors such as peer pressure (Sieving, Perry, & Williams, 2000), parental substance use (Clark, Cornelius, Kirisci, & Tarter, 2005; Sartor, Lynskey, Heath, Jaco, True, 2007), parenting practices (Barnes & Welte, 1986), lack of school bonding (Barnes, 1990), and negative community influences (Donovan et al., 2004; Wright & Fitzpatrick, 2004). The assumption behind this approach is an exposure model—the greater the exposure to risk, the more likely it is that adolescents and young adults who experiment with alcohol will progress along the trajectory to abuse and dependence. Although specific assets and protective factors such as academic achievement, school connectedness, and parental monitoring have been identified (Dekovic, 1999; Dryfoos, 1990; Garnier & Stein, 1998), the impact of assets is often measured by their absence (Fisher et al., 2007; Scheier, Botvin, & Baker, 1997). This tendency to focus on risk appears to be particularly prominent when the sample of interest is African American or Hispanic. The risk and protective factors paradigm widely disseminated by Hawkins, Catalano, and Miller (1992) may inadvertently overemphasize risk when measures are applied to communities that experience discrimination and socioeconomic disadvantage.

For example, lower rates of alcohol, tobacco, and drug use among African Americans compared to Whites on self-report surveys, such as the Youth Risk Behavior Surveillance Survey, are sometimes explained by school drop-out rates. However, reduced levels of use are also found in the Monitoring the Future survey (Johnston, O'Malley, Bachman, & Schulenberg, 2006) and the National Household Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007), which are not affected by school dropout rates.

Research into the predictors of negative trajectories often emphasizes risk without balancing risk factors against resilience and resources. For example, an important analysis of family-related assets estimates the effects of parental dysfunction and parent–adolescent distress on the relationship between peer pressure and drug use (Farrell & White, 1998) but does not estimate the moderating effects of a high level of parental functioning on drug use. In other words, an asset is of interest only to the extent that it reveals a mirror image of risk.

Similarly, an investigation of the effects of race, neighborhood, and social network on age at initiation of drug use characterizes contextual factors by a negative geography—the distance from a needle exchange site (Fuller, Borrell, Latkin, & Galea, 2005)—without looking at other contextual factors that might reflect a different geography of protective factors and resources. Risk is real, as illustrated by a study of African American adolescents that found that early experiences of discrimination could be linked with subsequent drug use (Gibbons et al., 2007). However, the majority of quantitative studies have been cross-sectional and limited to describing correlates of alcohol use, and we do not have longitudinal studies that include information about nondrinkers among racial and ethnic minorities. For these reasons, we lack the evidence to support a nuanced position that balances risk and resilience.

Farrell and White (1998) use a more complex approach to frame their study of peer influences and drug use among urban adolescents. They acknowledge that risk factors are more likely to be intensified in low-income African American neighborhoods because of residential segregation, neighborhood deterioration, and inadequate social and economic resources but note that these same circumstances may also engender culturally unique responses that act as modifiers.

Although socialization, maladaptive coping, problem behavior theories, and social learning models (Cooper, Russell, & George, 1988) form a reasonable basis for inquiry about risks, they do not, by themselves, capture the complexity of the interaction between risk and resilience. Nor do they generally account for the influences of culture and racial identity and their interaction with neighborhood and community factors. Most important, risk alone does not explain the extent of diversity *within* each minority grouping (Szapocznik, Prado, Burlew, Williams, & Santisteban, 2007). Qualitative studies, however, show clear differences in drug use, in drinking patterns (quantity and type of alcohol), drinking motives, and the cultural context of alcohol use across race

and/or ethnicity (Quintero, Young, Meier, & Jenks, 2005; Stimson et al., 2004; Strunin, 2001; Strunin & Demissie, 2001; Strunin et al., 2010).

In the motivational model for adolescents and young adults developed by Cox and Klinger (1988) and enhanced by Kuntsche, Knibbe, Gmel, and Engels (2005, 2006a, 2006b), the decision to drink in a specific set of circumstances has both rational and affective components. A standardized instrument validated in different samples has been used to establish levels of risk for four categories of drinking motives—enhancement, social, coping, and conformity—and these motives have been shown to be associated with different patterns of alcohol use and different levels of risk behavior. (Cooper, Russell, Skinner, & Windle, 1992; Maarten, Rocha, & Martine, 2008; McLean & Lecci, 2000; Stewart & Chambers, 2000). Drinking motives appear to have an independent effect on drinking problems, and they also moderate quantity consumed for an indirect effect (Carey & Correia, 1997). There is evidence that drinking to cope is associated with the highest levels of consumption and consequences (Maartens, Cox, & Beck, 2003). The coping motive may play an influential role in the development of dependence (Carpenter & Hasin, 1998, 1999), especially when combined with a history of parents with alcohol problems (Chalder, Elgar, & Bennett, 2006). Drinking to manage mood also appears to index genetic risk for alcoholism (Prescott, Cross, Kuhn, Horn & Kindler, 2006).

If race and/or ethnicity are associated with differences in alcohol use and problem prevalence in the14 to 25 age group, as national data suggest, it is reasonable to assume that race, ethnicity, and culture may affect the definitions, presentations, and interpretation of drinking motives and that there is much to learn from an analysis of minority youth experiences. Parental racial socialization, for example, has been shown to predict healthy adolescent outcomes among African Americans (Caughy, Ocampo, Randolph, & Nickerson, 2002), possibly mediated by positive family function (Frabutt, Walker, & MacKinnon-Lewis, 2002). This article examines drinking motives and the relationship between motives and patterns of risk and resilience among a diverse group of youth and young adults enrolled in an independent trial of brief intervention for alcohol use at an inner-city pediatric emergency department and reports on their own understandings of their experiences, particularly their reasons for drinking.

Method

Sample selection

The 60 participants in this study were enrollees in a large randomized, controlled trial of brief intervention for risky drinking, either alone or in combination with marijuana, in the Pediatric Emergency Department at Boston Medical Center, an urban, academic Level I trauma setting, selected because "evidence shows that for some adolescents, safety-net settings may be more accessible, acceptable, appropriate, effective, and equitable than mainstream services, especially for more vulnerable populations of uninsured or underinsured adolescents" (National Research Council and Institute of Medicine, 2009).

Enrollees did not need to self-identify a drinking issue to qualify for this study. All patients presenting to the Pediatric ED daily during the hours of 8 a.m. to 10 p.m. for all types of presenting medical and/or mental health problems were screened for at-risk drinking using standard general survey questions embedded in a health and safety survey (for more information about the parent study, see Bernstein et al., 2010). Enrollees eligible for this trial were aged 14 to 21, engaged in high-risk alcohol use, had an Alcohol use Disorders Inventory Score (AUDIT) ≥4 for age 14 to 17 or ≥8 for age 18 to 21, or had experienced consequences related to drinking. This relatively low cut point for eligibility ensured that enrollees would span the gamut of unhealthy alcohol use, from at-risk behaviors (an occasional binge episode) to alcohol abuse and dependence (a history of consequences and/or life organized around alcohol use).

According to study design, a third of enrollees in the RAP trial received an intervention, a 30-min brief negotiated interview (Table 1) that is evidence based and supported by theoretical work in values expectancies (Bandura, 1997), reasoned action (Rogers, 1977), and the transtheoretical model (Prochaska & DiClemente, 1992). The intervention is entirely client-centered and directed, allows the patient to name and prioritize concerns, elaborates goals, and facilitates exploration of goal discrepancies and ends with the client, not the intervener, setting an agenda for change. For all of these reasons, this type of interview is suitable for qualitative analysis.

Interventions were audio-recorded for qualitative analysis, with permission from participants. The sample for this analysis is therefore purposive, comprising the first 60 enrollees who received an intervention and were willing to allow interviews to be tape-recorded for analysis.

Data Collection and Data Analysis

The semistructured intervention script for the brief negotiated interview appears in Table 1. The interview begins with the story of a typical day, through the pros and con of alcohol use, a readiness discussion, and the referral process. Information about drinking motives was elicited specifically with the questions, "What do you like about your alcohol use" and "What do you like less?"

Table 1. The Brief Negotiated Interview

BNI steps	Dialogue/procedures
Ask permission Address privacy	• Hello, I am _______ Would you mind taking a few minutes to talk with me confidentially about your use of [X]? <<Pause and listen>>
Engage	• Before we start, could you tell me a little about a day in your life?
Provide feedback	• From what I understand, you are using [insert screening data]...We know that drinking above certain levels, smoking and/or use of illicit drugs can cause problems, such as [insert medical info]...I am concerned about your use of [X].
• Ask how X fits in with life goals	• Ask about enrollee's goals for self (what's important to them)
• Make connection (no arguing)	• What connection (if any) do you see between your use of [X] and this ED visit? • If patient sees connection: reiterate what patient said • If patient does not see connection: make one using medical info
• For alcohol...Show NIAAA guidelines & norms for adults	• These are what we consider the upper limits of low-risk drinking for adults. By low risk we mean that you would be less likely to experience illness or injury if you stayed within these guidelines. From what you say, you are drinking above the adult guidelines
Enhance motivation	
• Explore pros and cons	Ask pros and cons • Help me to understand what you enjoy about [X]? <<Pause and Listen>> • Now tell me what you enjoy less about [X] or regret about your use of [X]
• Use reflective listening	• <<Pause and listen>> • On the one hand you said...On the other hand you said....
• Adminster CRAFFT	• Ask CRAFFT* questions, then sum up and restate in patient's own words
• Readiness to change	• So tell me, where does this leave you? [show readiness ruler] On a scale from 1-10, how ready are you to change any aspect of your use of [X]?
• Reinforce change talk	• Ask: Why did you choose that number and not a lower one like a 1 or a 2? Other reasons for change?
Negotiate & advise	What's the next step?
• Negotiate goal	• What do you think you can do to stay healthy and safe? [elicit action plan]
• Benefits of change	• If you make these changes, what do you think might happen to you now and in the future?
• Reinforce resilience/ resources	• Have you made changes before or have you accomplished goals you feel proud of? Who helped? Could you use these methods now?
• Summarize	• This is what I've heard you say you want to change • Offer menu of resources
• Offer resources	• I've written down your plan—a prescription for change. Use it as an agreement between you and yourself
• Prescription for change	• Provide agreement and information sheet • Make primary care f/u and other referrals to support carrying out plan; if CRAFFT >3, refer for further assessment/treatment
• Provide handouts • Refer	Thank patient for his or her time

(continued)

Table 1. (continued)

Note: CRAFFT = Acronym for Car, Relax, Alone, Forget, Friends, Trouble (keywords in a screening questionnaire).

Because the interview was semistructured and participants were allowed to return to any topic in the course of the intervention, the entire interview was coded for themes related to drinking motives, drinking patterns, and risk and resilience.

Each interview was evaluated by a set of thematic codes developed from the interview scripts. Codes represent a category or theme found in the data and the codes were attached to corresponding segments of text. The coding process involved three steps of data coding. In step one, three researchers and two coders (the analysis team) read through the interviews and underlined important words or phrases and developed a set of thematic codes based on the issues and themes of relevance. In step two, codes were put directly into the text in the form of an abbreviation of a category name that represents a category or theme (code) found in the data. To improve interrater reliability,

Table 2. Sample Characteristics

Characteristics	n	%
Gender		
Male	31	51
Female	29	59
Age (mean = 18 years)		
16	1	1
17	4	6
18	11	18
19	18	30
20	15	25
21	11	18
Race/ethnicity		
Hispanic	11	18
Black	37	62
White	5	6
American Indian	2	3
Asian/Pacific Islander	3	5
Unknown	2	3

each team member coded five interviews, and the team reviewed the codes for differences and clarity. When it was clear that the entire team understood the coding scheme, the two coders coded all the interviews. In step three, the findings were analyzed to explore for linkages between and/or among particular themes using HyperResearch software, a text retrieval program geared toward in-depth exploration of data. Any problem cases were discussed by the analysis team until agreement on appropriate coding was reached. Data analysis was conducted using an iterative process, first using single codes and looking at each group separately. Searches were also performed looking at multiple codes and categories. A final analytic step explored whether or not linkages existed among particular categories.

Results

Sample characteristics

The 60 interviewees were diverse in race/ethnicity and gender (see Table 2) but drawn from similar neighborhoods in the same zip codes. Age ranged from 16 to 21 years, with a mean of 18. More than half (n = 33) used alcohol in

combination with marijuana. Mean AUDIT scores were similar for the two drinking motive groups: 7.2 for "copers," and 7.8 for "chillers."

Findings

The motives for drinking among the youth and young adults in this study fall largely within two categories—drinking to "chill" or drinking to "cope." Only 16 of the 60 did not clearly identify either chilling or coping; we were able to classify 12 of these 16 cases under the commonly observed drinking motive of conformity (being accepted by peers), but in four cases there was insufficient information to specify drinking motives. We did not label a drinking motive when there was a suggestion, but not a definitive presentation one of the four standard categories of motivation discussed in the literature (enhancement, social affiliation, conformity, coping). Those who drank to chill did not mention coping, and similarly those who drank to cope did not mention drinking to chill. These two drinking categories represented very different motives for drinking and different approaches to goals and life trajectories.

Drinking to "Chill"

The reasons given for drinking by the young people who drank to chill indicate enhancement and social motives for drinking. They described drinking for fun or pleasure or for sociability and engaging with peers. They drank at clubs, parties, or "hanging out" with friends and although they described drinking as part of having a good time, not every good time involved drinking. In general, "chillers" described reasonable if challenging life goals, and step-by-step plans to achieve them. They appeared to be aware of discrepancies between goals and present situations, and described a variety of strategies, including creative efforts, group activities, and discussions with relatives and neighbors. They were also able to give examples of how they used these sources of support to resolve contradictions and move forward in a positive direction.

The "chillers" associated drinking with entertainment and pleasure. KT, a 20-year-old employed Black male, described his motivation to drink in a way that was typical for this group:

> Um, usually it's just like, I don't know, when me and my friends are drinking together, we used to start laughing, and it's just fun like with friends like. I don't drink by myself . . . whenever I drink it's usually three or four of my friends . . . like a party . . . sporting event, stuff like that.

The fun and party aspects associated with drinking were echoed by others, such as TH, a Black female, 20 years old, who was living with her boyfriend at his mother's house:

I go to the club which is like once in a blue moon and then I am just drinking for fun.

AD, a 20-year-old Hispanic male, described his drinking this way:

It just gives me a buzz. I just feel good. If it's there I might choose to drink it. If it's not, I'm all right, you know.

echoed by JS, a Black male, 20 years old, who was working as an electrician:

Alcohol is when the fun is around . . . .anytime we drink, it will just be, everything is going on. It's more a party . . . just the party.

and by MB, a 20-year-old Hispanic female

Sometimes it tastes good. We have a good time when we're all hanging out. That is it.

A social motive was also described explicitly as heard from AC, a 16-year-old Asian male who is in school:

I like it that you can drink with your friends and have a good time and stuff.

Drinking to Cope

In contrast to those who drank to chill, the young people who drank to cope described motives solely related to coping and talked about drinking to relieve feelings of stress. The "copers" described stress situations that they identified with drinking motivation, including drinking to numb feelings of loss, to "feel better," "ease problems" and not think about things that made them angry or sad. For the "copers," drinking helped relieve the stress and problems of their everyday lives. The weight of problems and negative feelings often appeared overwhelming. They did not have concrete goals that they were working toward; instead, the future was just "going to come. For example, AB, a Black female, 20 years old, who had just completed probation and was job hunting, made a direct connection between substance use and stress:

If I feel as if I'm stressed and the first thing I say is, I need a drink.

Others such as LK, a 19-year-old Black male daily drinker, described direct connections between drinking and trouble coping with serious losses:

And I'm not dead. But all the people around me, one by one, would disappear. I got a picture with six people in it; all six of them people are dead. I'm the only one alive in that picture, and that stresses me out too, because I start thinking am I the next one to go? Or not? You don't know. You can't read the future. You can just let the future come . . . . I want to get over it [drinking] . . . but I know it's something that's going to continue. I want to think of my cuz where it won't hurt me; where I could just be like, I don't need a drink to be thinking what I am thinking about this . . . because sometimes when you think about it you just be like, damn, and you be stressed with that, since he's so close to me.

Other "copers" referred to drinking to "feel better," "ease problems," and not think about things that result in feeling "mad or sad or everything." SP, a 20-year-old pregnant Black female with a 4-year-old child described an ordinary day as

I don't really do nothing . . . sleep until 10, take a shower, brush my teeth, smoke a cigarette, roll a blunt, smoke all day until like 7, go to the store, buy some liquor, drink until 2. That's my day. If I get depressed I'll go to the store and buy a drink and I'll feel better.

DL, an 18-year-old Black male, whose brother was in the hospital and not expected to recover, talked about drinking to relieve problems:

I been smoking [marijuana] since I was 14 and joined drinking two years ago when I was 16 . . . [alcohol helps me] not think about things that get you mad or sad or everything.

as did MF, a 17-year-old White female with a 2-year-old son:

On a daily basis if I drink or smoke . . . it helps me out to handle my problems on my own . . . it will blank it out for that day.

and AT, a 16-year-old Hispanic female, who talked about her daily drinking as helpful to her because

> When I drink, I feel so much better, like I'll be calmer, like it just gets rid of the, it takes the moment away, you feel me?

"Chillers" and "Copers"—Similarities and Differences in Daily Life Challenges

Life is difficult for the youth and young adults who use an inner-city emergency department for their medical care. "Chillers" and "copers" referred to similar daily life challenges related to safety, family chaos, and life goals and described struggling with stress and negative affect: anger and aggravation, boredom and loneliness, "not caring," and depression or sadness. Both groups experienced significant losses and dealt daily with dangerous situations. Although those who use alcohol only to chill are confronting considerable burdens, they neither referred to any relationship between alcohol use and what they were feeling nor ascribed a coping motive to alcohol use. The difference between the groups did not appear to be the level of stress or type of stress they experienced, but whether or not they used alcohol to cope with essentially similar life challenges.

Safety and Violence

Both "copers" and "chillers" expressed concerns about safety and the threat of violence. Most "copers" talked about safety, but some chillers also described significant stressors related to safety issues, with similar intensity and concerns as copers. For example, JS, the 20-year-old Black male "chiller" employed full time by an electric company said

> I know but it's like, honestly, in the hood it's like, you don't even have to be doing nothing to run into a beef. Somebody, there's so much ego . . . .You could be just about your business and somebody just look at you, looking like, yeah, we want to fight you and you have nothing.

and others such as AD, a Hispanic male, 20-year-old "chiller" expressed concern about neighborhood violence:

> I just have been through a lot of problems since I was young and I just kept seeing it every day, whether it was murders, whether it was fights, whether it was people just getting their teeth smashed in, whether it was my mom and dad arguing, whether it was my sister getting punched by one of her boyfriends, whether it, I just had a lot of problems . . . .It's the same shit every day. So I don't know. . .I don't want to worry about everything else I used to worry about or care about whatever I used to care about, I just want to live my life and get to where I wanted to go when I get there I will be happy. I'm chilling right now, I'm just me.

as did TH Black female, 20-year-old "chiller":

> I am little and I am scared of Boston period. . . .You just can't walk down the street anymore, you know. . . .I can't defend myself as opposed to like if a man approaches me your size so I just carry a knife. . . .I don't want to be a victim so I just carry a knife.

Family chaos

Family chaos and turmoil was a subject most copers and some chillers talked about but both "copers" and chillers reported similar intensity of problems including rapes, domestic violence, fights among relatives, and parental addiction and mental health problems. Again what is different is that chillers do not appear to use alcohol to cope. Not surprisingly, more copers (5/11) than chillers (5/33) faced legal charges or supervision.

Restricted opportunities

All of the interviewees are inner-city youth with limited financial resources and educational opportunities. Despite this similarity, there seems to be a marked difference in the way that "chillers" and "copers" approach this common problem. In particular, all the "copers" described a lack of goals and/or an ability to envision carrying out goals. Although most of the "chillers" were in some type of educational or work-readiness program or were working, only one of the "copers" reported having a GED or high school diploma. The other "copers" described the need to return to school or find a job, but often their statements seemed contradictory. They described being bored, having nothing to do and passing time with alcohol and marijuana. In terms of career aspirations, they did not seem to understand the duties or responsibilities of their career choice. The following exchange illustrates the lack of concrete detail in the plan of a female "coper," aged 20, who wanted to be a physician:

Interviewer: So please tell me, what are some of your goals?
SP: My goals. I want to be. I want to be a doctor in the future.
Int: Ok. So you think you can do it. . .
SP: Yes, absolutely.
Int: What kind of doctor?
SP: A pediatrician.
Int. And how will you get to that position?
SP: What happens?
Int: What's the path? How will you get there?
SP. I just got to do one more year of high school or get a GED or whatever I have to do, you see what I mean? Then go to college. Get my degree. . .you know what I'm saying? That's what I can do.
Int: What are some of your other goals?
SP: To buy a house, cars, you know what I'm saying. To stop drinking and smoking [marijuana].

"Chillers" described many sources of resilience, including writing stories, poetry, and plays, positive mentoring experiences, friends, and caring adults, yet none of the 1 "copers" described these types of assets.

Discussion

It is important to note that the lives of the inner-city youth who participated in our study differ radically from the largely White, middle-class college students who have been the primary focus of drinking motive investigations. Bradizza, Reifman, and Barnes (1999) found significant racial differences in the relationship between drinking motives and alcohol misuse outcomes in their investigation among a diverse sample of adolescents in Buffalo, recruited through random digit dialing. In that study, social motives predicted risky behavior patterns among Whites, while coping motives were associated with higher risk of alcohol-related consequences among African Americans.

The similarity in types of stressors between the two motive groups was remarkable, but perhaps not surprising. Both groups have problems to solve and many young people drank because of "pressure" and "problems" of their daily life. Alcohol appears to relieve them of these stressful situations. We found similar reasons for drinking in a study of African American and Haitian youth living in an inner-city environment (Strunin & Demissie, 2001). Problem-focused coping, however, has not been demonstrated to be associated with either alcohol consumption or outcomes. In contrast, emotion-focused forms of coping are clearly related to both alcohol intake and drinking complications

(Karwacki & Bradley, 1996; Windle & Windle, 1996). Recent data suggest that drinking to cope with emotions may also be an important modifier in the path from adverse events in childhood to alcohol dependence as an adult (Heeren, Edwards, & Rosenbloom, 2008). In our study, both "chillers" and "copers" experienced serious life challenges and threats, but only those who were drinking solely to cope described themselves as drinking alone and feeling hopeless and desperate. In analyses by race/ethnicity, solitary drinking appears to be most strongly related to high-quantity consumption among African American youth (Neff, 1997). Although the context of multiple life challenges (safety, housing, access to education, jobs, and health care) is similar for all participants in our study regardless of drinking motives, the "copers" stories and the intensity of their losses and barriers suggest that strategies to motivate them will need to be shored up with a network of services and supports.

"Chillers" described many sources of resilience, including writing stories, poetry and plays, positive mentoring experiences, friends, and caring adults; none of the "copers" described these kinds of assets. We found a remarkable range of resources, supports, and creative strategies among the "chillers" despite the fact that the level of drinking in this group created considerable risk. If we attempt to understand drinking patterns among youth and young adults by limiting ourselves to an inventory of social and psychodynamic risks, we may be missing a very important predictor of future outcomes. All of these students "walked the mean streets" and were surrounded by the "code of the street" (Rich, 2009), but these interviews suggest two very different trajectories. The same positive energy that directed the "chillers" into education, jobs, meaningful relationships, and the arts may well protect them from a potential spiral downward into alcohol dependence in early adulthood. We need longitudinal studies that assess sources of resilience and support as well as risk to determine the extent of protection that these supports confer.

The responses to questions about life goals are important. Griffin, Botvin, Nichols, and Scheier (2004) also found that low "perceived chance of success in life" was correlated closely with rates of heavy episodic drinking in a study of both boys and girls in an inner-city Black and Hispanic population, controlling for change over time in both variables from seventh to eighth grade ($n = 774$). The life goals described by the "chillers" appear more incremental and believable than those expressed by "copers," who seemed to be at a loss as to how to take the first steps toward a distant, tenuous vision.

Intensity of alcohol problems and the potential for consequences may be similar for "chillers" and "copers" but differences in motives for drinking may signify a different response to attempts at intervention and a different life course, as suggested by previous work-tying coping motives in adolescents and

emerging adults to a higher level of negative outcomes and greater potential for development of alcohol use disorders when they reach full adulthood. What we have learned suggests that results from the administration of a standardized, well-validated instrument such as the *Drinking Motives Questionnaire-R* (Grant, Stewart, O'Connor, Blackwell, & Conrod, 2007; Kuntsche et al., 2006b) might contribute valuable information to an intervention to reduce high-risk drinking. One of the goals of the brief motivational intervention devised for the parent study was to encourage identification of strengths and reinforce supports. The next step is to incorporate into the next iteration of the intervention what we learned about drinking motives from this study, and make sure that probes about chilling and coping are included as key elements. Our study also suggests that for copers, intervention must include social service referrals, culturally competent mental health counseling, and case management services in addition to standard referrals for substance abuse assessment and treatment.

There will be challenges along the way as we begin to expand our models of drinking trajectories for emerging adults to include resilience factors as well as risks. Community and family supports are sometimes difficult to specify accurately, because many factors have multiple layers, some representing risk and others indicating resilience. Wine drinking in a family context may be protective, for example, depending on the cultural context (Strunin et al., 2010). Boarded-up buildings may actually be a marker for pockets of community strength, not devastation, as described in a study of Baltimore neighborhoods, and not an indication of risk (Furr-Holden et al., 2010). Validation will be necessary to preclude misclassification, but as this study's new perspectives on "chilling" and "coping" suggest, the effort to expand research perspectives beyond risk has the potential to generate useful lines of inquiry.

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The authors declared no potential conflicts of interest with respect to the authorship and/or publication of this article.

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References

Bandura, A. (1997). *Self-efficacy: An exercise of control.* New York: W.H. Freeman.

Barnes, G. M. (1990). Impact of the family on adolescent drinking patterns. In R. L. Collins, K. E. Leonard, & J. S. Searles (Eds.), *Alcohol and the family: Research and clinical perspectives* (pp. 137-161). New York: Guilford Press.

Barnes, G. M., & Welte, J. W. (1986). Patterns and predictors of alcohol use among 7-12th grade students in New York State. *Journal of Studies on Alcohol, 47*, 53-62.

Bernstein, J., Heeren, T., Edwards, E., Dorfman, D., Bliss, C., Winter, M., et al. (2010). A brief motivational interview in a pediatric emergency department, plus 10-day telephone follow-up, increases attempts to quit drinking among youth and young adults who screen positive for problematic drinking. *Academic Emergency Medicine, 17*, 890-902.

Bradizza, C. M., Reifman, A., & Barnes, G. M. (1999). Social and coping reasons for drinking: Predicting alcohol misuse in adolescents. *Journal of Studies on Alcohol, 60*, 491-499.

Carpenter, K. M., & Hasin, D. (1998). A prospective evaluation of the reasons for drinking and DSM-IV alcohol-use disorders. *Addictive Behaviors, 25*, 887-897.

Carpenter, K. I. M., & Hasin, D. (1999). Drinking to cope with negative affect and DSM-IV alcohol use disorders: A test of three alternative explanations. *Journal of Studies on Alcohol, 60*, 694-704.

Carrey, K. B., & Correia, C. J. (1997). Drinking motives predict alcohol-related problems in college students. *Journal of Studies on Alcohol, 58*, 100-105.

Caughy, M., Ocampo, P., Randolph, S., & Nickerson, K. (2002). The influence of racial socialization practices on the cognitive and behavioral competence of African American preschoolers. *Child Development, 73*, 1611-1625.

Chalder, M., Elgar, F. J., & Bennett, P. (2006). Drinking and motivations to drink among adolescent children of parents with alcohol problems. *Alcohol and Alcoholism, 41*, 107-113.

Clark, J., Cornelius, J. R., Kirisci, L., & Tarter, R. E. (2005). Childhood risk categories for adolescent substance involvement: A general liability typology. *Drug and Alcohol Dependence, 77*, 13-21.

Cooper, M. L., Russell, M., & George, W. H. (1988). Coping, expectancies and alcohol abuse: A test of social learning formulations. *Journal of Abnormal Psychology, 97*, 218-230.

Cooper, M. L., Russell, M., Skinner, J. B., & Windle, M. (1992). Development and validation of a three-dimensional measure of drinking motives. *Psychological Assessment, 4*, 123-132.

Cox, W. M., & Klinger, E. (1988). A motivational model of alcohol use. *Journal of Abnormal Psychology, 97*, 168-180.

Dekovic, M. (1999). Risk and protective factors in the development of problem behavior during adolescence. *Journal of Youth and Adolescence, 28*, 667-687.

Donovan, J. E. (2004). Adolescent alcohol initiation: A review of psychosocial risk factors. *Journal of Adolescent Health, 35*, 7-18.

Donovan, J. E., Leech, S. L., Zucker, R. A., Loveland-Cherry, C. J., Jester, J. M., Fitzgerald, H. E., et al. (2004). Really underage drinkers: Alcohol use among

elementary students. *Alcoholism: Clinical and Experimental Research, 28*, 341-349.

Dryfoos, J. G. (1990). *Adolescents at risk: Prevalence and prevention*. New York: Oxford University Press.

Farrell, A. D., & White, K. S. (1998). Peer influences and drug use among urban adolescents: Family structure and parent-adolescent relationship as protective factors. *Journal of Consulting and Clinical Psychology, 66*, 248-258.

Fisher, L. B., Fisher, S. M., Miles, I. W., Austin, S. B., Camargo, C. A., & Colditz, G. A. (2007). Predictors of initiation of alcohol use among US adolescents: Findings from a prospective cohort study. *Archives of Pediatric and Adolescent Medicine, 161*, 959-966.

Frabutt, J., Walker, A. S., & MacKinnon-Lewis, C. (2002). Racial socialization messages and the quality of mother/child interaction in African American families. *Journal of Early Adolescence, 22*, 200-217.

Fuller, C., Borrell, L. N., Latkin, C. A., & Galea, S. (2005). Effects of race, neighborhood, and social network on age at initiation of injection drug use. *American Journal of Public Health, 95*, 689-695.

Furr-Holden, C. D., Campbell, K. D., Milam, A. J., Smart, M. J., Ialongo, N. A., & Leaf, P. J. (2010). Metric properties of the Neighborhood Inventory for Environmental Typology (NIfETy): An environmental assessment tool for measuring indicators of violence, alcohol, tobacco, and other drug exposures. *Evaluation Review, 34*, 159-184.

Garnier, H. E., & Stein, J. A. (1998). Values and the family. *Youth and Society, 30*, 89-120.

Gibbons, F. X., Yeh, H. C., Gerrard, M., Cleveland, M. J., Cutrona, C., Simons, R. L., et al. (2007). Early experience with racial discrimination and conduct disorder as predictors of subsequent drug use: A critical period hypothesis. *Drug and Alcohol Dependence, 88*, S27-S37.

Grant, V. V., Stewart, S. H., O'Connor, R. M., Blackwell, E., & Conrod, P. J. (2007). Psychometric evaluation of the five-factor Modified Drinking Motives Questionnaire—Revised in undergraduates. *Addictive Behavior, 32*, 2611-2632.

Griffin, K. W., Botvin, G. J., Nichols, T. R., & Scheier, L. M. (2004). Low perceived chances for success in life and binge drinking among inner-city minority youth. *Journal of Adolescent Health, 34*, 501-507.

Hawkins, J. D., Catalano, R. F., & Miller, Y. J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*, 64-105.

Heeren, T., Edwards, E., & Rosenbloom, D. (2008). Drinking motives & age of drinking onset as mediators of associations between adverse childhood experiences & alcohol dependence in young adulthood. Presented at the Annual Meeting of the Research Society on Alcoholism, Washington DC.

Hingson, R. W., Heeren, T., & Winter, M. (2006). Age at drinking onset and alcohol dependence: Age at onset, duration, and severity. *Archives of Pediatric and Adolescent Medicine, 160*, 739-746.

Hingson, R., Heeren, T., Zakocs, R., & Winter, M. (2002). Age of first intoxication, heavy drinking, driving after drinking and risk of unintentional injury. *Journal of Studies on Alcohol, 63*, 136-144.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2006). *Monitoring the Future: National results on adolescent drug use*. Bethesda, MD: National Institute of Drug Abuse.

Karwacki, S. B., & Bradley, J. R. (1996). Coping, drinking motives, goal attainment expectancies and family models in relation to alcohol use among college students. *Journal of Drug Education, 26*, 243-255.

Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2005). Why do young people drink? A review of drinking motives. *Clinical Psychology Review, 25*, 841-861.

Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2006a). "I drink spirits to get drunk and block out my problems . . ." Beverage preference, drinking motives and alcohol use in adolescence. *Alcohol and Alcoholism, 41*, 566-573.

Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2006b). Replication and validation of the drinking motive questionnaire revised (DMQ-R, Cooper, 1994) among adolescents in Switzerland. *European Addiction Research, 12*, 161-168.

Maartens, M. P., Cox, R. H., & Beck, N. C. (2003). Negative consequences of intercollegiate athlete drinking: The role of drinking motives. *Journal of Studies on Alcohol, 64*, 825-828.

Maarten, M. P., Rocha, T. L., & Martine, J. L. (2008). Drinking motives and college students: Further examination of a four-factor model. *Journal of Counseling Psychology, 55*, 289-295.

McClean, M. G., & Lecci, L. (2000). A comparison of drinking motives in a university sample. *Psychology of Addictive Behavior, 14*, 83-87.

National Research Council and Institute of Medicine. (2009). *Adolescent health services: Missing opportunities*. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, R. S. Lawrence, J. A. Gootman, & L. J. Sim (Eds.). Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academies Press.

Neff, J. A. (1997). Solitary drinking, social isolation, and escape drinking motives as predictors of high quantity drinking, among anglo, African American and Mexican American males. *Alcohol and Alcoholism, 32*, 33-41.

Nigg, J. T., Wong, M. M., Martel, M. M., Jester, J. M., Puttler, L., Glass, J. M., et al. (2006). Poor response inhibition as a predictor of problem drinking and illicit drug use in adolescents at risk for alcoholism and other substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 468-475.

Pardini, D. A., White, H. R., & Stouthamer-Loeber, M. (2007). Early adolescent psychopathology as a predictor of alcohol use disorders by young adulthood. *Drug and Alcohol Dependence, 88*, S38-S49.

Prescott C.A., Cross, R.J., Kuhn, J.W., Horn, J.L., Kindler, K.S. (2006). Is risk for alcoholism mediated by individual differences in drinking motivations? *Alcoholism: Clinical Experimental Research, 28*, 29-39.

Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Progress in Behavior Modification, 28*, 183-218.

Quintero, G. A., Young, K. J., Meier, N., & Jenks, S., Jr. (2005). Perceptions of drinking among hispanic college students: How qualitative research can inform the development of collegiate alcohol abuse prevention programs. *Journal of Drug Education, 35*, 291-304.

Rich, J. (2009). *Wrong place, wrong time: Trauma and violence in the lives of young black men*. Baltimore: Johns Hopkins University Press.

Rogers, C. R. (1977). *Carl Rogers on personal power*. New York: Delacorte Press.

Sartor, C., Lynskey, M. T., Heath, A. C., Jaco, T., & True, W. (2007). The role of childhood risk factors in initiation of alcohol use and progression to alcohol dependence. *Addiction, 102*, 216-225.

Scheier, L. M., Botvin, G. J., & Baker, E. (1997). Risk and protective factors as predictors of adolescent alcohol involvement and transitions in alcohol use: A prospective analysis. *Journal of Studies on Alcohol, 58*, 652-657.

Sieving, R. E., Perry, C. L., & Williams, C. L. (2000). Do friendships change behaviors, or do behaviors change friendships? Examining paths of influence in young adolescents' alcohol use. *Journal of Adolescent Health, 26*, 27-35.

Stewart, S. H., & Chambers, L. (2000). Relationships between drinking motives and drinking restraint. *Addictive Behavior, 25*, 269-274.

Stimson, G. V., Fitch, C., Des Jarlais, D., Poznyak, V., Perlis, T., Oppenheimer, E., et al. (2004). Rapid assessment and response studies of injection drug use. Knowledge gain, capacity building, and intervention development in a multisite study. *American Journal of Public Health, 96*, 288-295.

Strunin, L. (2001). Assessing alcohol consumption: Developments from qualitative research methods *Social Science Medicine, 53*, 215-226.

Strunin, L., & Demissie, S. (2001). Cultural identification and alcohol use among "Black" adolescents. Substance Use and Misuse. 36, 2025-2041.

Strunin, L., Lindeman, K., Tempesta, E., Ascani P., Anav, S. E., & Parisi, L. (2010). Familial drinking in Italy: Harmful or protective factors? *Addiction Research and Theory, 18*, 344-358.

Substance Abuse and Mental Health Services Administration. (2007). *National Household Survey on Drug Abuse and Health*. Retrieved August 11, 2010, from http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm

Szapocznik, J., Prado, G., Burlew, K., Williams, R. A., & Santisteban, D. A. (2007). *Annual Review of Clinical Psychology, 3*, 77-105.

Viner, R. M., & Taylor, B. (2007). Adult outcomes of binge drinking in adolescence: Findings from a UK national birth cohort. Journal of Epidemiology and Community Health, 61, 902-907.

Windle, M., & Windle, R. C. (1996). Coping strategies, drinking motives and stressful life events among middle adolescents: Associations with emotional and behavioral problems and with academic functioning. *Journal of Abnormal Psychology, 105*, 551-560.

Wright, D. R., & Fitzpatrick, K. M. (2004). Psychosocial correlates of substance use behaviors among African American youth. *Adolescence, 39*, 653-667.

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