It is during adolescence many youth are subject to close scrutiny by peers. This scrutiny sometimes results in negative evaluations. The acting White accusation, which is operationally defined here as an interpersonal indictment made against a Black adolescent, asserting that the adolescent is not Black enough, has been documented as early as elementary school. However, existing research indicates it is most salient and first likely to occur during early adolescence. “Acting White” is one of the most negative accusations a Black adolescent can hurl at or receive from another (Neal-Barnett, Stadulis, Singer, Murray, & Demmings, 2010). After nearly 30 years of sparse research, particularly in the area of quantitative research, we still know very little about the psychological impact of the accusation. As such, this study seeks to investigate the association between being accused of “acting White” and the experience of bother among a clinical sample of adolescents. Additionally, this study investigates potential relationships between the level of bother associated with the accusation, internalizing or bottling-up behaviors (e.g., anxiety and mood disorders) and externalizing or acting out behaviors (e.g., disruptive, impulse-control and conduct disorders). Lastly, the current study explores the potential for ethnic-racial identity and social support to act as protective or risk factors relative to this association. Data from a sample of Black adolescents are evaluated using paired t-tests to
examine whether or not adolescents endorsed social items of the AWA more frequently and as more bothersome than academic items. Additionally, bivariate correlational and linear regression analyses are used to examine relationships between bother and psychopathology, ethnic/racial identity and social support.
THE IMPACT OF ETHNIC/RACIAL IDENTITY AND SOCIAL SUPPORT ON THE ACTING WHITE ACCUSATION AMONG A CLINICAL SAMPLE OF BLACK ADOLESCENTS

A thesis submitted to
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It has been a long and winding road filled with many potholes of various depths. But this road has provided much more than mere obstacles. Unclear at first glance, this road and its twists and turns has provided tests of tenacity, dexterity and ambition. Without these challenges, it is hard to know whether I would truly know my level of desire to pursue this rewarding but challenge-ridden path. Additionally, and of equal importance, this path has allotted me the opportunity to learn and re-learn the merits of social support and to practice seeking and receiving such support. I have been blessed with the help, assistance and guidance of so many that I doubt my list will be exhaustive but among the brightest stars that provided the light necessary to traverse this path are; my understanding family, Bethany, Cameron, Dane (recently transitioned, but still shining his light) and Barbara, my loving parents Fred and Sherry, my encouraging uncle and aunt Jesse and Jonnie, my ever-present aunt Lola, my tireless advisor, Dr. Angela Neal, my lab’s ever-available and encouraging quantitative consultant, Dr. Robert Stadulis, my lab mates Martale Davis, Delilah Ellzey, and Elizabeth Jean, my cohorts, and friends especially Kennard Johnson-Bey, William “Billy” Goodwin, Walter Johnson-Bey, Tina Nobile, Adam Hicks, and Colin Gallagher, mentors and friends Dr. Lee Horowitz, and Dr. Janet Stadulis, Clinical Advisor, Alanna Updegraff, and of course, DCT Director, Dr. Beth Wildman, an ever-available and capable mentor.
INTRODUCTION

The prevalence of most psychological disorders varies across ethnic/racial groups and has important implications for prevention and intervention efforts (McLaughlin, Hilt & Nolen Hoeksema, 2007). In 2009, The National Comorbidity Survey-Adolescent Supplement (NCS-A) found that 31.9% of adolescents met criteria for at least one anxiety disorder (Merikangas, Burstein, Swanson, Avenevoli, Cui,…& Swendsen, 2010). Prevalence studies (e.g., Breslau, Aguilar, Kendler, Su, Williams & Kessler, 2006; Breslau, Kendler, Su, Gaxiola-Aguilar & Kessler, 2005; Himle, Baser, Taylor, Campbell & Jackson, 2009) indicate that most anxiety disorders (e.g., generalized anxiety disorder, panic disorder, and social anxiety disorder) are experienced at a greater rate among non-Hispanic Whites than among non-Hispanic Blacks. Thus, it has been generally concluded that anxiety disorders are less prevalent among Black populations than among White populations. However, 25% of the Black population, now the second most populous minority group, is affected by anxiety disorders (Breslau, Kendler, Su, Gaxiola-Aguilar & Kessler, 2005). Also, Blacks’ experience of anxiety symptoms is different in that Blacks experience symptoms for a longer duration and with greater perceived severity than their White counterparts (Breslau et al., 2005; Friedman, Braunstein & Halpern, 2006; McLaughlin, et al., 2007; Neal-Barnett & Crowther, 2000; Williams & Chambless, 1994).
Myriad factors, including racism and discrimination, may contribute to these distinctions. However, little work has been conducted examining ethnic/racial differences in the experience of psychopathology in adolescents.

Human development theories consider the successful formation of a salient identity a fundamental task theorized to take place during adolescence (Erikson, 1968; Parham & Helms, 1981; Ponterotto, 1989; Tajfel & Turner, 1979). The development of ethnic and/or racial identity (ERI), terms that will be used interchangeably in this investigation, is particularly critical for early and middle adolescents of color (French, Seidman, Allen & Aber, 2006). The American Psychiatric Association (2013) asserted that ERI can be a source of strength and group support that enhance resilience. However, adolescents are under the close scrutiny of their peers in a number of domains including those related to ERI (Murray, Neal-Barnett, Demmings, & Stadulis, 2012), and poor evaluation of these ethnic/racial identities can also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment (APA, 2013; p. 749).

The literature suggests that adolescence is also a period marked by individuation and a quest for independence from parents and caretakers. As such, the support and opinions of peers takes on greater intensity and importance (Bell, 1981; Brown, Eicher & Petrie, 1986; Douvon & Adelson, 1966). This combination of factors can render the adolescent more vulnerable.

Negative evaluations by peers can be upsetting for adolescents and negatively impact their well-being (Coleman & Cross, 1988; Savin-Williams & Berndt, 1990). One such experience that both educators and clinicians have become increasingly aware of, with relevance to Black youth, is the “acting White accusation” (AWA; Bergin & Cooks 2002; Neal-Barnett
The Acting White Accusation.

Any discussion of the AWA requires distinction be made between the Acting White Accusation and the Acting White Phenomenon. Misperceptions that acting White is all about academic achievement and the fear associated with being accused of acting White are widespread and has, for decades, been the prevailing definition among many academics and the media alike (Cook & Ludwig, 1997; Fordham & Ogbu, 1986; Kunjufu, 1988, Neal-Barnett, 2001; Tyson, Darity, & Castellino, 2005). This idea is referred to as the acting White phenomenon, to which some educators have attributed the academic achievement gap, and is the product of what Signithia Fordham (2008) has referred to as a misinterpretation of Fordham and Ogbu’s (1986) “The Burden of Acting White” study. Although the existence of the acting White phenomenon remains a topic of contentious debate, there is little question as to whether the acting White accusation exists (Bouie, 2010; Cook & Ludwig, 1997; Fryer, 2006; Lewin, 2000; McWhorter, 2014; Murray et al., 2012; Neal-Barnett, Stadulis, Singer, Murray & Demmings, 2010; Wright, 2014). Further, this thesis does not seek to explain or provide evidence for the acting White phenomenon instead opting to focus on the acting White accusation.

Research from multiple areas including psychology (Murray et al, 2012; Neal-Barnett et al, 2010) sociology (Tyson, Darity, & Castellino, 2005) and policy and analysis (Cook & Ludwig, 1997) has indicated that the AWA relates to much more than academic achievement. A reconceptualization of the AWA undertaken by Neal-Barnett (2001) revealed that academic achievement is merely one of multiple components of the accusation; however, it is an important component. Further, the results from a preliminary quantitative study conducted by Neal-Barnett,
Stadulis, Singer, Murray & Demmings (2010) confirm that valuing academics plays a less important role than social activities in receiving and subsequently reacting to the accusation of acting White.

Whereas the nascent literature has documented the existence of the acting White accusation for other racial groups including Hispanic/Latin Americans (Fryer & Torelli, 2010) and Asian Americans (Lew, 2006) the accusation is most closely associated with Blacks (e.g., Cook & Ludwig, 1998; Durkee & Williams, 2015; Fordham & Ogbu, 1986; Fryer & Torelli, 2010; Horvat & Lewis, 2003; Spencer, Noll, Stoltzfus, 2001; Tyson, Darity & Castellino, 2005). The acting White accusation is made when a Black person’s, in this case an adolescent’s, ERI is perceived by another Black adolescent or group of adolescents as not Black enough (Neal-Barnett, et al., 2010). Neal-Barnett and colleagues (2010) posit that acting White has nothing to do with actually wanting to be White, and everything to do with what it means to be Black, in this case, a Black adolescent. To this end, ERI perception is conceptualized by action and behaviors (Fordham & Ogbu, 1986; Neal-Barnett, 2001; Neal-Barnett et al., 2010).

Accordingly, the acting White accusation (AWA) involves being accused of exhibiting what is perceived by other Blacks as stereotypically “White” characteristics, in a variety of areas. As a result of data from focus groups and a comprehensive literature review, Neal-Barnett and colleagues (2010) identified six themes for acting White—academic achievement, dress, economics, music preferences, speech, and values and standards. Murray et al. (2012), offer as an example, “a Black adolescent who earns a 4.0 GPA, dresses preppy, speaks proper English, and has friends of various ethnicities, may be accused of acting White” (p. 2).

The accusation may be experienced directly, “you are acting white” or indirectly, “you talk like a White boy.” The indirect accusation is a subtle form of the acting White accusation.
Regardless of whether it is direct or indirect, many adolescents when accused experience the AWA as an attack on their ERI (Neal-Barnett, 2001; Neal-Barnett et al., 2010) and thus experience distress in relation to the accusation.

The following is a real-world example of the injurious nature of the acting White accusation. An investigation of workplace conduct in the National Football League (N.F.L.) was conducted by Rifkind, W., Garrison, L. L. P., Wells Jr, Karp, Birenboim, & Brown (2014). This investigation revealed that after experiencing bullying victimization including being accused of acting White, Jonathan Martin who began the 2013 National Football League (NFL) season as the starting left tackle for the Miami Dolphins, abruptly walked out of the Dolphins’ practice facility, mid-season. He then checked himself into a nearby hospital, requesting psychological treatment. An independent investigation resulted in a report which asserted that two Black teammates, John Jerry and Mike Pouncey, routinely accused Martin of not being “black enough.”

Given the severe level of distress experienced by adults like Martin as a result of this example of peer-based discrimination it is reasonable to assume the AWA is “especially harmful for adolescents given the heightened role of social feedback during this period” (Douglass, Mirpuri, English & Yip, 2016; p. 69) when adolescents typically have control of fewer coping mechanisms than adults. Such an assumption aligns well with the idea that the AWA is one of the most harmful accusations a Black adolescent can hurl at another (Bolton & Moniz, 1993; Kunjufu, 1988; Neal-Barnett, 2001; Steele, 1992; Steinberg, Dornbusch, & Brown, 1992). Black youth can encounter the accusation as early as elementary school, but research has shown that the accusation is most likely to occur during adolescence, when identity development is most salient (Neal-Barnett, 2001; Spencer, Noll, Stoltzfus, & Harpalani, 2001; Tyson, 2002) and when fitting-in is a critical issue (Neal-Barnett, 2001; Spencer, Noll, Stoltzfus, & Harpalani, 2001; Tyson, 2002). Being accused of acting White can lead to myriad negative results (Douglass et
al., 2016) including reduced academic motivation (Grantham & Biddle, 2014) withdrawal from White friends and withdrawal from Black adolescent society (Fordham & Ogbu, 1986; Kunjufu, 1988; Neal-Barnett, 2001).

A review of the acting White literature suggests the prevalence of the acting White accusation among Black youth is high. Murray et al. (2012) found that 97 of 110 participants, ranging in age from 14 to 18, reported being accused of acting White. In that study, 52 participants (nearly half) reported experiencing the accusation directly, while 45 experienced it indirectly. Bergin and Cooks (2002) found that 10 of 17 participants (8th graders; ages were not reported), who were specifically asked, reported being accused of acting White, most of whom were bothered by it. Additionally, Durkee and Williams’ (2015) found that 74% of their sample of 145 college students had been accused of acting White. Ages in their sample ranged from 18 to 23 with a mean age of 20 ($SD = 1.31$). Their sample included an equal representation of second, third and fourth year students. These findings speak not only to prevalence of the AWA during adolescence but throughout early adulthood as well. The AWA is an indictment suggesting an adolescent’s ERI and associated social value is unsatisfactory from the perspective of the accuser. Such a challenge to the adolescent’s identity is posited to have an impact on identity development and on mental health more broadly. For this reason, it is important to understand the potential negative implications for Black youth.

A variety of factors can interact with the AWA and its relationship with mental health (e.g., bother, internalizing and externalizing problems). These include ERI and social support. The following sections will address these potential interactions.

**AWA and Bother.** Although, being accused of acting White may impact an adolescent’s well-being, not all adolescents are negatively impacted by the AWA. Neal-Barnett et al. (2010) and Murray et al, (2012) examined a distinction between adolescents who experienced distress and those who did not. This distinction was measured along a variable referred to as bother. An
examination of bother, as per Neal-Barnett et al. (2010), is an examination of the extent to which an adolescent is “bothered” by or experiences distress, in this case, in association with being accused of acting White.

Murray (2008) found a significant correlation between bother and adolescent anxiety. As such, adolescents who reported higher levels of bother also reported higher levels of anxiety. Because the level of bother experienced by an adolescent in relation to the accusation is associated with psychological well-being, bother is a key variable to examine.

Data related to bother can be useful in helping identify and treat adolescents who may be accused and negatively impacted by the AWA. Specifically, those adolescents likely to experience the following chain of events represent the target group: AWA → Bother → Anxiety. Not all Black adolescents are accused of acting White. And it must be noted that an adolescent’s experience of the acting White accusation does not mean he/she will absolutely be bothered by the accusation. However, of those who are accused of acting White, some report being bothered.

Murray et al (2012) provided quantitative evidence of an association between anxiety and bother. Evidence that anxiety is a significant predictor of bother is illustrated in findings suggesting that, of adolescents who experienced the accusation indirectly, sixty percent (60%) of adolescents reported experiencing bother related to the AWA.

**AWA and Psychopathology.** Psychological problems among adolescents are often categorized as internalizing or externalizing in nature. Internalizing is said to occur if and when an individual, in this case an adolescent, turns her problems inward. Internalizing problems are those that affect an adolescent within himself (e.g., mind, body) rather than affecting his external environment (Liu, 2004). Examples of internalizing problems include those related to anxious, depressive and somatic symptoms. Examples of externalizing problems, on the other hand,
include “defiance, impulsivity, disruptiveness, aggression, antisocial features, and over-activity” (Hinshaw, 1992; p. 127).

Findings of various researchers have differed regarding the conceptualization as well as the effects of the AWA. However, there is some qualitative and quantitative data suggesting that, as a result of the acting White accusation, adolescents experience distress as the accusation attacks one's ERI (Fordham and Ogbu, 1986; Murray, 2008 and Neal-Barnett, 2001). Kunjufu (1988) suggests this distress triggers a period of questioning known as the “acting White trap” wherein the primary focus is on what it means to be Black. The assertion here is that time spent by the adolescent in the trap may have a profound positive or negative impact on adolescents’ racial identity development (Kunjufu, 1988; Neal-Barnett et al., 2010; Murray et al., 2012). The direction of this impact is contingent upon the adolescent’s success in reaching an understanding about what it means to be Black. Accordingly, as a result of this process there is potential for either a positive or negative impact on anxiety levels experienced by the accused adolescent.

A course resulting in a positive impact involves an adolescent’s successful determination of what she believes it means to be Black and subscription to a corresponding identity. Alternatively, a course resulting in a negative impact is exemplified by Murray et al.’s (2012) assertion that if adolescents in the acting White trap fail to develop an understanding of what it means to be Black and/or subscribe to an identity they do not truly believe in, an increase in the adolescent's level of anxiety may be the result. Unable to reach the goal of an achieved identity status (e.g., Marcia, 1980) the adolescent may become stuck in a more preliminary stage of racial identity development and experience feelings of inadequacy, inferiority and anxiety (Carter, 1991; Parham and Helms, 1985; Phinney, 1989; Phinney & Ong, 2007; Yasui, Dorham & Dishion, 2004). Correspondingly, Marcia (1993) posits “the ability to bind anxiety, to perform effectively in the face of inner turmoil, is a characteristic associated with higher levels of ego
functioning, such as would ensue from formation of an identity.” A more stable ethnic identity may provide protection against anxiety.

It is widely accepted that there exist high levels of comorbidity between anxiety and mood disorder. Lawrence & Brown (2009) reported that studies of clinical samples have found that the majority of patients with a current principal diagnosis of generalized anxiety disorder have other co-occurring anxiety or mood disorders (Brawman-Mintzer, Emmanuel, Jarrell & Ballenger, 1993; Brown, Campbell, Lehman, & Mancill, 2001; Massion, Warshaw, & Keller, 1993). Brady and Kendall (1992) conducted a study which concluded that there exists a meaningful association between anxiety and depression among children and adolescents, specifically. Given the strong co-occurrence amidst the anxiety disorders and between anxiety disorders and mood disorders (Mineka, Watson & Clark, 1998), evidence suggestive of a relationship between the acting White accusation and anxiety may also indicate a need to investigate potential relationships between the accusation and other internalizing disorders.

**AWA and Ethnic/Racial Identity.** A review of links between ethnic/racial identity (ERI) and psychosocial, academic, and health risk outcomes among ethnic minority adolescents was conducted by Rivas-Drake, Seaton, Markstrom, Quintana, Syed, Lee and colleagues (2014). The review examined a number of studies that yielded evidence of the buffering potential of ERI. Among these, when ethnic identity was assessed by the Multidimensional Ethnic Identity Measure (MEIM; Phinney, 1992), Swenson & Prelow (2005) found an indirect link among a 13 to 19-year-old sample between a higher composite MEIM score and fewer depressive symptoms. In a study of seventh graders, Zaff, Blount, Philips, and Cohen (2002) found a positive correlation between ethnic/racial identity (ERI) and engagement in positive coping strategies.

Additionally, Blash and Unger (1995) found a correlation between adolescent boys’ composite MEIM score and high levels of personal mastery and community with others. Further,
RivasDrake et al. (2014) highlighted the findings of Seaton, Scottham, & Sellers (2006) which suggested that the highest levels of psychological well-being had been reported by 11 to 17-year-olds with an “Achieved” identity (boys who have explored and feel positively about the group).

To the extent that ethnic identity is a salient variable relative to coping, mastery and to the manifestation and experience of anxiety, depressive symptoms, and externalizing symptoms, it is reasonable to explore whether psychological distress might be rendered less potent as a function of higher levels of racial and/or ethnic identity. This study seeks to explore potential relationships between these variables via the use of a noteworthy ethnic identity measure and widely used measures of psychopathology in the context of the AWA as measured by the AWEQ. Findings may afford parents, educators and clinicians greater insight as to the role(s) of ERI in relation to the AWA. Information of this nature may be utilized in the development of interventions designed to reduce adolescents’ bother associated with threats against their ethnic/racial identity such as the AWA.

**AWA and Social Support.** Social Support, as defined by Sarason, Levine, Basham and Sarason (1983) as “the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us” (p. 1), has been shown to increase in importance during adolescence (Steinberg, 2005). Blacks in America, in the absence of institutional support, have historically created, maintained and relied on their own forms of social support including fictive kinship and friend networks (Brown, 2008). Pipes-McAdoo (2002) asserted that, for Blacks, social support networks have contributed to overcoming adversity. A study conducted by Brown (2008; p. 34) confirms that social support serves as Blacks’ “first line of defense” against psychological distress.
During middle adolescence (e.g., 15–18 years of age), in particular, friends are posited to impose a stronger influence on socialization than family does (Regnerus, 2002; Steinberg, 2005). Umana-Taylor, Quintana, Lee, Cross, Rivas-Drake, Seth, and others (2014) posited that given the increased amount of time spent with peers or otherwise outside the family context during adolescence and thereafter, an understanding of nonfamilial socialization processes and roles is critical. Positively perceived peer interaction is posited to act as a protectant against teasing and subsequent harm thereof (Prinstein, Boergers & Spirito, 2001). The social support of peers is of special importance given Douglass, et al.’s (2016) finding that teasing related to race and ethnicity is a commonplace way of interacting among adolescents. The aforementioned findings play well with those of Clark (1991) who asserted that more resilient Black adolescents are those with social support systems in place.

In a study of 9th–12th grade students, it was found that social support buffered the negative effects of victimization on adjustment (Prinstein et al., 2001). These findings align well with the position of Baldwin and Hoffmann (2002) who asserted that social support is “beneficial to one’s well-being and appears to function as a protector against the undesirable effects of stress” (p. 103-104). In a study conducted by Lewis, Byrd and Ollendick (2012) social support was found to be negatively associated with anxiety. In other words, with more social support people tend to experience less anxiety. These findings mirrored those of Demaray and Malecki (2002) who also found negative relationships among social support (as perceived by students in grades 3-12) and internalizing and externalizing behaviors.

Snowden and Thomas (2000) posit that social support tends to be an even more salient factor within the Black community. Given the potential salience of cultural factors in the experience of social support, it is equally important to examine the role of ERI in the relationship between the acting White accusation and internalizing and externalizing disorders (as suggested above). In studies examining both normative adolescent development and the manifestation of
maladaptive and clinical behaviors in adolescence, both social support and ethnic identity play noteworthy roles (Carter, 1991; Giordano, Cernkovich & DeMaris, 1993; McCreary, Slavin, & Berry, 1996; Murray et al., 2012; Yasui, Dorham, & Dishion, 2004).

Given the salience of these variables, in general and possibly specific to the acting White accusation (AWA), it is incumbent that the investigation of the AWA and its relationship to psychopathology (e.g., internalizing and externalizing symptoms), as is hypothesized here, include social support, and ethnic identity as variables. Findings resultant of the present study may inform parents, educators and clinicians about relationships between social support factors and bother associated with being accused of acting White. Such information may be useful in developing interventions that seek to reduce problems associated with the AWA.

The Present Study

One goal of the current study is to evaluate the relationship between the acting White accusation and the intensity of the Bother experienced by a clinical sample of Black adolescents who meet criteria for internalizing (e.g., social anxiety, generalized anxiety, panic, and depression) and/or externalizing problems. Although the accusation has been studied among adolescents, a comprehensive review of the literature revealed no studies among clinical samples of adolescents. In that way, this study is novel. A further goal of this study is to determine whether ethnic/racial identity and social support moderate these relationships. As such, the current study includes four central hypotheses.

Hypothesis 1. Firstly, this study seeks to determine which Acting White Questionnaire items are more frequently endorsed by adolescents as well as which items resulted in higher levels of Bother Intensity. Membership in this sample was largely resultant of referrals by school
personnel based on academic and behavioral problems. As such, it is assumed that AWA items associated with academic achievement will be less likely received by members of this sample. Given this likelihood, it is predicted based upon previous study that AWEQ items related to social and non-academic themes will be endorsed more frequently than items related to academically-oriented themes. It is probable that these problem-youth are not high academic performers thus making academic performance less salient. Further, it is predicted that these social and non-academically-oriented items will be endorsed as more bothersome than academically-oriented items.

**Hypothesis 2.** It is predicted that positive correlations will be found between bother and internalizing disorders (e.g., generalized anxiety, social anxiety, panic, depression) and also between bother and externalizing problems. On average, the more intense the bother experienced as a result of being accused of acting White, the greater the experience of internalizing and externalizing problems experienced by adolescents is predicted to be.

**Hypothesis 3.** Hypothesis 3 predicts that there exists a negative correlation among ethnic identity and Bother experienced as a result of being accused of acting White. The more strongly an adolescent identifies with his/her ethnic identity the less he/she will feel bothered by being accused of acting White. Conversely, adolescents with lower ERI are predicted to experience more bother.

**Hypothesis 4.** Existing literature suggests that social support may provide protection from teasing (Prinstein et al. 2001). Thus, lastly, it is predicted that there exists a negative correlation between social support and bother in association with receiving the AWA. The more an adolescent perceives he/she is socially supported, the less bothered he/she will feel if and when accused of acting White.
A clinical sample is useful in this study as it affords access to adolescents who are likely to exhibit the patterns of psychopathology under investigation and who are otherwise unlikely to be accessible by psychology researchers due to multiple factors (e.g., cultural stigma, poverty, lack of insurance).

**Methods**

**Participants**

Participants (N=24) were recruited from among adolescents who had been referred to a community counseling facility in the Midwestern United States by administrators in a public school system. The Kent State University Institutional Review Board approved this study.

**Measures**

*Acting White Experiences Questionnaire (AWEQ) (Neal-Barnett et al., 2010).* The AWEQ was administered to adolescent participants as a measure of the direct and indirect accusation of acting White. The AWEQ is a 38-item measure that assesses the degree to which adolescents experience different aspects of the acting White accusation and the extent to which each aspect of the accusation bothered adolescents. Examples of AWEQ items include: “Have you ever been accused of acting white?” which when answered in the affirmative denotes the test-taker has been directly accused of acting White, “The kids around me say I talk proper” and other items such as “Because of my friends, my peers don’t think I’m black enough,” which when answered in the affirmative denotes the test-taker has been accused indirectly of acting White. The AWEQ requires adolescents to respond to each item using a six-point Likert-type scale ranging from “never” (1) to “almost all of the time” (6) to relate the frequency of
experiencing each aspect of the accusation. Because scores of 0 better described responses of “never” or “not at all,” these scales were recoded from a range of 1-6 and 1-5 to a range of 0-5 and 0-4, respectively, so that if an adolescent has not experienced an item, their score for that item would be 0.

The AWEQ also addresses the concept of Bother which refers to the degree to which adolescents experience negative affect as a result of receiving the accusation. Adolescents’ responses are measured on a five-point Likert-type scale ranging from “didn’t bother me at all” (0) to “bothered me a whole lot” (4). The score is configured by adding the total score of Bother and dividing that score by the total number of items by which the test-taker has been bothered.

The total number of items an adolescent experienced/endorsed is indicated by the Item Experience score. For example, an adolescent’s Item Experience score would be 3 if they were to report being accused of talking proper, dressing preppy and listening to White music. Item Experience scores can range from 0 to 18. The Frequency score indicates the mean level of frequency an adolescent endorses. For example, were an adolescent to report being accused of talking proper —most of the time (score of 4), dressing preppy —once in a while (score of 1), and listening to White music —once in a while (score of 1), their Frequency score would be 2.

The Item Frequency and Item Experience scores further add to researchers’ clarity of the acting White accusation. For an ethnically identical sample, the AWEQ subscales were found to have adequate reliability, Frequency subscale ($\alpha = .88$) and Bother subscale ($\alpha = .87$). Previous research (Neal-Barnett et al., 2010) has also found the measure to be a valid assessment of the acting White accusation.

*Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney, 1992).* The MEIM-R is a six item questionnaire which assesses the degree of one’s ethnic group affiliation (Phinney & Ong, 2007). All items are measured on a 5-point scale ranging from *strongly disagree* (1) to
**strongly agree** (5), with 3 as a neutral position. The score is calculated as the mean score of the scale on a whole. For the purpose of additional clarity when referencing scores, verbal descriptors were assigned to the measures numerical scoring system ranging from (1) *very weak* to (5) *very strong*. The MEIM-R has been shown to have good reliability among middle school students (α = .81) (Herrington, Smith, Feinauer & Griner, 2016).

*Children’s Behavioral Checklist (Achenbach, 2001).* The CBCL (Achenbach & Rescorla, 2001) is a structured rating scale whereupon children, parents (in this study) or teachers rate the occurrence of 118 behavioral and emotional problems. Parental participation was considered important to this study as potential inaccuracy is commonly associated with self-report (e.g., Cronbach & Furby 1970). The scale is intended to assess children between the ages of 4 and 18 years of age. The CBCL yields scores on seven different syndrome scales (emotionally reactive, anxious/depressive, somatic complaints, withdrawn/depression, sleep problems, attention problems, and aggressive behavior) and five different DSM-oriented scales (affective problems, anxiety problems, pervasive developmental problems, attention deficit/hyperactivity problems, and oppositional defiant problems). The CBCL also assesses social support via two factors; friend quantity (*number of close friends*) and frequency of interaction (*number of times a week a participant did things with any friend outside of regular school hours*). This study focused on withdrawn/depression, internalizing problems more broadly (anxious/depressed, withdrawn/depressed, and somatic complaints, combined), externalizing problems (aggressive behavior, hyperactivity, and oppositional defiant problems, combined) and social support scores. The CBCL allows raw scores to be converted to T scores, which were used in this study, based on normative data.

Additionally, strong one-week test-retest reliability (r = .93) has been reported. When retested over a 3-month period, test-retest correlations for inpatients’ scores averaged .60 for
parents’ ratings of behavior problems and competence scores. Mean correlations ranged between .46 and .76 over an 18-month period. In addition to adequate validity and reliability, adequate internal consistency for the CBCL has been reported by Achenbach (2001).

Multidimensional Anxiety Scale for Children 2 (MASC; March, 2013). The MASC 2-SR is a multi-rater assessment tool comprised of a 50-item self-rating form. This is a revision of the Multidimensional Anxiety Scale for Children. It assesses the presence of symptoms related to anxiety disorders in youth aged 8 to 19 years.

The scale distinguishes with specificity between important anxiety symptoms and dimensions that broadband measures fail to capture. The rating form was administered in paper-and-pencil format. Administration time was estimated at 10 minutes. All forms were scored using MASC scoring software. The MASC 2-SR facilitates early identification, diagnosis, treatment planning and monitoring of anxiety-prone youth. The MASC-2 has been shown to be a valid and reliable measure for similar demographic populations (Fraccaro, Stelnicki, & Nordstokke, 2015; March, 2013).

Procedures

Twenty-four participants between the ages of 12 and 17 who were being seen for the first time at a community behavioral health center by licensed therapists trained in counseling psychology were administered surveys. Parental consent and adolescent assent for all participants was required for participation and was obtained by licensed therapists working with the aforementioned community counseling facility. Upon completion of the measures, participants received a $10 McDonald’s gift card.
Data Analysis Plan

In the current study, hypothesis 1 was examined via two methods: a) by conducting paired t-tests to test whether differences existed between social and academic aspects of the AWA and b) by using descriptive statistics related to the number of participants who endorsed experiencing individual AWA items, the mean frequency with which the AWA item was experienced and the mean level of Bother Intensity experienced in association with individual items. This method provided an item level examination of the AWEQ. Additionally, it allowed for distinction as to which AWEQ items were endorsed more frequently among a clinical sample of adolescents. To answer the question of whether academic or non-academic items were endorsed more frequently among this sample, the first paired t-test was conducted. Further, the second paired t-test would provide evidence as to whether non-academic oriented items resulted in higher levels of Bother Intensity than academic-oriented items.

The second hypothesis listed in this study predicted a positive correlation between bother and internalizing and externalizing problems. Hypothesis 2 was examined using bivariate correlational analyses.

Hypothesis three predicted a significant negative association between ethnic/racial identity and Bother Intensity. Hypothesis 3 was examined using bivariate correlational analyses.

Lastly, in the current study, hypothesis 4 predicted significant negative relationships between each CBCL (Achenbach, 1991) social support variable (number of close friends, and number of times spent a week doing things with any friends outside of regular school hours) and Bother Intensity. This hypothesis was examined using regression and bivariate correlational analyses.
Power Analysis

Statistical power analyses examine relationships among the four variables that comprise statistical inference: 1) sample size, 2) significance criterion, 3) population effect size, and 4) statistical power (Cohen, 1992). Each of these individual variables acts as a function of the other three. As part of research design, power, effect size (ES), and significance criterion (alpha) are used to determine the sample size required to yield a specific power level for a given alpha and ES. In order to reduce the likelihood of statistically non-significant finding, studies generally set the alpha level at .05 and the power level at .80 (Cohen 1992).

In the present study, the proposed hypotheses were evaluated using dependent t-tests, bivariate correlational analyses and linear regression. Cohen (1992) provided an easy reference guide for estimation of the sample size needed to detect significant differences. In accordance with Cohen (1992), for an alpha = .05, Power = .80 and a medium expected effect size, the required \( N = 29 \). Commonly, the average effect size is based on previous studies in a given area of research. However, given that this is a new area of research, there were a limited number of studies to use to make this determination.

Results

Membership in this sample was based on clinical symptomatology as indicated by referral to and treatment at a community behavioral health center in the Midwestern United States by administrator in a public school system. T-Scale scores for the MASC and CBCL all evidenced higher levels than the norms ranging from \( T = 54.7 \) (MASC Social Anxiety) to 66.7 (CBCL Externalizing). As indicated in Tables 1 and 2, diagnostic criteria for several internalizing orders and externalizing disorders, more generally, were considered.
MASC-2-SR Results

Table 1.

*Frequency and type of clinical diagnosis as per the MASC-2-SR (MASC; March, 2013).*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>12</td>
</tr>
<tr>
<td>Social Anxiety Disorder</td>
<td>10</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>11</td>
</tr>
<tr>
<td>Sample Size</td>
<td>24</td>
</tr>
</tbody>
</table>

CBCL Results

Table 2.

*Frequency and type of clinical diagnosis as per the CBCL (Achenbach, 2001).*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externalizing</td>
<td>9</td>
</tr>
<tr>
<td>Internalizing</td>
<td>8</td>
</tr>
<tr>
<td>Depression</td>
<td>5</td>
</tr>
<tr>
<td>Internalizing and Externalizing Problems (both)</td>
<td>6</td>
</tr>
</tbody>
</table>
AWEQ Results

Both social and academic items were added and averaged into means for each participant. Following this, paired t-tests were conducted to test whether or not differences existed between social and academic items and between being bothered by social items and being bothered by academic items. A predictable difference was found between social and academic items. Participants endorsed being more frequently accused of social items ($M = 1.98, SD = 1.01$) than academic items ($M = 1.53, SD = .50, t = 2.20, p = .04$) of the AWA. No significant difference was found between being bothered by social items and being bothered by academic items of the AWA.

Presented in Table 3, the AWEQ items most frequently endorsed were 1) *The kids around me say I talk proper*, 2) *The kids around me say I’m full of myself or bigheaded*, 3) *The kids around me say I dress preppy* and *People around me say I listen to White music*. Additionally, presented in Table 3, the frequency of AWA experiences is rated by the participants as being experienced from *sometimes* to *a lot*. Among the items endorsed by individual participants, certain items were endorsed more frequently than others; 1) *My peers criticize me because I try to use big words*, 2) *People say my extracurricular activities are not Black activities*, 3) *Because of my friends my peers don’t think I’m Black enough*, and 4) *People don’t consider my hobbies as Black hobbies*. Of interest, academically-related items such as *The people around me say because*
I’m in honors courses, I don’t act my race, I get talked about because I go to class everyday, Kids around me look at me differently because I want to go to college, and Kids around me talk bad about me because I get good grades do not rate as highly relative to number of participant endorsements nor frequency of experiences by participants who received that item.

Also presented in Table 3, the level of Bother experienced by the participants is rated from didn’t bother me at all to bothered me somewhat. The AWEQ items demonstrating the highest mean levels of Bother Intensity (BI) were ethnic/racial identity of peers, perceived family economic status, and extracurricular activities. The AWEQ items related to education or academic status evidenced low levels of bother. The relationship between frequency and bother intensity was low and negative ($r = -.21$).

Table 3.

*Items Most Frequently Endorsed (Social)*
The kids around me say I talk proper.
The kids around me say I dress preppy.
People around me say I listen to White music.
The kids around me say I’m full of myself or bigheaded.
People say my extracurricular activities are not Black activities.
Because of my friends my peers don’t think I’m Black enough.
Kids around me look at me differently because I want to make something of myself.
Because my mom/dad make a lot of money it is harder for people to see me as Black.
Because I sit at the lunch table with different races, my peers criticize me.
People don’t consider my hobbies as Black hobbies.
My peers criticize me because I try to use big words.
Kids around me talk about me because I take pride in myself.

Items Most Frequently Endorsed (Academic)

The people around me say because I’m in honors courses, I don’t act my race.
Kids around me talk bad about me because I get good grades.

My peers say I study too much and that I am always in the library.

Kids around me look at me differently because I want to go to college.

I get talked about because I go to class everyday.

Table 4 indicated how frequently participants had been accused of acting White with respect to being direct or indirect. The majority of participants experienced indirect only. However, all 24 participants reported experiencing the AWA, directly or indirectly.

Note. Item = AWEQ items

N = Number of participants who reported experiencing a given AWEQ item

M Freq = Mean frequency of experience

M Bother = Mean level Bother Intensity

Table 4.

Frequency and type of accusation reported by adolescents

<table>
<thead>
<tr>
<th>Accusation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect</td>
<td>24</td>
</tr>
<tr>
<td>Both Direct and Indirect</td>
<td>9</td>
</tr>
<tr>
<td>Indirect Only</td>
<td>15</td>
</tr>
<tr>
<td>Direct Only</td>
<td>0</td>
</tr>
<tr>
<td>No Accusation</td>
<td>0</td>
</tr>
<tr>
<td>Sample Size</td>
<td>24</td>
</tr>
</tbody>
</table>

Note. Direct = “Yes” to “Have you ever been accused of acting White?”

Indirect = Endorsed being accused of behaviors associated with acting White as measured by the AWEQ
MEIM-r Results

Presented in Table 5, no participants reported having the strongest level of ethnic identity. While, half of all participants’ scores on the MEIM-R (Phinney & Ong, 2007) were consistent with a neutral ethnic identity the remaining half of all participant reports varied widely between having the weakest and having a strong ethnic identity.

Table 5.

*Level of Ethnic identity as reported by participants*

<table>
<thead>
<tr>
<th>Weakest</th>
<th>Weak Neutral</th>
<th>Strong</th>
<th>Strongest</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4</td>
<td>12</td>
<td>5</td>
</tr>
</tbody>
</table>

CBCL- Social Support Results

In accordance with Achenbach (1991), this study allowed for the determination of social support along two variables; a) number of “close friends” and b) number of times a week the participant does things with any friends outside of regular school hours. As indicated in Table 6, most participants in this study (71%) had 2 or more friends. Also, most participants in this study (71%) did things with any friends outside of regular school hours one or more times per week while 28% of participants did things with friends outside of regular school hours less frequently than one time per week.

Table 6.

*Levels of social support*
Correlational Matrix of Study Measures

To determine which variables of interest were related to bother or receiving the Acting White Accusation, a correlational matrix was conducted. Presented in Table 7, a significant positive correlation was found between the ethnic identity (as measured by MEIM-R) and bother and ethnic identity was found to significantly predict bother (as measured by AWEQ). Additionally, four other relationships approaching significance were found. Of these, two (internalizing and externalizing) were found to be negatively correlated to bother, though not significantly so. A positive correlation was found between panic and bother intensity. Also nonsignificant, a small negative correlation was found between the number of times a week the participant did things with any friend outside of regular school hours and bother. The remaining variables (Generalized Anxiety, Social Anxiety, and Withdrawn/Depression) all demonstrated very low association with bother.
Table 7.

*Correlation Matrix of Study Measures*

<table>
<thead>
<tr>
<th>Variables M (SD)</th>
<th>V1</th>
<th>V2</th>
<th>V3</th>
<th>V4</th>
<th>V5</th>
<th>V6</th>
<th>V7</th>
<th>V8</th>
<th>V9</th>
<th>V10</th>
<th>V11</th>
<th>V12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r (p-value)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V1</td>
<td>3.33 (1.13)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V2</td>
<td>1.63 (1.51)</td>
<td>- .21 (1.7)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V3</td>
<td>3.19 (1.02)</td>
<td>-.15 (.24)</td>
<td>.40* (.03)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V4</td>
<td>1.93 (1.07)</td>
<td>-.50* (.04)</td>
<td>.03 (.46)</td>
<td>-.37 (.09)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V5</td>
<td>2.07 (.83)</td>
<td>.09 (.38)</td>
<td>-.34 (.13)</td>
<td>-.20 (.25)</td>
<td>.27 (.18)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V6</td>
<td>57.26 (16.90)</td>
<td>-.08 (.36)</td>
<td>.15 (.26)</td>
<td>-.16 (.23)</td>
<td>-.25 (.21)</td>
<td>-.66”(.01)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V7</td>
<td>57.74 (16.52)</td>
<td>-.10 (.32)</td>
<td>.03 (.45)</td>
<td>-.13 (.28)</td>
<td>-.24 (.22)</td>
<td>-.38 (.10)</td>
<td>.91”(.00)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V8</td>
<td>54.70 (13.30)</td>
<td>-.08 (.36)</td>
<td>.07 (.38)</td>
<td>-.04 (.43)</td>
<td>-.51* (.04)</td>
<td>-.40 (.09)</td>
<td>.91”(.00)</td>
<td>.91”(.00)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V9</td>
<td>60.43 (13.91)</td>
<td>.12 (.30)</td>
<td>.33 (.07)</td>
<td>.01 (.48)</td>
<td>-.33 (.14)</td>
<td>-.42 (.08)</td>
<td>.76”(.00)</td>
<td>.53”(.01)</td>
<td>.65”(.00)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V10</td>
<td>63.65 (9.25)</td>
<td>.01 (.48)</td>
<td>-.10 (.36)</td>
<td>-.40* (.05)</td>
<td>.03 (.47)</td>
<td>.17 (.34)</td>
<td>.35 (.09)</td>
<td>.36 (.08)</td>
<td>.38 (.07)</td>
<td>.10 (.35)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V11</td>
<td>V12</td>
<td>V13</td>
<td>V14</td>
<td>V15</td>
<td>V16</td>
<td>V17</td>
<td>V18</td>
<td>V19</td>
<td>V20</td>
<td>V21</td>
<td>V22</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
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<td>-----</td>
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<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>61.24 (9.52)</td>
<td>66.71 (7.31)</td>
<td>- .39 (.07)</td>
<td>- .36 (.08)</td>
<td>.46 (.11)</td>
<td>- .21 (.30)</td>
<td>.54* (.01)</td>
<td>.57** (.01)</td>
<td>.53* (.01)</td>
<td>.10 (.35)</td>
<td>.75** (.00)</td>
<td>1</td>
</tr>
<tr>
<td>V21</td>
<td>.46 (.11)</td>
<td>-.21 (.30)</td>
<td>.46 (.11)</td>
<td>.04 (.44)</td>
<td>-.35 (.39)</td>
<td>.68* (.02)</td>
<td>- .15 (.28)</td>
<td>- .01 (.49)</td>
<td>-.04 (.44)</td>
<td>-.41* (.05)</td>
<td>.28 (.14)</td>
<td>.33 (.10)</td>
</tr>
</tbody>
</table>


**Correlation is significant at the 0.01 level (1-tailed)
Based on the results of the correlational matrix, four variables of interest were examined relative to their ability to predict bother intensity (see Table 8). Multiple linear regressions (backward) were calculated to predict bother intensity based on ethnic identity (as measured by MEIM-R), panic (as measured by MASC-2-SR), internalizing and externalizing symptoms (as measured by CBCL) (see Table 8.). When examined together, a strong, significant correlation was found. Successively removing the variable with the smallest $F_{to-remove}$ statistic provided it was less than the threshold value for $F_{to-remove}$ resulted in Externalizing and Internalizing dropping out, in that order. The removal of Externalizing from the model yielded a small reduction but still resulted in a significant regression. Next, the removal of Internalizing from the model yielded a greater reduction but a substantial $R$ remained present in the model. Model 3 indicated that Ethnic Identity and Panic were the best and significant predictors of Bother Intensity experienced as a result of the AWA.
Table 8.

*Descriptive statistics of Bother Intensity predictors*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bother Intensity</td>
<td>16</td>
<td>1.55 (1.46)</td>
</tr>
<tr>
<td>Ethnic Identity (MEIM-R)</td>
<td>16</td>
<td>3.00 (1.20)</td>
</tr>
<tr>
<td>Internalizing (CBCL)</td>
<td>16</td>
<td>61.00 (9.78)</td>
</tr>
<tr>
<td>Externalizing (CBCL)</td>
<td>16</td>
<td>66.44 (7.47)</td>
</tr>
<tr>
<td>Panic (MASC-2-SR)</td>
<td>16</td>
<td>61.81 (15.02)</td>
</tr>
</tbody>
</table>

Table 9.

*Predictors of Bother Intensity (ethnic identity, panic, and externalizing variables)*

<table>
<thead>
<tr>
<th>Model</th>
<th>n</th>
<th>M (SD)</th>
<th>R</th>
<th>p</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>.78</td>
<td>.03b</td>
<td>.60</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>.77</td>
<td>.01c</td>
<td>.60</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>.71</td>
<td>.01d</td>
<td>.51</td>
</tr>
</tbody>
</table>

Note. a. Dependent Variable: Bother Intensity, b. Predictors: (Constant), Ethnic Identity,
Panic (MASC-2-R), Internalizing (CBCL), Externalizing (CBCL), c. Predictors: (Constant) Ethnic Identity (MEIM), Panic (MASC-2-SR)

Given a significant positive correlation between the number of close friends and AWEQ Item Frequency, a linear regression (backward) was conducted to determine the variables that contributed greatest to frequency of receiving the AWA. Table 10 shows the descriptive statistics of variables included in a regression analysis (see Table 11) for AWA frequency. Results indicated that the number of close friends was not a significant predictor of AWA frequency. However, given limitations related to low sample size, the direction of these findings may still be interesting and useful. Bother intensity was also not a significant predictor of AWA frequency.

Table 10.

Descriptive statistics of AWEQ predictors

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWEQ Item Frequency</td>
<td>13</td>
<td>3.08 (1.04)</td>
</tr>
<tr>
<td>Bother Intensity</td>
<td>13</td>
<td>2.06 (1.58)</td>
</tr>
<tr>
<td>Number of close friends</td>
<td>13</td>
<td>1.85 (1.068)</td>
</tr>
</tbody>
</table>

Table 11.

Predictors of AWEQ Item Frequency

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>p</th>
<th>$R^2$</th>
</tr>
</thead>
</table>
Note. a. Predictors: (Constant), Number of close friends (CBCL), Bother Intensity (AWEQ). b. Predictors: (Constant) Number of close friends (CBCL).

Discussion

This study examined the impact of the AWA on a clinical sample. All participants had been referred for counseling at a community behavioral health center. Results of the study partially support Hypothesis One so far as that, among a clinical sample of Black adolescents, AWEQ items with social themes would be endorsed more frequently than those with academic themes. However, although social items were endorsed as more bothersome to participants than academic items, no significant difference was found. Support for Hypothesis Three was found in the opposite direction than predicted; a positive correlation was found between ethnic identity and Bother intensity. It was found that the more strongly adolescents identified with their ethnic identity the more they felt bothered by being accused of acting White. No other hypotheses were supported.

Findings in support of Hypothesis One are not surprising given that the AWA has little to do with valuing academics. Of further interest, the items most frequently endorsed indicated concerns about criticism based on social matters. These concerns are
suggestive of a fear of negative evaluation which is a hallmark of social anxiety. Indeed 42% of this sample scored higher than average on a measure of social anxiety.

Membership in this sample is based on presentations of internalizing, and/or externalizing problems such as difficulty concentrating and failure to conform to social norms, respectively. Of the 24 participants in this study, 6 reported clinically significant internalizing and externalizing problems. Three reported externalizing problems, only. Two reported internalizing problems, only. And, three participants reported problems at a sub-clinical level. The cognitive/emotional (e.g., anxiety provoked by exposure to certain types of social or performance situations) and disruptive (e.g., patterns of behavior that violate age-appropriate societal norms) characteristics associated with these problems are consistent with the aspects of the AWA about which most adolescents were accused (e.g., *My peers criticize me because I try to use big words, People say my extracurricular activities are not Black activities* and *Because of my friends my peers don’t think I’m Black enough*), and by which most adolescents were bothered (e.g., *Because I sit at the lunch table with different races, my peers criticize me, People don’t consider my hobbies as Black hobbies*). Although the experience of receiving social aspects of the AWA appears to be similar to aspects of internalizing and externalizing problems, the experience of being bothered by these social aspects seems to be wholly an internal experience. In support of this assumption, findings of the current study indicate a negative correlation, approaching significance, between bother and externalizing problems. It might be concluded from this that adolescents bothered by the AWA are less
likely to act out than those who are not. As there is an externalizing component to the social aspects of the AWA, this could be indicative of an effort to reduce the likelihood of receiving the AWA in the future.

The finding of Hypothesis Three was unexpected. The predominant view throughout the literature is that ERI is a protective factor against internalizing disorders (Carter, 1991; Parham & Helms, 1985; Phinney & Kohatsu, 1997; Seaton, Scottham, & Sellers, 2006; Swenson, Prelow, 2005; Witherspoon, Speight & Thomas, 1997; Yasui, Dorham & Dishion, 2004) and externalizing disorders. Our finding indicates that within a clinical sample of Black adolescents, high ERI increases the risk for bother. One possibility for this result is that high levels of ERI makes the AWA more salient for this population. This is consistent with self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) by which it is assumed that people attenuate to environmental cues relevant to their identity. In alignment with this, Yip, Gee & Takeuchi et al (2008) hypothesized that a strong sense of ethnic identity may exacerbate the effects of racial discrimination (the exacerbating hypothesis). Thus, it appears that when one cares about their ERI, an attack, such as that of the AWA, is felt more deeply resulting in the experience of bother.

Similar to the relationship between ERI and internalizing disorders, ERI is predominantly viewed as a protectant against externalizing disorders (Yasui, Dorham & Dishion, 2004). In the current study, a negative, albeit not significant association, was found between ERI and externalizing problems. It appears that adolescents with clinical
symptomatology and higher ERI, while more likely to experience bother as a result of the AWA, may be less likely to act out. This makes sense given that these adolescents’ identification and expression of Blackness is likely consistent with behaviors consistent with social acceptance and thus less inconsistent with externalizing problems and to that extent less consistent with social aspects of the AWA.

**Limitations**

The limited sample size of this study presents a limitation. It should be noted that conducting research with this population (minority youth) is commonly considered challenging. In this study, this challenge may have been compounded by working with adolescents who had been identified as having academic or social problems. Still, other factors may have played parts in this limitation. In addition to limiting factors more typical of this population such as cultural stigma and problems related to access, data was collected by an outside source for which insufficient incentivizing may have been provided thus resulting in fewer administrations of surveys than was projected. In the future, with regard to participants, efforts should be made to normalize the experience of academic and social problems, provide psychoeducation around cultural stigma associated with psychology, and make efforts to troubleshoot access problems in hopes of increasing sample size relative to studies of the AWA. Additionally, proper incentivization of parties charged with collecting data may reduce barriers to data collection.
Conclusion

Despite the limitations, further support of these findings may have implications for clinicians who work with Black adolescents. Overall, our results suggest that not only must clinicians be aware of the AWA but they must probe to determine how it is impacting adolescent clients’ lives. Such a determination can be accomplished by engaging the adolescent in a guided discussion about the AWA which should include asking the adolescent about its impact on her/his life.

Our results for this clinical sample are similar to those found in non-clinical samples. In a study conducted by Murray et al. (2012), ninety-six (96%) of adolescents reported having been accused of acting White. In a study conducted by Davis, Stadulis and Neal-Barnett (2018), all participants reported having been accused of acting White as was the case in this study. These examples of high prevalence of the AWA among Black adolescents in both clinical and non-clinical samples suggests the AWA is an experience from which, regardless of clinical symptomatology, few are excluded. This finding underscores the importance of clinicians’ developing awareness of the AWA.
References


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