Talk to me how I talk: The role of African American Vernacular English in mental health diagnosis and communication

by

Char'dae Chanell Bell

B.A., Emporia State University, 2011
M.S., Liberty University, 2016
M.A., Washburn University, 2019

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Applied Human Sciences
College of Health and Human Services

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

This qualitative study explored how African American millennial women understood their mental health diagnoses and whether language, particularly African American Vernacular English (AAVE), influenced that understanding. Guided by Critical Discourse Analysis and Critical Theory, the results demonstrate how diagnostic communication intersects with culture, language, and identity. Twelve participants were interviewed to capture their lived experiences and perspectives surrounding diagnosis comprehension. Findings revealed that participants did not receive clear explanations of their diagnoses of generalized anxiety disorder (GAD) and often had to seek understanding independently. Cultural and spiritual norms also shaped how participants interpreted their experiences and approached mental health care. The use of AAVE emerged as a culturally grounded means of expressing and making sense of these experiences. The results emphasize the importance of culturally responsive and linguistically inclusive communication to improve understanding, trust, and engagement among African American millennial women in clinical settings.

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Dedication

I dedicate this to Little Char’dae.

To little Char'dae aka Dae Dae,

You always believed you were different. Thinking you would never be normal or be like everyone else. You lived life with the idea that something was wrong with you. That the way you were wired was innately incorrect. Like you were a mistake.

This is my message to you:

You were created for a world that wasn't yet ready for your light. You had no idea how to use the brilliance you were gifted with. I didn't believe in you and for that I'm sorry. It took me some time to realize and fully understand how extraordinarily beautiful you truly are and appreciate you for being brave enough to be different. We have accomplished the impossible because you are magnificent!!

It is time for you to take your places among greatness. It's time for you to fully step into your divine purpose. You are different and unique as you were created to be. You shine bright in a way that is awe-inspiring. Your brilliance is magnetic. You were never a mistake and will never be like everyone else. AND, You are no longer just Char'dae C. Bell, you will now and forevermore be Dr. Char'dae MF Bell, PhD!!

And I will never let us forget it!!

Chapter 1 - Your Chapter Title

Black American millennial women (BAMW) are at the forefront of shifting mental health narratives within the Black community and face unique challenges in mental health due to historical, social, and cultural factors (Cuevas et al., 2016). Unlike previous generations, they have greater access to mental health discourse through digital platforms, social movements, and increased advocacy for mental wellness (McCall et al., 2023; Watson & Hunter, 2015). However, Black women also experience high rates of stress-related disorders due to workplace discrimination, economic instability, microaggressions, and the dual burden of racism and sexism (Silas & Seward, 2002). Additionally, due to sexism and societal expectations of strength and resilience (Silas & Seward, 2002), many Black women feel pressure to exhibit resilience and portray the "strong Black woman" stereotype, often suppressing emotional struggles and avoiding professional help (Morris, 2001), contributing to significant mental health burdens (Dana, 2002).

Inaccessibility of quality mental health care creates disparities in diagnosis, treatment, and overall well-being (Morris, 2001), as financial barriers, a shortage of culturally competent providers, and community stigma hinder effective treatment (Bailey et al., 2009). Culturally competent mental health care is essential for improving outcomes among Black women, as it significantly influences engagement, treatment adherence, and overall well-being (Drinane et al., 2024). Cultural competence extends beyond surface-level awareness to include an understanding of historical trauma, systemic oppression, and the ways in which racism and discrimination have shaped Black women’s experiences with mental health care (Dana, 2002). It also involves recognizing the significance of language, including African American Vernacular English (AAVE), in shaping identity, self-expression, and understanding of medical and psychological

concepts by Black communities (Dunson et al., 2022). AAVE conveys lived experiences, emotions, and perspectives of Black Americans in ways that mainstream English often fails to capture (McWhorter, 2017). Despite its significance, the use of AAVE by African American's is frequently stigmatized in professional settings, leading to code-switching, defined as "alternating between languages, or dialects of the same language," (Johnson et al., 2021, p. 6) allowing speakers to shift between AAVE and Standard American English depending on the context, and linguistic adaptation. In mental health care, failure to acknowledge AAVE may result in miscommunication, misdiagnoses, and disengagement of Black communities (Dana, 2002). Acknowledging AAVE in mental health care means recognizing it as a legitimate and culturally significant dialect, rather than viewing it as incorrect or unprofessional language (Cassell, 2021).

When providers use culturally responsive practices—such as incorporating language that resonates with patients and acknowledging sociocultural stressors—they can create a more inclusive and affirming therapeutic environment, ultimately leading to improved mental health outcomes (Morris, 2001). Providers who understand cultural and linguistic nuances, specifically, can build stronger therapeutic relationships, foster trust, and enhance comprehension of diagnoses and treatment plans (Dana, 2002). AAVE is a vital aspect of Black identity and communication, serving as a linguistic and cultural marker that fosters connection and shared understanding (Filmer, 2003).

Although many Black women report feeling dismissed by clinicians who fail to consider their cultural and linguistic backgrounds (Watson & Hunter, 2015), traditional diagnostic explanations continue to rely on Standard American English and there is little research on how AAVE impacts comprehension of mental health diagnoses among BAMW (Dunson et al., 2022). Accordingly, critical theory is an essential lens for exploring how language, race, and mental

health intersect within clinical spaces as it challenges systems of power, inequality, and oppression (Ryoo & McLaren, 2010) while critical discourse analysis provides the tools to analyze how language—specifically AAVE—is used, understood, and often marginalized within diagnostic conversations (Van Leeuwen, 2008). This methodological approach allows for the unpacking of power dynamics embedded in clinical discourse and highlights how standard language expectations may obscure comprehension or invalidate the lived experiences of BAMW (Cuevas et al., 2016). By combining these frameworks, the study critically interrogates whether mental health professionals communicate diagnoses in ways that are linguistically accessible and culturally relevant, and how AAVE might be a tool for clarity, resistance, or identity affirmation in these interactions. Specifically, this study has two primary objectives: (1) to explore BAMW's experiences with receiving a mental health diagnosis and their comprehension of diagnostic explanations, and (2) to examine the role of AAVE in improving understanding, engagement, and culturally responsive communication in mental health contexts. Given AAVE's cultural and linguistic significance, this study assesses whether the use of culturally competent and affirming language enhances diagnostic clarity and contributes to more equitable mental health outcomes for BAMW.

For the purposes of this dissertation, the term "Black American" will be used to refer to individuals of African descent born and raised in the United States, specifically those whose ancestry traces back to enslaved Africans brought to this country. While "Black" and "African American" are often used interchangeably in broader conversations, the use of "Black American" here is intentional. Many Black Americans are several generations removed from their African roots and may not have specific knowledge of their ancestral origins beyond the United States. As such, the term "Black American" more accurately reflects the unique historical, cultural, and

social experiences of this group. It acknowledges both the legacy of forced displacement and the distinct identity that has been shaped within the American context (Hall, 2005; Kachun, 2003). Throughout this dissertation, "Black American" will be used to center and honor that specificity.

Also, traditional academic and clinical writing often privileges Standard American English, sidelining the linguistic realities and cultural expressions of marginalized communities. However, in the context of this dissertation, it is not enough to simply write about AAVE as a topic of study, it is equally important to use it as a legitimate mode of expression. Writing portions of this dissertation in AAVE is a deliberate methodological choice that reflects a commitment to linguistic justice. It affirms AAVE as a valid and sophisticated form of communication, challenges dominant language hierarchies within academia, and honors the voices, experiences, and identities of the African American women at the center of this research. Using AAVE within the dissertation disrupts traditional academic norms and makes space for the authenticity, creativity, and resistance embedded within Black language practices.

Chapter 2 - Literature Review

Black American Mental Health

Mental health conditions affect Black Americans at rates comparable to or higher than those of other racial and ethnic groups in the United States, yet they are often underdiagnosed, misdiagnosed, or untreated (Bailey et al., 2009). This disparity stems from systemic racism, clinician bias, lack of culturally competent care, and stigma, which all contribute to inadequate or delayed mental health treatment (Dana, 2002). According to national data, approximately 16% of Black Americans reported experiencing a mental illness in a given year, which translates to over 7 million individuals (National Alliance on Mental Illness, 2022). Black Americans are particularly vulnerable to conditions such as major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder (PTSD), often due to cumulative exposure to chronic stressors like racism, socioeconomic inequality, and community violence (Williams et al., 2019). Black youth are also increasingly affected, with rising rates of suicide, especially among Black girls and adolescents, sparking national concern (Centers for Disease Control and Prevention, 2021).

BAMW are at particularly heightened risk for mental health challenges due to the intersection of racial and gender-based stress, caregiving responsibilities, and the cultural expectation to maintain emotional strength at all times (Liao et al., 2019). This demographic often experiences high levels of anxiety, depression, and emotional burnout, yet they are among the least likely to receive adequate mental health support (Watson-Singleton, 2017). These conditions are frequently compounded by experiences of microaggressions, workplace discrimination, and generational trauma, all of which may contribute to chronic psychological distress (Crenshaw, 1991).

Barriers to Effective Mental Health Care

Despite the prevalence of mental health conditions in Black communities, multiple systemic, cultural, and interpersonal barriers continue to limit access to effective care. As a foundation, Black Americans' deeply rooted mistrust in the U.S. medical system can be traced back to centuries of racial violence, unethical experimentation, and structural neglect. One of the most well-known examples is the Tuskegee Syphilis Study (1932–1972), in which nearly 400 Black men with syphilis were intentionally left untreated by the U.S. Public Health Service under the false pretense that they were receiving free healthcare (Washington, 2006). Even after penicillin became the standard treatment for syphilis in the 1940s, researchers withheld care and continued to monitor the progression of the disease until the study was exposed in the 1970s (Centers for Disease Control and Prevention, 2022). This betrayal not only resulted in preventable suffering and death but also eroded trust in the medical community for generations of Black Americans (Nnoli, 2023). The Tuskegee study is just one instance in a broader historical pattern of medical abuse—including involuntary sterilizations of Black women, unethical gynecological experiments on enslaved women, and disparities in pain management and maternal mortality rates—that have collectively shaped the cultural memory of medicine as an institution of harm rather than healing in Black American communities (Washington, 2006).

This historical trauma continues to impact the ways Black Americans engage with health services today, particularly mental health care (Dana, 2002). Studies show that Black individuals are less likely to trust mental health professionals and more likely to delay or avoid seeking care due to concerns about bias, cultural incompetence, or mistreatment than other American demographic groups (Ward et al., 2013). For Black American women, these concerns are further compounded by intergenerational narratives that frame healthcare institutions as unsafe or

untrustworthy, reinforced by personal and community experiences of discrimination through the discrediting of their problems and symptoms (Cuevas et al., 2015). Even when care is accessible, it is often perceived as racially biased or disconnected from their lived realities, which can lead to disengagement and underutilization of services (Alang, 2019). Understanding this history is critical to addressing current disparities in mental health outcomes and requires a shift toward culturally responsive and reparative care models that acknowledge, rather than ignore, the past.

The conceptualization of mental health in Black American communities is shaped not only by systemic factors but also by cultural norms and values. Specifically, one of the most significant obstacles is the lingering stigma around mental illness within many Black families and communities. Cultural values that emphasize strength, endurance, and self-reliance often discourage Black American communities from seeking professional support, leading to underutilization of mental health services (Liao, 2019). For many Black families, mental illness is viewed through a lens of strength and survival, often accompanied by silence, minimization, or spiritual explanations (Alvidrez et al., 2008). The Black church, in particular, plays a significant role in shaping meaning-making around mental health, often framing distress as a spiritual battle rather than a medical condition (Alvidrez et al., 2008). Additionally, patriarchal norms within many Black communities may discourage emotional vulnerability, especially in women who are expected to carry the burden of resilience while caregiving and maintaining composure under stress (Green, 2003).

Even when Black Americans do desire professional mental health services, access is limited due to financial and geographical barriers and disparities in representation (APA, 2020). Financial challenges, such as underinsurance, high out-of-pocket costs, or competing financial priorities like caregiving or student debt, can make therapy feel inaccessible or unsustainable

(Bailey et al., 2009). Geographical disparities, particularly for those in rural or underserved areas, further limit access to mental health professionals, especially Black women therapists who may be more culturally aligned with the client's background.

Given this limited historical representation of Black Americans in mental health professions, the way mental health is conceptualized and communicated is not based in the cultural and linguistic communication styles of Black Americans (Delphin-Rittmon et al., 2015), resulting in the potential for linguistic and cultural disconnects between providers and clients. Specifically, many mental health professionals rely heavily on clinical language and standardized diagnostic frameworks that may not reflect the lived realities or cultural expressions of Black Americans (Alang, 2019), which may lead to miscommunication, feelings of alienation, or even misdiagnosis for Black clients who speak AAVE (Dunson-Caputo & Stoelie, 2022). Emotional expressions or communication styles common in Black culture, such as intensity in tone or affect, can be pathologized as defiance or aggression by culturally incompetent clinicians (Dunson-Caputo & Stoelie, 2023). When clients feel misunderstood or judged based on their communication style, they are more likely to disengage from therapy, limiting the overall effectiveness of the treatment (Neal-Barnett & Crowther, 2000). Addressing linguistic barriers and incorporating culturally affirming practices is therefore critical to improving therapeutic outcomes and increasing retention in care for Black clients.

Black folks, especially Black American millennial women, be dealin' with hella mental health struggles, but don't always get the help they need. That's 'cause the system ain't never been built for us—too much racism, too many doctors not listenin', and not enough folks who understand how we talk or what we goin' through. A lotta BAMW be strugglin' with anxiety, depression, and burnout, but between tryin' to stay strong, take care of everybody, and push

through; they don't always feel safe speakin' up. Add on all the medical mess from back in the day—like Tuskegee and forced experiments—and it's no wonder we don't trust the system. Then when we *do* show up, folks don't hear us right, especially when we speak in AAVE. They take our tone or the way we say things and twist it, like we angry or defiant, when really we just tryna be real. That's why this study gotta center how we talk, feel, and show up—so we can finally get care that see us for who we really are.

The BAMW

Black American Millennial Women (BAMW), typically defined as individuals born between 1981 and 1996 (Dimock, 2019), exist at the intersection of multiple identities (Black, woman, and Millennial), each carrying its own unique social, cultural, and historical weight (Nelson et al., 2020). These overlapping identities influence how they navigate everyday life, shape their relationships, and impact how they experience and manage mental health (Silas & Seward, 2023). BAMW face racialized gender norms, expectations of emotional labor, and systemic inequities within education, healthcare, and employment (Bartholomew et al., 2018). At the same time, they are part of a generation that grew up during the rise of the internet and social media, the 2008 recession, political unrest, and increased visibility of racial violence. While older generations may have suppressed conversations about mental health, many Millennial women are attempting to redefine what mental wellness looks like by engaging in self-care and therapy (Silas & Seward, 2022). These generational and cultural factors converge to produce a heightened sense of psychological distress, compounded by the pressure to succeed in spaces that often were not built for them (Neal-Barnett & Crowther, 2000).

The Strong Black Woman

The emotional labor expected of Black women—often framed through the "strong Black woman" schema— is one of the most deeply ingrained cultural narratives shaping BAMW's relationship with mental health that can mask symptoms of distress, delaying diagnosis and access to care (Abrams et al., 2014; Spivey et al., 2024). This identity construct idealizes Black women as unbreakable, emotionally contained, hyper-independent, and self-sacrificing (Burnett-Zeigler, 2021). It often discourages expressions of vulnerability, pain, or the need for help, as these are perceived as weaknesses that conflict with the image of strength (Watson & Hunter, 2015). For BAMW, this internalized pressure to always "push through" can delay the acknowledgment of mental health struggles and prevent them from seeking support (Watson & Hunter, 2015). Many feel a responsibility to hold everything together—career, family, community—at the expense of their own emotional health (Nelson et al., 2020). Even in moments of burnout or crisis, they may feel compelled to present as high-functioning or emotionally unaffected (Bartholomew et al., 2018). These expectations, both external and internalized, lead to a dangerous silence around mental health concerns (Watson & Hunter, 2015). This schema also impacts how BAMW experience therapy when they do enter it. They may downplay their pain, struggle to articulate emotional needs, or worry about being judged by providers who don't understand their lived experiences (Nelson et al., 2020). Without intentional, culturally competent support, the strong Black woman schema becomes a barrier not just to seeking help, but to receiving meaningful care once inside the system (Burnett-Zeigler, 2021).

Help-Seeking

McCall et al. (2023) reports 29% higher anxiety rates among Black women than non-Hispanic women. Despite elevated levels of stress, anxiety, depression, and trauma, Black

women are significantly less likely to seek professional mental health support compared to their white counterparts (Silas & Seward, 2023; Spivey et al., 2024). This disparity in help-seeking behavior persists even when controlling for socioeconomic status, education, and symptom severity, highlighting deeper systemic and cultural factors at play (Watson & Hunter, 2015). For BAMW, this trend reflects a layered reality, one shaped not only by cultural stigma around mental illness, but also by structural inequities such as provider bias, underrepresentation of Black clinicians, financial barriers, and limited access to culturally competent care (Spivey et al., 2024). As a result, many Black women turn to alternative or informal coping strategies that feel safer and more validating (Silas & Seward, 2023), including: spirituality and religious faith, support from family and friends, engagement with social media communities that affirm Black womanhood, participation in peer support networks, and creative forms of expression like journaling, art, and music (Giles & Newbold, 2010; Sherman et al., 2023). These coping mechanisms, while valuable, are often used in place of, rather than in tandem with, professional support.

Even when a BAMW seeks care, remaining in therapy can be difficult if the environment feels culturally unsafe (Watson & Hunter, 2015). If a provider minimizes racial trauma, avoids discussions about identity, or reinforces stereotypes, it can leave the client feeling unseen or even harmed (Morris, 2001). This is where language becomes not just relevant, but critical. The way mental health professionals communicate, how they explain diagnoses, discuss symptoms, and frame treatment can either alienate or affirm (Spivey et al., 2024). Many BAMW report feeling dismissed, misunderstood, or even pathologized in therapeutic spaces when providers fail to grasp the nuances of their experiences (Dana, 2002). For instance, expressions of frustration or sadness may be misread as aggression, and cultural idioms or emotional language rooted in

AAVE may be invalidated or misunderstood (Drinane et al., 2024). This linguistic disconnect can create emotional distance and mistrust between client and clinician, often resulting in disengagement from treatment altogether (Delphin-Rittmon et al., 2015). The emotional labor of constantly having to explain one's culture, defend one's emotions, or translate one's pain into "standard" English takes a toll (Alvidrez et al., 2008). For many, the therapeutic space becomes yet another place where they cannot fully show up as themselves. Understanding and integrating culturally grounded language practices may not only improve comprehension but also foster a sense of cultural affirmation and belonging within therapeutic spaces (Morris, 2001).

See, BAMW been facin' all kinda barriers when it come to gettin' real mental health support. Folks don't always take they pain serious 'cause of that whole *Strong Black Woman* thing. They expect BAMW to push through everything without breakin'. But that strength narrative be makin' it hard to ask for help or even admit somethin' wrong. On top of that, doctors and therapists don't always be listenin' right, or they twist our words when we tryna explain how we feel. And we can't forget how the medical system got a long history of doin' Black folks dirty. From experiments to flat out ignorin' our symptoms. All that make it hard to trust the system, let alone feel safe enough to open up.

AAVE

AAVE is a widely recognized non-standard variety of English spoken in the United States. It is a distinct dialect with unique phonological, morphological, syntactic, and semantic features, as well as specific usage patterns (Rickford & Rickford, 2007) that is spoken across various regions in the United States, with notable regional variations in speech patterns among its speakers (Smitherman, 2000). AAVE traces its roots to the transatlantic slave trade when enslaved Africans from various regions, who spoke different languages, were forced to

communicate with one another and with English-speaking colonists (Bailey et al., 2013). The first recorded acknowledgement of Black language was in a 1776 play written by John Leacock called *The Fall of British Tyranny* or *American Liberty Triumphant* (Rickford & Rickford, 2000). In the play, there is a verbal exchange between an American slave who has escaped and is enlisting into the British navy. The blend of African linguistic features and English resulted in a distinct creole or pidgin language that allowed enslaved people to communicate (Filmer, 2003). Lanehart (2015) contributes that AAVE was influenced by British colonials, African languages, and creole varieties.

After slavery was abolished in 1865, Black communities remained socially and economically isolated, particularly in the segregated South, which contributed to the preservation of AAVE (King, 2020). During the Great Migration (1916-1970), many African Americans moved away from the South to cities in the north and east for employment opportunities and to escape racism (King, 2020). During this move, African Americans took AAVE with them. During the Civil Rights and Black Power Movements of the 1960s and 1970s, AAVE gained greater cultural significance (Alim & Baugh, 2007; Smitherman, 1994). It became a symbol of pride, identity, and resistance against systemic oppression. Black authors, poets, and musicians used AAVE to express the experiences of Black Americans (Rickford & Rickford, 2007). During this period, linguistic studies began recognizing AAVE as a legitimate dialect with its own rules and structure, dispelling the earlier notion that it was just "broken" English (Lanehart, 2022).

Although AAVE has become one of the most studied dialects of English in America (Filmer, 2003; Poplack, 2000), it has been historically devalued due to socio-economic factors, including education and wealth disparities (McWhorter, 2017). Different terms have been used to describe AAVE, including “Black English,” “Black Vernacular English,” and “Ebonics,” though

AAVE remains the most widely referenced term in academic and literary discourse (Filmer, 2003, Johnson et al., 2022). The variety of names given to AAVE reflects the complexity of its usage and historical significance. “Ebonics” gained attention during the Oakland School Board Resolution and the Ann Arbor Case (Harris & Schroeder, 2013), combining "ebony" (black) and "phonics" (sounds) to emphasize the African roots of this speech form (Rickford, 1999). While “Black English” and “Black Vernacular” are often used interchangeably with AAVE, some scholars advocate for the term “African American English” (AAE) as a more neutral and inclusive designation (King, 2020). Despite these terminological differences, all these labels refer to the same linguistic system.

The classification of AAVE has evolved over time, with linguistic scholars debating whether it should be considered a dialect of English or a sociolect—a speech variety associated with a specific social group (Filmer, 2003; King, 2020). Contrary to common misconceptions that portray AAVE as “broken” or “incorrect” English, it is, in fact, a complex and rule-governed linguistic system. AAVE developed through a combination of African linguistic influences and adaptations to English-speaking environments, reflecting the historical and cultural experiences of African Americans (McWhorter, 2017; Rickford, 1999; Rickford & Rickford, 2007) Moreover, AAVE speakers often engage in code-switching, shifting between AAVE and SAE depending on the social context and communicative goals (McWhorter, 2017; Lanehart, 2015). The ongoing debate over AAVE’s role in society underscores its significance—not only as a linguistic system but also as a cultural marker of Black American identity and heritage (Lanehart, 2023).

AAVE Linguistic Structure

In contemporary linguistics, AAVE is recognized as a legitimate and rule-governed dialect of English, with its own grammatical structure, phonology, and lexicon (Mendia, 2022). Linguists have identified specific features that distinguish it from Standard American English such as its unique verb conjugation patterns, use of double negatives, and pronunciation shifts, like the omission of the final consonant in words like “cold” (pronounced "col’") (Burling, 1973). These features are consistent across regions and social classes, proving that AAVE follows well-established linguistic rules (Lanehart, 2023). Structurally, AAVE includes features such as the use of double negatives for emphasis, as in "ain’t no" to convey strong negation (Burling, 1973). Unlike Standard American English, AAVE frequently omits the auxiliary verb "does," replacing it with "don’t" in phrases like "She don’t know.”, instead of "She doesn’t know." (Kongsatt et al., 2023). Another characteristic is the use of the past tense in present conversations, such as "I seen her yesterday.”, which reflects a unique syntactic structure rooted in oral traditions (Smitherman, 2000). AAVE also employs questions without explicit subjects or verbs, as in "Why he always late?" instead of "Why is he always late?” (McWhorter, 2017). Other features include consonant cluster reductions ("tes’" for "test") (Rickford &Rickford, 2007), habitual "be" to denote recurring actions ("She be singing at church.") (Burling, 1973), and the absence of the copula in sentences like "She nice." instead of "She is nice." (Lanehart, 2023; Welden, 1994). Through AAVE, speakers can emphasize relationships, assert identity, and communicate with nuance in ways that resonate deeply within their community (Alim & Baugh, 2007). For example, the rhythmic and tonal qualities of AAVE align closely with oral storytelling traditions, where intonation and pacing play crucial roles (Lanehart, 2015). Collectively, these elements showcase how AAVE operates as a rule-governed and expressive

language system, rather than simply a deviation from Standard American English norms (Lanehart, 2015).

Modern Evolution and Cultural Relevance

AAVE holds significant social relevance as it functions not only as a linguistic system but also as a cultural identity marker among African Americans (Lanehart, 2023; Smitherman, 1994). Rooted in a rich historical context shaped by systemic oppression and resistance, AAVE has been instrumental in fostering community, solidarity, and resilience among its speakers (Rickford & Rickford, 2000). The linguistic framework of AAVE encapsulates the lived experiences, shared histories, and unique worldviews of Black communities, thus serving as a powerful tool for self-expression and solidarity within the Black community (Campbell, 2005; McWhorter, 2017; Smitherman, 1994).

Despite its complexity and legitimacy as a language variety, AAVE is often stigmatized in mainstream contexts, reinforcing linguistic discrimination and reflecting broader systems of racial bias and inequality (Campbell, 2005; Filmer, 2003; Lanehart, 2023; McWhorter, 2017). Specifically, speakers of AAVE continue to face stigmatization in academic and professional settings where Standard American English is considered the norm (Lewis, 2008). Code-switching—shifting between AAVE and Standard American English—is often a necessary skill for African Americans navigating environments where their natural dialect is not seen as "professional" or "educated" (Baugh, 1999; Lanehart, 2023). This linguistic discrimination can reinforce negative stereotypes about Black intelligence and professionalism, creating barriers to social and economic advancement (Rickford & Rickford, 2007; Smitherman, 1994). However, many in the Black community embrace AAVE as an essential part of their cultural identity, rejecting the notion that Standard American English is superior (Lanehart, 2023).

Recognizing the value and relevance of AAVE within both academic and clinical settings is vital to affirming the identities of Black individuals and ensuring culturally responsive care, especially in areas such as mental health, where language profoundly impacts comprehension, trust, and treatment outcomes (Morris, 2001; Washington, 2006). Promoting the linguistic validity of AAVE not only fosters greater respect for its speakers but also affirms its role as a vibrant and integral component of Black cultural heritage (Johnson et al, 2022; King, 2020).

AAVE ain't just slang—it's a whole language rooted in our history, born outta survival and connection when our people was forced to find ways to communicate. It got its own rules and rhythm, with things like habitual "be" and dropped endings that still follow structure. Over time, it evolved, shiftin' with the culture and reflectin' who we are today. From music to social media, AAVE be everywhere, and it stay holdin' space for how we express emotion, identity, and everyday life. It ain't broken English—it's Black English, and it matter.

Mental Health Diagnosing and the BAMW

Historically, mental health diagnosing in the United States has reflected broader patterns of racial and gender bias (Dana, 2002). Diagnostic tools, such as the DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2022), were created within Eurocentric frameworks that often ignored cultural variation in symptom expression, communication, and lived experience (Liang et al., 2015). Black individuals, and particularly Black women, have been over-pathologized, receiving severe diagnoses like schizophrenia at higher rates than white patients presenting with similar symptoms (Bailey et al., 2009). These historical trends set the stage for present-day disparities in diagnosis and treatment, with BAMW frequently navigating a mental health system that wasn't built with their cultural realities in mind (Alvidrez et al., 2008).

Effective Communication Supports Accurate Mental Health Diagnosing

Receiving an accurate and appropriate diagnosis is a critical first step in effective mental health treatment. A correct diagnosis provides a roadmap for care by guiding therapeutic approaches, medication decisions, and coping strategies (Liao et al., 2020). For BAMW, whose mental health concerns may be shaped by systemic racism, intergenerational trauma, and cultural expectations, accurate diagnosis becomes even more essential; a misdiagnosis can lead not only to ineffective treatment but also to internalized stigma, frustration, and mistrust in the system (Jones et al., 2021). When the diagnostic process overlooks cultural context or misinterprets culturally specific behaviors, the result is a skewed representation of the individual's psychological health, potentially reinforcing harmful stereotypes (Dunson-Caputo & Storlie, 2023). Moreover, a correct diagnosis has the power to validate experiences that BAMW may have struggled in a society that often dismisses or minimizes their pain, diagnosis can be a form of affirmation, acknowledging that what they are going through is real and worthy of care (Spivey et al., 2024). However, that affirmation is only possible when the diagnosis feels accurate and resonates with their lived reality. If the process feels foreign, overly clinical, or disconnected from how they express themselves emotionally and linguistically, the diagnosis may not land as meaningful or actionable (Dunson-Caputo & Storlie, 2022). Thus, the intersection of culturally competent diagnosing and effective communication is vital to building trust and engagement in treatment.

Effective communication includes both verbal and nonverbal elements of how providers explain diagnoses, respond to client concerns, and create space for clients to speak in their natural voice (Dunson-Caputo & Storlie, 2022). For BAMW, this may involve expressing themselves using AAVE, which carries its own structure, emotional tone, and cultural meaning

(Dunson-Caputo & Storlie, 2022). When clinicians fail to recognize or value AAVE as a legitimate form of communication, it can result in misinterpretation of symptoms or underestimation of distress (Drinane et al., 2024). A clinician who dismisses or misunderstands a BAMW's way of speaking may also unintentionally undermine the therapeutic relationship, reinforcing barriers to care (Dana, 2002). Incorporating clear, culturally grounded communication into the diagnostic process can increase comprehension, emotional resonance, and diagnostic accuracy. It also reflects a level of cultural humility on the part of the provider, signaling that they are not only listening but learning from the client's worldview (Morris, 2001). This kind of communication can make a significant difference in whether a diagnosis feels empowering or alienating.

When it come to BAMW and mental health, a lot get lost in translation. Sometimes providers don't speak our language—not just words, but the feelin' behind it. If you don't understand AAVE, you might miss what we tryna say or think we bein' dramatic when really we speakin' truth. Communication matter heavy when folks tryna diagnose us, and if they ain't listenin' right or they don't get our vibe, they might end up mislabelin' what's really goin' on. Effective communication—one that respects our voice and our way of speakin'—could be the key to gettin' it right the first time.

Generalized Anxiety Disorder (GAD) in BAWM

Generalized Anxiety Disorder (GAD) affects approximately 3.1% of the U.S. population annually, but studies suggest the prevalence is significantly higher among BAMW, particularly those navigating intersecting stressors related to race, gender, and socioeconomic inequality (McCall et al., 2023). GAD is characterized by persistent and excessive worry that is difficult to control and extends across multiple areas of an individual's life, including work, education,

relationships, finances, and health (American Psychiatric Association, 2022). This level of anxiety differs from ordinary stress, as individuals with GAD often experience a continuous cycle of "what if" thinking and anticipate worst-case scenarios, even in the absence of immediate or tangible threats (American Psychiatric Association, 2022). In addition to psychological distress, GAD commonly presents with physical symptoms such as restlessness, fatigue, muscle tension, irritability, difficulty concentrating, and disrupted sleep patterns (American Psychiatric Association, 2022). A key distinction of GAD is that these symptoms persist for a minimum of six months and significantly interfere with daily functioning (American Psychiatric Association, 2022). Due to its gradual onset and normalization of stress in certain communities, GAD frequently goes unrecognized or untreated—particularly in populations that have been culturally conditioned to endure rather than seek support (American Psychiatric Association, 2022).

For BAWM, GAD often shows up as "strong Black woman" stigma: constantly holding it together and carrying the weight of everything and everyone while silently struggling (Silas & Seward, 2022). The anxiety might not be named, but it's there in the overthinking, the sleepless nights, the need to stay busy, and the feeling that something bad might happen if they ever stop grinding (Neal-Barnet & Crowther, 2000). Because of cultural expectations and medical mistrust, many BAMW don't seek formal help or get misdiagnosed when they do (Spivey et al., 2024). Instead, they might be told they're "too emotional," "angry," or just need to "calm down" (Silas & Seward, 2022). GAD in this population is often masked as perfectionism, people-pleasing, or hyper-independence, survival traits passed down through generations (Burnett-Zeigler, 2021). Understanding how GAD presents through this cultural lens is key to supporting BAMW in ways that actually make sense to them.

Communicating GAD in AAVE

Translating GAD criteria into AAVE creates space for culturally relevant communication that reflects how Black folks actually talk about mental health. For example, saying “You stay worried or anxious 'bout a whole lotta stuff” instead of “excessive anxiety and worry” captures the emotional tone and frequency in a way that feels more familiar and real (Lanehart, 2023). AAVE often uses habitual "be" (e.g., “folks be tired,” “your mind be blank”) to describe ongoing or repeated actions, which is linguistically different from Standard American English, but still communicates duration and intensity. Similarly, dropping the final consonants in words (e.g., “goin’” instead of “going”) or using double negatives (e.g., “ain’t just from drinkin’”) are natural features of AAVE grammar, not mistakes (Burling, 1973; Lanehart, 2015; Rickford &Rickford, 2007). In AAVE, someone experiencing generalized anxiety might say, “My mind be racin’ all the time” or “I don’t be sleepin’ good,” using habitual "be" to emphasize the chronic, ongoing nature of their worry and restlessness—key features of GAD.

These communication choices by clinicians aren’t just about sounding informal; they carry cultural weight and make clinical information more accessible to people who’ve historically been left out of mental health spaces. Respecting these grammar rules and rhythms helps reduce stigma and build trust, especially when working with communities like BAMW who often feel unseen or unheard in traditional care models.

Critical Theory

Critical theory is a framework that seeks to challenge and transform the social, political, and cultural structures that contribute to oppression, inequality, and marginalization (Thompson, 2017). Originating in the early 20th century, critical theory was developed by scholars associated with the Frankfurt School in Germany, such as Max Horkheimer, Theodor Adorno, Herbert Marcuse, and later Jürgen Habermas (Bronner, 2002). These thinkers were concerned with the

ways traditional social theories often failed to address issues of power, ideology, and domination (Marrow & Brown, 1994). Rooted in Marxist thought but moving beyond its economic determinism, critical theory expanded to examine the cultural, psychological, and ideological dimensions of social life (Ryoo & McLaren, 2010). It calls for a deep interrogation of how societal structures maintain power dynamics and systemic injustices, particularly within dominant institutions and discourses.

Rather than simply describing or explaining social phenomena, critical theory is action-oriented; it seeks not just to understand the world but to change it. This means empowering individuals and communities by critically exposing and actively disrupting the mechanisms through which systems reproduce social hierarchies and inequalities (Marrow & Brown, 1994). Within this context, language is recognized as a powerful tool that is far from neutral. It reflects, sustains, and legitimizes the values and worldviews of those in positions of authority, often marginalizing or silencing alternative, non-dominant ways of knowing and communicating (Bronner, 2002). Thus, critical theory emphasizes the importance of giving voice to those historically excluded from mainstream narratives and fostering transformative social change.

Applied to the intersection of AAVE and mental health diagnosis, critical theory provides a foundation for questioning how clinical language norms, typically rooted in Standard American English while ignoring or pathologizing the use of AAVE (Dunson -Caputo & Storlie, 2022), may contribute to the underdiagnosis, misdiagnosis, or misunderstanding of Black individuals (Bronner, 2002). Critical theory calls attention to this power imbalance and highlights the need for diagnostic tools and communication strategies that affirm, rather than dismiss, culturally specific ways of speaking (Marrow & Brown, 1994). By applying a critical lens, this research challenges the default assumption that diagnostic understanding must occur solely in “standard”

language and instead advocates for a more inclusive, justice-centered approach to mental health care.

Critical Theory be all about callin' out the systems that keep folks stuck—like racism, sexism, and all them -isms that show up in healthcare, especially for Black women. It help us see how the mental health field wasn't built with us in mind, and how them power structures be showin' up when we try to get help. In this study, Critical Theory gon' help break down how the way providers talk, act, and diagnose don't always align with how Black women actually express what we goin' through—especially when we speak in AAVE. It ain't just about what's said, but who got the power to define what count as "real" symptoms.

Critical Discourse Analysis

Critical discourse analysis is a methodological approach that examines how language both reflects and shapes power relations within society. Emerging in the late 20th century, critical discourse analysis is largely associated with the work of scholars such as Norman Fairclough, Teun A. van Dijk, and Ruth Wodak (Amoussou & Allagbe, 2018), who built upon earlier traditions in linguistics, semiotics, and critical theory to more explicitly link discourse to issues of ideology, dominance, and social inequality (Locke, 2004). It is grounded in the understanding that discourse is not merely a neutral tool for communication, but a form of social practice that actively contributes to the construction of knowledge, identity, and social realities (Fairclough, 2012). Thus, rather than treating language as isolated or purely descriptive, critical discourse analysis positions discourse as both a product of, and a force within, complex social structures (Slemon, 2025). It seeks to uncover the often-hidden ideologies embedded in texts, conversations, media representations, and institutional language by critically analyzing how discourse functions to include, exclude, legitimize, or marginalize specific groups (Amoussou &

Allagbe, 2018). This method involves a detailed, systematic analysis of linguistic features such as word choice, tone, grammar, and rhetorical strategies, while situating these elements within broader social, political, and historical frameworks (Locke, 2004). Through this lens, critical discourse analysis reveals how everyday language practices sustain larger systems of inequality and opens possibilities for resistance and social transformation.

In the context of AAVE and mental health diagnosis, critical discourse analysis can be used to explore how clinical interactions and diagnostic explanations either support or undermine comprehension for BAMW. Traditional diagnostic language often fails to account for culturally relevant modes of expression, leading to gaps in understanding between clinicians and clients (Razon & Feldman, 2024). By applying critical discourse analysis, this research critically analyzes whether the use of AAVE enhances comprehension of mental health diagnoses and how language choices in clinical settings contribute to broader patterns of inequity reinforced through power dynamics between providers and patients. Through this lens, AAVE is not simply seen as a communication tool, but as a legitimate discourse with the potential to disrupt dominant clinical narratives and promote culturally responsive care.

CDA look at how language got power—it ain't just words, it's how folks use 'em to control the convo, the room, and sometimes, the outcome. In this study, CDA gon' be used to dig into how therapists and doctors talk to Black women when diagnosin' 'em, and whether they really hear us when we speak in our natural voice. Like, if I say *"I be stressed all the time,"* and they don't get that "be" mean it's constant, then they might miss the whole point. CDA gon' help show how misunderstandin' AAVE can lead to wrong diagnoses or no help at all.

Usin' AAVE in this study matter 'cause it's how a lotta Black women naturally talk—they express they feelings, pain, and anxiety through it. It ain't broken English, it's a real

language that tell you what's goin' on if you know how to listen. By bringin' AAVE into this research, we makin' sure our voices ain't just included—they centered. It's about meetin' us where we at, so folks can really understand what we dealin' with and give help that actually makes sense to us.

The present study aims to highlight that BAMW, particularly millennials, experience anxiety at higher rates than their peers but often encounter barriers to diagnosis and treatment due to systemic racism, clinician bias, and cultural stigma (Bailey et al., 2009; Drinane et al., 2024; McCall et al, 2023). Cultural frameworks like the strong Black woman schema and superwoman schema contribute to emotional suppression and self-silencing, which may exacerbate anxiety symptoms (Abdullah & Brown, 2020). Despite experiencing high rates of anxiety and related conditions, this population is often underdiagnosed, misdiagnosed, or untreated due to systemic racism, clinician bias, and the lack of culturally competent care (Giles & Newbold, 2011). To increase cultural competence in mainstream diagnostic tools, there is a critical need for language and frameworks, such as AAVE, that align with the lived experiences of Black American women. Grounded in critical theory and critical discourse analysis, this study investigates how AAVE may influence how Black women experience, articulate, and interpret their mental health, ultimately informing more inclusive and effective diagnostic communication.

Current Research Questions:

1. To what extent do BAMW feel their diagnosis was explained in language they understand?
2. How does the use of AAVE affect BAMW's comprehension of their mental health diagnosis?

3. What impact does diagnosis comprehension have on BAMW's help-seeking behaviors, trust in mental health professionals, and discussion of diagnosis with loved ones?

Chapter 3 - Methods

This study employs a qualitative approaches to explore the experiences of BAMW diagnosed with Generalized Anxiety Disorder (GAD). The qualitative component utilized phenomenological methods through in-depth, semi-structured interviews.

Participants and Recruitment

There were 12 participants who took part in this study. All participants self-identified as Black American women born between 1981 and 1996 and had received a diagnosis of Generalized Anxiety Disorder (GAD) from a licensed provider. Participants represented diverse educational, professional, and regional backgrounds, offering rich perspectives on how cultural context and language influenced their experiences with diagnosis, comprehension, and treatment.

Recruitment was conducted through digital and community-based outreach methods. Flyers were posted on social media platforms, distributed to mental health organizations, and shared within community groups that center the experiences of Black women.

Data Collection

Quantitative data was collected through an online survey hosted on Qualtrics. In addition to demographic information and when they were diagnosed with GAD, the survey consisted of 11 Likert-scale questions ranging from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*) designed to assess participants' perceptions of the language used by providers, their comprehension of their mental health diagnosis, and their overall satisfaction with the communication received. Example items include, "Did your provider use language that felt familiar or similar to how you naturally speak?" and "After receiving your diagnosis, did you conduct your own research to understand it better?". Participants completed the survey anonymously at their convenience, increasing accessibility and encouraging candid responses. Survey respondents chose to participate in the

qualitative interview by clicking on a sign-up link at the end of the survey that took them to a separate survey to enter their contact information, the option to choose a pseudonym, and indicate available times to participate in the qualitative interview.

Qualitative data was gathered through semi-structured, one-on-one interviews conducted via Zoom, each lasting approximately 60 to 90 minutes. These interviews allowed participants to share in-depth narratives about their experiences receiving the mental health diagnosis of GAD, with a particular focus on the language and cultural relevance of the explanation provided by their mental health provider. Open-ended questions included prompts such as "Can you describe how you felt when you received your diagnosis?" and "How did your provider's explanation impact your understanding of your diagnosis?" Follow-up probes explored whether the use of AAVE or culturally aligned communication could have enhanced their understanding. Interviews were audio-recorded and transcribed, removing any identifying information (Richards & Morse, 2013). 3 participants did not choose a pseudonym and were listed as Anonymous 1, Anonymous 2, and Anonymous 3.

Analysis Plan

A phenomenological framework was used to analyze the data, centering participants' lived experiences and cultural contexts. This approach facilitated the identification of recurring themes and meaning structures across participants, offering a deeper understanding of the role that linguistic and cultural congruence plays in diagnostic communication. The Hermeneutic approach to Phenomenology (Richards & Morse, 2013), is particularly suited to the current study, which explored how BAMW comprehended their mental health diagnoses and interpret the language used by providers through the lens of their cultural and linguistic identities. Given the centrality of language, culture, and personal meaning-making in this research, hermeneutic

phenomenology (Richards & Morse, 2013) allows for a deep examination of how participants make sense of their diagnostic experiences and the extent to which culturally aligned communication, such as the use of AAVE, shapes their understanding and engagement with mental health care.

Systematic coding process was used to interpret participants' interviews. The coding team consisted of 1 Black American Millennial woman, 1 Native American woman, and Dominican American generation Z woman. Each will review each transcript to remove identifying information as well as begin initial coding to gain an in-depth understanding of each participant's lived experience. Initial coding began with open coding, allowing key phrases, emotions, and patterns related to language use, comprehension, and cultural alignment to emerge organically from the data. These codes were grouped by the research team into broader thematic categories, which will help identify the underlying structures of meaning across participants' stories. To enhance credibility and reduce researcher bias, each transcript was independently coded by at least two researchers, followed by cross-coding sessions to compare interpretations and resolve discrepancies through discussion and consensus.

Chapter 4 - Results

Through the process of coding, three overarching themes emerged that captured participants' perceptions and meaning-making processes: *(1) Explanation of Diagnosis, (2) Diagnosis Comprehension, (3) Diagnosis Impact, and (4) Cultural Background Influence.* These codes were developed from research questions. Each theme reflects a critical dimension of how participants experienced and interpreted their mental health diagnoses, particularly in relation to the language used by providers and the cultural context shaping their understanding. Within these four themes, seven corresponding codes further illustrate the nuances of participants' narratives. The following sections describe each theme in detail, supported by participant quotations that highlight the depth, variation, and shared meaning across their experiences. The number of participants whose statements aligned with each code will be represented using the following language: few (2-3 participants), several (3-5participants), many (6-8 participants), most (9-11 participants), and all.

Explanation of Diagnosis

This first theme answered the question about how participants' providers explained their GAD diagnosis. Across the interviews, participants consistently described receiving minimal or unclear explanations from their providers, leaving them uncertain about the meaning, cause, or implications of their diagnosis. Several participants reported that their providers named the disorder without further elaboration or failed to describe how GAD manifests uniquely for them. This lack of communication directly influenced participants' understanding of their condition and contributed to feelings of confusion, frustration, and emotional detachment from the diagnostic process. The data revealed that, for these women, diagnosis was not experienced as a

collaborative process but rather as a brief, one-sided interaction that lacked both depth and empathy.

Lack of Explanation

When discussing how their providers explained their diagnosis, most participants shared that little to no effort was made to ensure they understood what GAD meant in their daily lives. The language used during participant Magic's diagnostic process was described as providers "…Meeting me with clinical language." Participant Sarah exemplified the experience of receiving a GAD diagnosis without any corresponding treatment planning: "...But there wasn't really any conversation about it. There's never actually ever been a follow-up..." She elaborated further, stating, "...I don't know, almost… I feel dismissive. Like, they're dismissive to me. And I would appreciate if it was more of a conversation..." Sarah's narrative reflects a recurring theme across participants' stories: the desire for relational dialogue and shared understanding rather than transactional diagnosis delivery. Several women described feeling dismissed, overlooked, or intellectually minimized in moments that should have provided clarity and reassurance. For example, participant Robin stated, "…The explanation I didn't understand. It left me confused…". As explained by Anonymous 1 participant, "...it wasn't really an explanation...". The absence of clear communication left participants feeling dismissed, uncertain, and emotionally disconnected from the process meant to bring them understanding and relief. Participant Shay states, "...the doctor was kind of just blank with it..". This lack of explanation became more than a procedural oversight. Sarah expressed this sentiment clearly when she said, "There wasn't really any conversation about it." Her statement illustrates how the absence of communication made the diagnosis feel less like a partnership and more like a verdict.

Unable to Explain Diagnosis

Even after receiving their diagnosis, participants expressed difficulty finding the language to describe their experience in ways that felt authentic and culturally grounded. Participant Anonymous 1 stated, "…I couldn't really give, like a, textbook definition broken down in Sister Girl language…". Participant Sharde' reflected, "...I don't know what it feels like to not be anxious... I kind of stopped talking to them [providers] about it..." Her comments illustrate both emotional fatigue and social isolation, suggesting that insufficient diagnostic explanation perpetuates silence rather than empowerment. Participant Robin stated, "… I stopped going to that therapist because I didn't trust the information I was being told…". Sharde's expectation that her provider would "offer more options" further underscores a missed opportunity for collaborative care. Collectively, these findings reveal that when providers fail to communicate with clarity and cultural resonance, they inadvertently reinforce the stigma and isolation that already shape how Black women navigate mental health systems.

Additional Research Needed

As a result of these informational and relational gaps, most participants turned to self-directed research to fill the void left by inadequate clinical explanations. Many sought answers through digital platforms, while others consulted books, peers, or secondary mental health professionals. Participant Simone described, "...So it's basically, you know, YouTube, TikTok, and books..." Similarly, participant Giselle reported, "...Different social media threads, like Reddit... I bookmark a thousand things... trying to understand my diagnosis and move through life with as much resources as possible..." These accounts suggest a proactive effort to reclaim agency and understanding, even outside formal treatment settings. For some, this process was empowering, as participant Shay states, "...I need to know... about myself...".

Diagnosis Comprehension

The second theme answered the question of how the participants understood their GAD diagnosis and captures how language shaped participants' comprehension of their GAD diagnosis. Across interviews, participants emphasized that understanding their diagnosis was not simply about the words used but about how those words were delivered. When providers used culturally relevant and conversational language rather than formal or clinical terminology, participants described feeling more connected, respected, and confident in their understanding of GAD. This communication style mirrored their lived experiences and speech patterns, creating a sense of cultural familiarity that bridged gaps in understanding and power between client and clinician.

Culturally Relevant and Relatable Language

For most participants, culturally aligned language transformed what could have been a confusing or intimidating diagnostic process into one that felt validating and collaborative. Many participants described how relatable communication from their providers helped them grasp the meaning and implications of their GAD diagnosis. Anonymous 3 participant stated, "…She [provider] was African American. She did not have to change, like, her dialect, and it was so cool. She closed the door and said, 'listen, let me have a conversation with you...'." This reflection highlights the importance of linguistic and cultural resonance in therapeutic exchanges; when providers communicated authentically, participants no longer felt pressure to shift into Standard American English (SAE) or suppress aspects of their identity to be understood. Similarly, Simone shared, "…It was very easy to understand. She didn't… use all the proper terminology… it was more laid back, more casual…," emphasizing that the tone and flow of the conversation made the information accessible and digestible. Sharde' echoed this

sentiment, cautioning that overly clinical language can create distance, stating, "…Don't try to use all the DSM language and things like that…"

Increased Understanding and Acceptance

Participants also connected the use of culturally appropriate and relatable language to increased trust with their providers. Six of the eight participants who noted improved comprehension when culturally relevant language was used, which further their therapeutic alliance. Shay explained, "…She was great with explaining what it is and how it affects all parts of my life. And even helped me figure out where the anxiety's coming from..." Such examples illustrate that culturally resonant language not only clarified the diagnosis but also expanded participants' understanding of how GAD functioned in their daily experiences. The relational and contextual nature of these conversations made participants feel seen and understood beyond their symptoms.

Importantly, this enhanced trust often motivated participants to pursue continued mental health care or explore additional diagnoses. Janell shared, "Now, I get that you want to diagnose the problem, and say, okay, let's do therapy, let's do this," indicating a willingness to engage in ongoing treatment after receiving a comprehensible and affirming explanation. Anonymous 3 participant reflected, " Well, I have a therapist, but I have ...ooh, I see a therapist once a month and then I used to see a therapist quarterly," suggesting that culturally grounded communication can influence long-term treatment engagement. Collectively, these findings suggest that culturally relevant and relatable language is not merely a communication style but a clinical strategy that improves comprehension, fosters trust, and encourages sustained participation in mental health treatment.

Diagnosis Impact

The third theme answered the questions about the impact of receiving their GAD diagnosis and captured the emotional and relational impact of receiving a GAD diagnosis. Participants described the experience of receiving a GAD diagnosis as validating, affirming, and transformative—marking a turning point in how they understood and managed their emotional well-being. For many, the diagnosis provided a language to name long-standing symptoms that had previously been dismissed, minimized, or internalized as personal weakness within the context of the Strong Black Woman (SBW) narrative. Prior to diagnosis, participants frequently endured cycles of anxiety, self-doubt, and emotional exhaustion, often attributing these struggles to personal failure rather than mental health concerns. Receiving a formal diagnosis allowed them to reframe these experiences, shifting from internalized blame to recognition that their distress was both legitimate and treatable. This moment of recognition was experienced not only as psychological relief but also as a form of resistance against cultural expectations of constant strength, self-sacrifice, and emotional suppression.

Validation and Affirmation

The majority of participants explicitly described receiving their diagnosis as a moment of validation and clarity. For many, the label of GAD served as a form of permission to acknowledge their distress without shame. Participant Janell captured this sentiment when she reflected, “It was like, here’s a solution...you’re not crazy.” Similarly, Participant Anonymous 2 shared, “It gave me a lot of clarification,” while Robin summarized her experience in one word: “Relieved.” This sense of relief stemmed not only from receiving an answer but also from the affirmation that their symptoms were real and worthy of care. Participant Magic elaborated, “…giving me the label of anxiety, but I do remember just, like, a lot of affirmation and

validation," and Simone similarly expressed, "I just felt like it confirmed I'm not losing my mind." Collectively, these reflections suggest that for BAMW, diagnostic acknowledgment holds a deeper meaning. It serves as a counter-narrative to societal scripts that pathologize or invalidate their distress.

Language Fosters Mutual Trust

Beyond emotional relief, participants connected diagnostic validation to relational trust within the therapeutic setting. Half of the participants discussed how being able to communicate authentically, with culturally relevant language and without fear of judgment, amplified the emotional impact of their diagnosis. These participants described a dual process: receiving the diagnosis offered cognitive clarity, while culturally resonant communication fostered emotional safety. Participant Giselle explained, "I didn't want to be judged, even though I know that's not what she was doing… Pamela wasn't gonna judge me." Her reflection illustrates that the therapeutic space became safer not merely because of the diagnosis itself, but because of the provider's nonjudgmental stance and openness to cultural authenticity.

However, not all participants experienced such openness. Some described the need to modify their communication or "code switch" to avoid being stereotyped or dismissed. Janell reflected on this tension:

> If you speak in a certain way, yeah, they'll treat you differently. Now, I can code switch all day if that's what it's gonna take… You have to put on an act in order to get what you need, and you shouldn't have to do that.

This statement underscores the psychological cost of linguistic and cultural adaptation within healthcare encounters. Similarly, Anonymous 3 expressed frustration with having to educate her provider, stating, "I don't want to have to explain my culture to you." These accounts emphasize

that for many BAMW, authenticity within therapy is not guaranteed; it must be earned through culturally responsive practice.

Participants also offered insight into what culturally responsive communication looks like in practice. Giselle urged providers to "meet us where we are, so that we're not always in translation," while another participant advised, "Homegirl me some… Don't talk to me like I'm another doctor because I'm not." These reflections demonstrate that authenticity and cultural attunement are not about informality but about relational alignment and communicating in ways that acknowledge shared humanity and respect linguistic and cultural nuance. When providers achieved this balance, participants reported feeling seen, accepted, and empowered to engage more deeply in their healing process.

Cultural Background Influence

Participants discussed how their cultural and religious backgrounds shaped their understanding of mental health and influenced their willingness to seek treatment. The findings revealed that stigma surrounding mental illness within Black communities, combined with the long-standing role of the Black church, continues to influence perceptions of mental health care. For many participants, cultural expectations of strength, silence, and self-reliance contributed to the dismissal or minimization of mental health symptoms. Simultaneously, religious beliefs often portray emotional or psychological distress as an issue of faith rather than health, reinforcing the belief that prayer should be the primary means of coping. Together, these factors show how the combination of cultural norms and faith traditions influences not only how mental health is discussed but also how it is treated with BAMW.

Cultural Privacy and Dismissal of Mental Health

Most participants described growing up in environments where mental health was either ignored or dismissed. Participants noted that their families and communities emphasized privacy, resilience, and gratitude rather than open discussion of emotional distress. The expectation to remain strong and emotionally contained has functioned as both a survival mechanism and a silencing force in Black U.S. communities (Abrams et al., 2014; Watson & Hunter, 2015). These norms often reinforced silence and secrecy around mental health concerns. Anonymous 1 participant expressed, "...You know, I'm Black. We don't believe in that shit..." Similarly, Robin explained, "...We didn't have conversations about anxiety or depression… my parents or loved ones never used that language....". Simone and Sharde' also shared experiences where silence was expected. Simone provided examples of messages that perpetuated silence: "...You don't need to talk to anybody about your problems… there's no need to talk about anything. Like, lots of secrets, lots of lies... what happens here stays here...". Similarly, Sharde' heard messages like, "...You don't talk about those type of things outside of the home..." Participants' experiences demonstrate how this cultural silence continues to shape perceptions of mental health as something shameful or inappropriate to discuss, particularly outside of the home. Collectively, these accounts highlight how cultural expectations of privacy and emotional restraint contribute to ongoing stigma surrounding mental health within Black communities. Participant Magic stated, "…culturally, it means so much that's running rampant in the community, and… We are aware of it, but there's just that gap…"

This code reflects a broader cultural stigma deeply rooted in historical and social contexts. Participants' narratives show this internalized expectation, where admitting to mental health challenges is related to weakness or a lack of faith. Participant Giselle offered, "...My upbringing is very much, or my cultural context, is very much, like, you just have to be

grateful...” This stigma is further complicated by intergenerational messages that mental health struggles should be endured privately rather than treated professionally (Alvidrez et al., 2008). Participant Giselle stated “... Stress in your life was to be silent. Was to make do. And I think, in general, Black women are measured by how much they can endure...”. While participant Sarah stated the advice her father gave her, “... you don't need this medication, just, you know, get it together...”. These participants provided critical insight into why many BAMW may be hesitant to seek treatment or disclose mental health concerns to professionals. Anonymous 3 participant stated, “... I thought that Black people, you know… We just… we did what we had to do, and then whatever came with it, you just ended up crazy....”.

Religious Beliefs and Spiritual Treatment of Mental Health

Half of the participants discussed how their religious upbringing and church involvement shaped beliefs about mental health and healing. Many participants described being told that prayer and faith were the appropriate responses to emotional or psychological. Giselle shared, “...When I would talk about my mental health stress, and then other physical issues, sometimes it would be like, oh, you just gotta pray on it...” Although the church has historically served as a cornerstone of resilience, offering community, spiritual guidance, and emotional refuge during times of systemic oppression, participants noted that this same faith-based structure can perpetuate the belief that mental illness results from spiritual weakness or insufficient prayer. Simone received the message, “...You’re just not praying enough...”. Sharde’ echoed this sentiment, noting, “If you worry, you don’t trust God.”

The intersection of faith and mistrust of mental health providers further complicates this dynamic. As noted by Ward et al. (2013) and Benkert et al. (2006), Black Americans’ hesitancy to engage with mental health systems is deeply influenced by historical and contemporary

experiences of bias, misdiagnosis, and mistreatment. When combined with stigma and religious framing, this mistrust often results in delayed help-seeking and increased reliance on informal supports such as prayer or community elders rather than licensed professionals. For example, Sarah was encouraged to "...Go to church and pray on how you're feeling...". Shay recalled hearing, "...You're supposed to give it to God, and He'll take care of it...". These experiences demonstrate how faith-based teachings, while often supportive, can also discourage open discussion of mental health and delay engagement with clinical treatment options.

Chapter 5 - Discussion

This study explored the lived experiences of BAMW diagnosed with GAD. Using a phenomenological approach, the goal was to understand not just what participants experienced when receiving their diagnosis, but how they made meaning of those experiences in their own words and through their cultural lens. The findings revealed that the diagnostic process was not simply a clinical exchange, but a deeply personal and cultural event shaped by language, history, and trust. This discussion of the results is framed by Critical Theory and Critical Discourse Analysis (CDA), which together uncover the power dynamics and linguistic patterns that shape clinical communication and mental health understanding among BAMW.

As a reminder, this chapter continues the intentional integration of African American Vernacular English (AAVE) as discussed earlier in this dissertation. This decision is not stylistic convenience but a continuation of my commitment to linguistic justice and cultural authenticity. The use of AAVE within the discussion chapter serves to demonstrate that culturally relevant language can coexist with academic rigor. It reinforces the idea that AAVE is not "broken English," but a dynamic, expressive, and legitimate linguistic system that effectively communicates complex thought, emotion, and lived experience. By using AAVE to summarize and reflect on key findings, this chapter embodies the very principles of representation, accessibility, and resistance that ground this research.

Explanation of Diagnosis

The first theme revealed that many BAMW received little to no meaningful explanation of their GAD diagnosis. For most participants, providers briefly named the disorder without providing sufficient information about what it meant, how it developed, or how it impacted their lives. Participants often described the diagnostic process as one-sided and transactional rather

than relational and collaborative, which reinforces distrust and positions BAMW as passive recipients of care instead of active partners in their own treatment. This pattern mirrors findings from Liao et al. (2019), who identified that clients frequently receive diagnostic labels without corresponding education or treatment planning. Through Critical Theory, this theme reflects the institutionalized power imbalance that exists between provider and patient (Thompson, 2017). The clinician, as the expert, holds the authority to define, name, and interpret symptoms, while the client's lived experience is often minimized. When providers use overly clinical or detached language, they reinforce a system in which the voice of the clinician outweighs the voice of the client. CDA further explains that language is not neutral; it is a form of social power (Fairclough, 2012). The participants' experiences showed that the clinical discourse surrounding GAD often privileges standardized, Eurocentric communication while marginalizing culturally specific forms of expression.

Further, because many BAMW received minimal or unclear explanations about their GAD diagnosis, several participants described turning to outside sources to fill in the gaps left by their providers. Without meaningful dialogue or culturally resonant guidance, they were forced to become their own advocates, researchers, and educators. Rather than being guided through their diagnostic process, they had to piece together fragmented information from social media, online forums, and peer conversations. This experience underscores the unequal burden placed on Black women to educate themselves about conditions that should have been clearly explained in accessible, compassionate, and culturally relevant language by their providers (Burnett-Zeigler, 2021). The participants' frustration with "not knowing what this means" reflects not only a cognitive gap but also an emotional rupture. The lack of culturally responsive explanation

contributes to a sense of alienation that mirrors the larger systemic inequities BAMW encounter across health care (Dunson-Caputo & Storlie, 2022).

This theme demonstrates that the lack of clear, culturally competent explanation from providers does not merely limit comprehension, it disrupts trust and autonomy within the therapeutic relationship. Participants' experiences point to a larger systemic issue wherein diagnostic communication often centers clinical language rather than client understanding. Through the lens of Critical Discourse Analysis, this dynamic reflects broader power imbalances between providers and clients, particularly for Black women whose cultural and linguistic expressions are often marginalized in clinical spaces. The following theme, *Diagnosis Comprehension*, builds on these findings by examining how the use of culturally relevant and relatable language enhances participants' understanding and strengthens their connection to both the diagnosis and the therapeutic process.

So basically, a lotta the women in this study said the doctors told 'em they had GAD but ain't really break it down. They just threw the name out there and kept it pushin'. Folks was left sittin' there like, "Okay, but what that even mean for *me*?" That's why so many of 'em had to do their own research. They was Googlein', scrollin' through TikTok, and readin' up on Reddit. They was tryin' to make sense of somethin' their own provider should've explained. It wasn't just about not gettin' info; it was about not feelin' seen. The whole thang felt cold, like the doctor talkin' at them instead of to them. It reminded a lot of these women what it's like to be a Black woman in a system that don't always listen or care to understand. At the end, they still found ways to learn, but it shouldn't have had to be that hard to get somebody to simply talk to them like a person.

Diagnosis Comprehension

The second theme explored how language shaped participants' comprehension of their GAD diagnosis. Participants emphasized that understanding was not just about receiving information, but about how that information was conveyed. When providers communicated in ways that were conversational, relatable, and culturally aligned, comprehension increased significantly (Dunson-Caputo & Storlie, 2023). Several participants described how the use of culturally resonant language, such as casual or familiar phrasing, helped them make sense of their diagnosis and shifted the tone and experience from clinical to collaborative. This type of interaction built trust and demonstrated respect for the participant's linguistic identity. For many BAMW, culturally aligned communication signaled that their provider saw them as a whole person rather than as a case file. The ability to speak freely without needing to code switch or censor oneself was described as freeing and humanizing.

Through Critical Theory, this theme highlights that language can serve as both a barrier and a bridge (Dunson –Caputo & Storlie, 2022). When providers rely solely on standardized, academic, or diagnostic language, they maintain a hierarchical dynamic that positions themselves as authority figures. However, when providers intentionally use accessible, culturally relevant language, they redistribute power, transforming the diagnostic encounter into a shared act of meaning-making. This relational understanding empowered participants to engage more actively in treatment, demonstrating that comprehension and trust are deeply intertwined. By engaging in language that honors shared cultural identity and lived experience, providers begin to disrupt the institutional dominance that often marginalizes Black women's voices in clinical spaces. Critical Theory positions these moments of mutual understanding as acts of empowerment, where participants regain interpretive agency over their mental health narratives. In this way, culturally

attuned dialogue not only clarifies diagnosis but also reclaims ownership of knowledge production, an essential step in dismantling historically oppressive structures that have defined Black women's emotional experiences through external, medicalized frameworks (Dana, 2002). Through discourse, participants not only received information but also participated in co-constructing meaning about their mental health, bridging gaps between cultural identity and clinical understanding. CDA highlights that this co-construction is both relational and political: by using accessible, affirming language, providers challenge dominant discourses that often frame Black speech patterns as unprofessional or unintelligent. The participants' appreciation for this linguistic inclusion reveals how discourse can act as a tool of liberation, affirming cultural identity while simultaneously redefining what competent care looks like for Black American women.

Basically, what the women were sayin' is that how you talk matter just as much as what you say. When the providers came at them all stiff and clinical, it made it hard to really take in what was bein' said. But when the providers talked regular, like a real conversation, not a lecture, it just hit different. It made them women feel seen, like, "Okay, you talkin' *to* me, not *at* me." Some of the women said it felt good when they didn't have to switch up how they talked just to be understood or respected. That's what made 'em feel human in them moments, not like just another file or diagnosis. It showed that when a doctor can meet you where you at, when they respect your language, your vibe, your culture, that's when trust get built. And once that trust there, you can really start doin' the work to heal for real.

Diagnosis Impact

The third theme captured the emotional and relational significance of receiving a GAD diagnosis. For many participants, finally having a name for their long-standing distress brought

an overwhelming sense of relief and clarity. The diagnosis provided not just an explanation, but validation, permission to recognize that their experiences were real, complex, and worthy of care. This moment often served as a turning point, offering a sense of grounding after years of uncertainty. Several participants described this experience as liberating, reflecting how the diagnosis transformed what once felt like chaos into something understandable and treatable. The diagnosis became more than a label; it became a form of communication and connection, a way to articulate pain that had often gone unacknowledged.

From the perspective of Critical Theory, the act of naming distress becomes political. Historically, Black women's pain has been minimized, misdiagnosed, or pathologized within systems designed without them in mind (Marrow & Brown, 1994). For participants, receiving a diagnosis that acknowledged anxiety rather than labeling their behavior as "angry," "dramatic," or "too emotional," symbolized a reclamation of humanity. It disrupted a long-standing narrative that strength and suffering must coexist in silence. Within this framework, the moment of diagnostic recognition becomes an act of reclamation: participants redefined the meaning of anxiety not as weakness, but as a legitimate, human experience worthy of care. Through CDA, language emerges as the central site of this reclamation. The way that participants described their relief, using phrases like "I'm not crazy" or "I'm not losing my mind", reflects their active redefinition of meaning. CDA draws attention to how the women's choice of language, direct, emotive, and affirming, contrasts with the detached clinical tone of traditional diagnostic dialogue. Their speech reframes the diagnostic encounter as a shared conversation rather than a unidirectional exchange of authority. Critical Theory situates these findings within a larger critique of power, emphasizing that emotional validation functions as both a psychological and social justice process. In reclaiming their own language, participants resisted the deficit

narratives historically imposed upon them and asserted their right to be seen, understood, and cared for on their own terms.

Still, the narratives also captured the emotional toll of code-switching (Johnson et al. (2021). This tension reflects a painful awareness: to be heard and believed, BAMW must often present their distress in ways deemed "acceptable" by a system not designed for their voices. Additionally, participants' discussions of code-switching underscore how linguistic adaptation within clinical spaces mirrors larger societal pressures to conform to White, middle-class norms of communication (Spencer et al., 2022). CDA reveals that by naming this process, participants are engaging in discursive resistance, exposing how language functions as both a site of oppression and a strategy for self-preservation. In doing so, they highlight that culturally grounded communication is not simply a therapeutic preference but a necessary disruption of linguistic hierarchies that have historically silenced Black women's emotional realities.

For real, gettin' that GAD diagnosis hit deep for a lotta the women 'cause it wasn't just a label, it was finally somebody puttin' a name to what they been feelin' for years. They been carryin' that pain, thinkin' somethin' wrong with them or that they just had to tough it out, so when the provider said "GAD," it felt like freedom, like "Okay, I'm not crazy after all." The way it was said mattered, though. When the doctor came with care and understanding, it brought peace, but when it was cold or dismissive, it just added to the hurt. Still, havin' somebody finally believe them hit hard, 'cause for once, their pain was seen and valid. It wasn't that Strong Black Woman mask no more, it was them sayin', "Yeah, I'm strugglin', but I'm human too." Some even had to switch up how they talked just to be taken serious, which ain't right, but even with that, they found power in knowin' the truth about what was goin' on with them and claimin' that understanding for themselves.

Cultural Background Influence

The final theme explored how participants' cultural, familial, and spiritual backgrounds shaped their experiences with mental health and diagnosis. Almost all participants referenced growing up in environments that valued privacy, resilience, and faith, often discouraging open discussion of mental health. Common phrases such as "pray about it," "give it to God," or "what happens in this house stays in this house" were described as deeply embedded in participants' upbringing (Menakem, 2017). These cultural messages shaped not only how participants viewed mental health but also how they interpreted their diagnosis. For many, seeking therapy or receiving a diagnosis was an act of courage that went against generations of silence (Burnett-Zeigler, 2021). Participants described internal conflict between their faith-based upbringing and their growing awareness of mental health as a medical and emotional issue.

Through Critical Theory, these narratives reflect the historical and systemic forces that have contributed to the stigma surrounding mental illness within Black communities, rooted in a legacy of systemic racism, unethical experimentation, and cultural invalidation (Washington, 2006; Whaley, 2001). CDA shows how cultural discourse reinforces this mistrust through shared language that privileges faith over vulnerability, teaching individuals to pray rather than seek professional help. Yet, participants' stories also revealed moments of reconciliation, where spirituality and mental health coexisted. Several participants expressed that faith was a source of strength that could complement, rather than replace, therapy. This evolving narrative suggests that BAMW are creating new cultural scripts that merge belief, healing, and self-awareness without shame. Critical Discourse Analysis (CDA) further reveals how participants' language choices and phrases such as "you don't talk about it" or "what happens here stays here" reproduce the social boundaries that protect cultural identity while also maintaining the silence

imposed by stigma. Through this lens, participants' words expose how language both reflects and resists power: it carries generational narratives of survival yet also reinforces the barriers to seeking care.

Critical Discourse Analysis further draws attention to the ways participants' faith-based language functions both as a coping mechanism and as a discursive strategy that resists the medicalization of Black suffering. These linguistic patterns reveal an ongoing negotiation between cultural identity, faith, and institutional authority. By critically examining these discourses, this study exposes how participants' reliance on spiritual language not only communicates belief but also encodes a collective mistrust of systems that have repeatedly failed to affirm or protect Black well-being. Additionally, viewed through Critical Theory, this theme illustrates how institutional and cultural power dynamics continue to dictate whose knowledge and healing practices are considered legitimate. The privileging of Western biomedical models, often disconnected from spiritual and cultural frameworks, mirrors broader systems of dominance that have historically invalidated Black epistemologies.

Most of the women talked about how they grew up in homes where you kept your business to yourself, prayed on it, and stayed strong no matter what. Talkin' about mental health wasn't really a thing, it was more like, "Give it to God," or "What happens in this house stays in this house." That's just how they was raised, to handle stuff in silence and lean on faith. So for a lotta them, even goin' to therapy or acceptin' that GAD diagnosis felt like breakin' a family rule, like steppin' outside what they been taught all their lives. It wasn't that they didn't believe in prayer. It's that they started to see that faith and therapy could work together instead of fightin' each other. They still trust God, but now they also know it's okay to talk to somebody, to get

help and heal in more than one way. It showed how Black women be carryin' generations of silence but still findin' ways to rewrite the story, mixin' strength, belief, and self-care all in one.

Clinical Implications

The findings of this study underscore the importance of culturally grounded, linguistically inclusive, and relationally responsive clinical practice. To improve diagnostic and therapeutic outcomes for BAMW, clinicians must move beyond cultural competence toward cultural humility and linguistic flexibility. First, clinicians should recognize that language is central to trust. Using AAVE or culturally resonant communication is not unprofessional, it is relational. Clinicians who adapt their language demonstrate respect for clients' identities and experiences, fostering deeper connection and engagement. Second, mental health education should include training on the cultural and historical context of Black mental health. Providers must understand how systemic racism, generational trauma, and community discourse shape help-seeking behaviors. Third, diagnostic delivery should be treated as an ongoing dialogue rather than a one-time event. Providers should ensure comprehension, invite feedback, and contextualize symptoms within clients' lived experiences. Finally, mental health professionals should approach faith and spirituality with openness rather than avoidance. For many BAMW, faith remains a primary coping strategy. Integrating spirituality in treatment discussions can help bridge cultural gaps and reduce stigma.

Strengths and Limitations of the Study

A major strength of this study is its phenomenological focus on lived experience. The use of participant narratives allowed for rich, authentic insights that centered the voices of BAMW in a field where they are often underrepresented. The inclusion of Critical Theory and CDA

provided a multidimensional analysis that examined not only what participants said, but how their language reflected broader systems of power and inequality.

Another strength is the diversity among participants. Although all self-identified as BAMW, they represented varied educational, professional, and regional backgrounds. This diversity revealed shared cultural experiences while also illuminating differences in how class, education, and exposure to therapy influenced understanding.

A notable strength of this study is that it is the first of its kind to explore BAMW's understanding of their GAD diagnosis through the lens of AAVE. This originality contributes to the limited body of literature examining the intersection of language, culture, and mental health comprehension within this population. By centering AAVE as both a subject of inquiry and a legitimate mode of expression, the study challenges traditional academic and clinical norms, paving the way for culturally responsive approaches to mental health communication. However, this same novelty also presents a limitation. As the first study of its kind, there are few, if any, existing frameworks or comparable studies to guide interpretation or validate findings. Consequently, the results should be viewed as exploratory and foundational, serving as a basis for future research rather than definitive conclusions.

However, the study also has limitations. The sample size, while consistent with qualitative research standards, limits the generalizability of findings. Participants were self-selected, meaning they may have already been more open to discussing mental health than others. The majority had access to higher education and digital platforms, which may have influenced their exposure to mental health language and resources. Additionally, interviews relied on self-report, which can be influenced by memory, comfort level, and interviewer presence.

Another limitation of this study is the lack of detailed information regarding the professional and cultural backgrounds of the providers who issued participants' GAD diagnoses. During interviews, it became apparent that BAMW are not always first exposed to diagnostic terminology through mental health professionals; instead, many encounter the term "anxiety" or "GAD" through primary care physicians, school personnel, social service professionals, or even informal community sources. Without distinguishing between these pathways, it becomes difficult to determine how provider training, discipline, or cultural identity may shape the quality and clarity of diagnostic communication.

Lastly, unclear or incomplete diagnostic communication may not be solely the result of cultural or linguistic differences between providers and AAVE. It is also possible that some therapists simply did not invest sufficient time or emphasis in helping clients understand their GAD diagnosis. This study cannot determine the exact cause of these communication gaps, and any interpretation should be viewed as a potential explanation rather than a definitive conclusion. Multiple factors, such as provider approach, time constraints, training, or competing clinical priorities, may have contributed to the limited diagnostic clarity reported by participants.

Future Research

The findings from this study highlight the need for continued exploration of how language and culture influence mental health understanding among BAMW. Future research could expand this work in several key ways. Researchers should also examine how the racial and cultural background of mental health providers influences communication patterns, diagnostic practices, and overall treatment experiences for BAMW. Understanding how provider identity interacts with language use, particularly in contexts where AAVE or other culturally specific expressions are present, may illuminate important dynamics in clinician–client relationships. For

example, shared cultural understanding between provider and client may foster trust, improve diagnostic accuracy, and encourage more open dialogue about symptoms and lived experiences. Conversely, a lack of cultural or linguistic awareness could contribute to miscommunication, misdiagnosis, or the reinforcement of racialized stereotypes about emotional expression and coping. Investigating these interactions can help identify best practices for culturally responsive and linguistically inclusive diagnostic processes, ultimately improving mental health outcomes for BAMW and other marginalized populations.

Second, future studies could explore the therapeutic potential of AAVE within counseling settings. Investigating how linguistic alignment impacts trust, comprehension, and long-term engagement could reshape cultural competence training and curriculum development.
Third, research should examine intergenerational perspectives on mental health among Black women, comparing millennial experiences with those of Gen Z and older generations. This could illuminate how shifting cultural narratives around therapy and mental health evolve across time.

Third, longitudinal research following BAMW through their treatment journey could provide valuable insight into how comprehension and cultural resonance influence long-term outcomes. Understanding the ongoing process of meaning-making around GAD can help clinicians support clients beyond the initial diagnosis.

Additionally, Future research should intentionally gather data on the type of provider (e.g., therapist, psychiatrist, primary care physician, nurse practitioner, school counselor), their racial/ethnic background, and their familiarity with culturally responsive communication practices. Additionally, future studies should explore where participants first learned or heard about GAD, as this may meaningfully shape their expectations, understanding, and willingness to seek mental health treatment.

Finally, future research should continue to explore how cultural background influences mental health understanding, diagnosis, and treatment engagement among Black American women. Specifically, studies could examine how factors such as family upbringing, spirituality, community norms, and cultural identity shape perceptions of mental illness and willingness to seek care. Comparative studies across different generations of Black women could also reveal how shifting cultural narratives and exposure to mental health discourse affect understanding over time. Additionally, researchers should investigate how incorporating culturally grounded language, such as AAVE, within therapeutic and diagnostic settings may improve comprehension, trust, and client–clinician rapport. Expanding this line of inquiry across diverse Black communities and intersecting identities (e.g., socioeconomic status, sexuality, or religious affiliation) would deepen the field's understanding of how culture operates as both a protective and restrictive force in mental health experiences.

Chapter 6 - Conclusion

This study explored the lived experiences of Black American millennial women (BAMW) diagnosed with Generalized Anxiety Disorder (GAD), with particular attention to how language, culture, and identity intersect within the diagnostic process. Through a phenomenological lens, the research illuminated how these women interpreted, understood, and internalized their diagnosis while navigating a mental health system not originally designed for them. Findings demonstrated that most BAMW received limited or unclear explanations of their GAD diagnosis, reflecting a larger issue of linguistic and cultural disconnection between providers and clients. Participants described the diagnostic process as overly clinical and impersonal, leaving them to seek understanding through self-directed research. Yet, when providers engaged in culturally resonant and relational communication, comprehension and trust increased significantly. Participants emphasized that being able to communicate freely, without needing to code-switch or conform to dominant linguistic norms, allowed them to feel seen and valued within the therapeutic process.

The diagnosis itself held profound emotional significance and provided validation that their pain was real, comprehensible, and deserving of care. This moment of recognition represented not just psychological relief, but a political and cultural act of reclaiming identity and agency. At the same time, participants' narratives reflected the ongoing tension between faith, culture, and mental health. While spirituality remained a foundational source of strength, participants described the need to move beyond the traditional silence and stigma surrounding mental health within Black communities, reframing healing as both spiritual and psychological.

Using Critical Theory and Critical Discourse Analysis (CDA), this study uncovered the ways in which diagnostic communication reflects and reproduces systemic inequities, while also revealing how language, particularly AAVE, can serve as a site of both resistance and healing. This study contributes to a deeper understanding of how language and culture shape mental health comprehension and care for BAMW. It challenges clinicians, educators, and researchers to critically examine the power embedded in diagnostic discourse and to reimagine communication as a shared, culturally grounded exchange. By honoring AAVE as a legitimate linguistic system and valuing clients' lived experiences, providers can move toward a model of practice that embodies linguistic justice, cultural humility, and relational empathy. The women in this study demonstrated that healing begins with being heard and that when language meets culture with respect, understanding becomes possible.

At the end of the day, this whole study came down to one simple truth, Black women just wanna be heard, understood, and treated like their story matter. Every woman who spoke in this study had been through years of holdin' it in, tryna be strong, prayin' through the pain, and still showin' up every day. So when they finally got that GAD diagnosis, it wasn't just a name, it was freedom. It was like sayin', "See, I wasn't trippin'. Somethin' really been goin' on with me." But that freedom hit different depending on how the provider said it. When the doctor came correct, talked with care, used plain words, and respected how they spoke, it opened up space for real trust. When they didn't, it just felt like the same ol' thing: not bein' seen, not bein' believed.

These women showed that language is power. When they could talk in their own voice, no code switchin', no explainin' themselves, they started to heal. They started to see that therapy and faith ain't opposites; they can work hand in hand. They showed what it look like to break generational silence while still holdin' on to belief and strength. What this study really says is

that Black women already got the tools, they got the faith, the voice, and the power. They just need the space to use it. And if the mental health world start listenin', really listenin', in our language, on our level, we'll see that healing was always ours to begin with.

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Appendix A - Informed Consent

PROJECT TITLE: Talk to Me How I Talk: The Role of African American Vernacular English in Mental Health Diagnosis and Communication

PROJECT APPROVAL DATE: 7/14/2025

PROJECT EXPIRATION DATE: 7/13/2028

PRINCIPAL INVESTIGATOR: Char'dae C. Bell

CO-INVESTIGATOR(S): Amber Vennum

CONTACT DETAILS FOR PROBLEMS/QUESTIONS: Char'dae C. Bell

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IRB CHAIR CONTACT INFORMATION:

Lisa Rubin, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224, rubin@ksu.edu; Brad Woods, Associate Vice President for Research Compliance, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224, comply@ksu.edu.

PURPOSE OF THE RESEARCH:

The purpose of this study is to advocate for more inclusive, accessible, and culturally responsive ways of communicating about mental health diagnoses by medical and mental health professionals. Specifically, the study seeks to understand how Black American millennial women understand their diagnosis of Generalized Anxiety Disorder (GAD), how the use of African American Vernacular English influences communication about mental health diagnoses, and how mental health communication by providers could better align with the experiences and communication styles of Black American millennial women.

PROCEDURES OR METHODS TO BE USED:

This study uses two ways to collect information. First, you'll take a short online survey (about 10 minutes long) where you'll read some short paragraphs and answer questions about your experience being diagnosed with GAD and provide your opinion on two different ways to explain GAD. Second, at the end of the survey, you have the option to sign up for a one-on-one interview (about 45 minutes long) to talk more about your personal experience with receiving the GAD diagnosis and thoughts about how medical and mental health providers could improve this process for Black American millennial women.

RISKS OR DISCOMFORTS ANTICIPATED:

Some participants may experience emotional discomfort when reflecting on or sharing personal experiences related to their anxiety diagnosis. Although the likelihood of distress is low, support resources (such as crisis hotlines or mental health referrals) will be provided at the end of the survey and/or interview. Participants may skip any question or stop participation at any time without penalty.

BENEFITS ANTICPATED:

There may be no direct personal benefit to you from participating in this study. However, your input may help improve how mental health professionals communicate diagnoses with Black American Millennial Women. Your experiences can contribute to changes in how care is explained, understood, and delivered in culturally respectful and accessible ways.

EXTENT OF CONFIDENTIALITY:

The survey is anonymous, so there is no way to link your responses to you. If you choose to participate in the interview, you will be able to choose a pseudonym. The interviews will be recorded on zoom and after the transcripts are checked for accuracy, all identifying information will be removed from the transcripts and they videos will be deleted. All data will be kept in a password-protected file on a password-protected computer accessible only to the research team.

Terms of participation: I understand this project is research, and that my participation is voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that I have received a signed and dated copy of this consent form.

Yes, I consent to participate in this study

No, I do not consent to participate in this study

Appendix B - Screening and Interview Questions

Screening Questions:

1. Are you a Black American Millennial Woman (born between 1981-1996) who has received an Generalized Anxiety Disorder (GAD) diagnosis from a mental health professional?
2. How long ago were you diagnosed with GAD?

Qual Questions:

1. **Can you tell me how you explained your feelings or symptoms to your doctor or therapist?**
2. **How did the way your provider explained your diagnosis help you understand it (or make it harder to understand)?**
3. **How did you feel when you found out you had anxiety?**
4. **Have you done anything else to help you understand your diagnosis?**

a. ***Follow-up:*** **What has helped you understand your diagnosis the most?**

5. **Can you tell me how your background, culture, or the way you grew up may have shaped how you understood your anxiety diagnosis??**
6. **If you were talking to another Black woman your age about anxiety, how would you explain it to her?**
7. **What would you want doctors or therapists to know about how to explain mental health to Black women so it feels clear and supportive?**

Appendix C - Debrief Statement

Debriefing Statement

Thank you for participating in this study on how Black American millennial women understand their diagnosis of Generalized Anxiety Disorder (GAD). This research aims to explore how language—especially African American Vernacular English (AAVE)—shapes communication between providers and clients, and how it may influence your understanding and experience of being diagnosed.

By sharing your experience, you are contributing to a larger effort to improve how mental health professionals communicate with Black women in culturally relevant and respectful ways. Your responses will remain confidential, and all identifying information will be removed from the data.

If you experienced any discomfort during this study or would like support, please consider the resources listed below. If you have questions about the study or would like to receive a summary of the findings, feel free to contact me at ccbell@ksu.edu.

Resources for Support

- *Therapy for Black Girls*: https://www.therapyforblackgirls.com
- *Crisis Text Line*: Text HOME to 741741
- *National Alliance on Mental Illness (NAMI)*: 1-800-950-NAMI (6264)
- *Black Mental Wellness*: https://www.blackmentalwellness.com

If there are any concerns or questions please contact the following persons:

Dr. Amber Vennum (Principle Investigator) avennum@ksu.edu

Char'dae Bell, M.A., Doctoral Candidate (Co-Investigator) ccbell@ksu.edu

Lisa Rubin (IRB Chair) rubin@ksu.edu