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The Intersectionality of Substance Use Disorders Among Black Americans and Critical Race Theory in Educating Counselor Trainees

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Abstract

Due to the advent Covid-19, racial profiling and police brutality people are stressed, anxious, angry, depressed, lonely, and filled with worries in ways they have not been. This constant race-related stress stemming from constant viewing of these negative images has been linked to maladaptive coping responses such as substance use. Black Americans have encountered unique experiences with racial microaggressions however few counseling programs have extended multicultural constructs to include topics such as racism, discrimination, police brutality, white privilege, white fragility, historical trauma, intergenerational trauma within the lens of critical race theory. This article will discuss racial disparities and trauma in mental health and how counselor education should focus on a holistic approach in these traumatic and stressful instances of time.

Keywords: Black Americans, Substance Use, Trauma, Microaggressions, Counseling Training, Critical Race Theory, Racial Tension

Introduction

Over 50 days ago on May 5, 2020, a video surfaced on the internet showing the killing of Ahmaud Arbery as he was out jogging. This was the beginning of a resurgence of videotaped deaths by police officers and white vigilantes to rock the Black American community. George Floyd. Breonna Taylor.

The resurgence to another wave of police killings sent an already traumatized community into outrage. When Black death goes viral, race-related stress which can mirror Post-Traumatic Stress Disorder (PTSD) like symptoms are triggered. Race-related stress stemming from constant viewing of these negative images has been linked to maladaptive coping responses such as substance use (Sinha, 2008).

It is often thought that Black Americans use illicit drugs at a higher rate as compared to other races. During a recent webinar hosted by NAADAC and entitled "Substance Use Disorders Among African American Communities" (2020), speaker Dr. Sherrá Watkins, polled over 800+ behavioral and medical professionals to determine their beliefs on whether Blacks are more likely to use drugs than white Americans. Over 60% of attendees believed that Blacks were more likely to use most kinds of illegal drugs. Additional myths on drugs of choice, why Black people use drugs, criminality, and poor treatment outcomes were also discussed due to reported perceived beliefs. Statistically, the rates of substance abuse among Blacks are similar to those of the general population, although there are some slight differences (National Survey on Drug Use and Health [NSDUH], 2018). The reform in policies in how we treat substance users has been stated for the last decade. A truly holistic approach must be implemented in order to see more success in treatment outcomes and sustained recovery. Though we have to reform the policies, one must also look at the reform of who and how treatment is being provided. The behavioral health and substance abuse fields continued to be dominated by white clinicians. Are white clinicians and counselor trainees prepared to engage in treatment successfully with Black clients? If the past few months of recent events, comments and social media posts is a snapshot of where we are as a field in multicultural competence and understanding of racial injustice, then we are truly in trouble. And so are Black clients who may receive treatment from a non-person of color (POC).

As clinicians of color in mental health and substance use, we have watched and engaged with white clinicians on social media, town halls, lectures and webinars. Unfortunately, the tale-tell sign that multicultural competence is considered to be only a one-time course permeated in responses and judgment around the Black Lives Matter movement. How do we as educators begin to move beyond the norm of not requiring renewal training by licensing boards or having a single course that teaches multicultural and racial competency to counselor trainees who will serve a racially and ethnically diverse client population? Critical race theory (CRT) has been used in K-12 education and higher education to analyze and expose racism. Applying the tenets of critical race theory (CRT) may help counselor educators develop counseling pedagogical practices that attend to the current racial issues and social justice in the counseling classroom as well as within faculty–student relationships (Closson, 2010).

The purpose of this article is to examine how CRT can be applied within a counselor education addiction curriculum to develop multiculturally competent clinicians who can also apply the lens of CRT in treating Black clients facing addiction. In this regard, we present an overview of historical trauma and CRT, substance abuse demographics associated with use, treatment methodology and success rates.

Historical Trauma, Trauma and Mental Health

We are not too far removed from being sprayed with water hoses, attacked by dogs, beaten, and sit-ins, it is just being played out through technology now. And it hurts. Chronic fear of living these experiences (e.g., microaggression, racism, bias, discrimination and more) may lead to constant vigilance or even paranoia, which over time may result in traumatization and/or contribute to mental health issues such as anxiety, depression, and PTSD. The National Child Traumatic Stress Network (NCTSN; 2016) reports that interventions to serve children and families in the United States in the 21st century must incorporate the current and historical context in which they live. The NCTSN (2016) reports that the legacy of slavery has been carried forward in many areas of American society, including the racially related injustices that persist, such as mass incarceration and the lethal violence directed disproportionately toward Black Americans. Moreover, NCTSN (2016) reports that the impact of the unresolved historical trauma of slavery on intergenerational trauma and community trauma should be addressed within a child trauma services framework. Furthermore, the NCTSN (2016) reports that embedded institutional racism associated with these traumas is not adequately addressed in child trauma care and continues to shape current policies and attitudes. Walters et al. (2011) describe “historical trauma” as an event or a set of events that happen to a group of people who share a specific identity. That identity could be based on nationality, tribal affiliation, ethnicity, race, and religious affiliation. The events are often done with genocidal or ethnocidal intent and result in annihilation or disruption of traditional ways of life, culture, and identity (Walters et al., 2011). The impact of these ongoing traumas affects a person’s brain and body, increasing their vulnerability to PTSD

and other mental health disorders (Walters et al., 2011). Research reports knowing how the human body holds on to this stress reminds us that we cannot ignore the social, historical, or cumulative experiences of stress and their impact on wellness (Sue, 2007). Sue (2007) reports that non-white people in the United States often deal with the continuous threat of discrimination and distress due to continuous microaggressions. Sue (2007) defines that microaggressions are the chronic and commonplace verbal, behavioral or environmental indignities and injustices, intentional and unintentional, that communicate hostile, derogatory, demeaning, invalidating, and negative (racial, ethnic, homophobic, etc.) slights and insults toward people (of color, homosexual individuals, etc.). A research study by Sellers and Shelton (2003), reports that 96% of Black Americans reported experiencing racial discrimination in one year, including being mistaken for a service worker, being ignored, receiving poor service, being treated rudely, or experiencing strangers who act fearful or intimidated when around them.

Mistrust and Microaggression

Minorities have high levels of societal mistrust that negatively impact the ability of mental health professionals to adequately serve their needs. Studies have shown this lack of trust regarding the mental health system to be significant (Whaley, 2004). Minorities tend to hold more negative attitudes than whites toward both professional and mental health treatment (Silva de Crane & Spielberger, 1981). The stereotype that ethnic groups such as Hispanic and Blacks are prone to violence also contributes to misdiagnosis. Racial discrimination of violence operates at the unconscious level in mental health professionals' diagnostic judgments (Whaley, 2004). Discriminatory experiences, cultural stereotypes, and unfavorable consequences in our society all contribute to the level of cultural mistrust. This mistrust and cultural paranoia create a conflicting perspective toward white society as a defense against threats of racism, prejudice, and discrimination. Black Americans have a higher lifetime prevalence of mental disorders; however, overall mental disorders occur in Black Americans at about the same or less frequency than in White Americans. Despite research indicating that Black Americans struggle with mental illness and may deal with more persistent mental health issues than white Americans, Black Americans seek mental health treatment at lower rates than white Americans (Buser, 2009). As well, Black Americans have lower treatment retention rates in mental health services than their white counterparts (Cruz et al., 2008). The existing literature suggests that minorities are less likely than whites to endorse the professional treatment of mental health problems (Broman, 1987). With apprehension among minorities to seek mental health, cultural disparities continue to be evident in applying appropriate, culturally sensitive mental health treatment. Literature suggests the levels of apprehension may also be a reflection of etiological beliefs. Combining the literature of mental illness with race and etiology implies three distinctive ways might mistrust impact treatment. Apparent effects of race on the beliefs about the etiology of mental illness, the rejection of biological explanations of mental illness, and the likelihood to endorse causes of mental illness that are neither biological nor environmental (Schnittker, Freese, & Powell, 2000). "With Black clients, if you don't connect with them, if you don't tell them something that has an impact on them, then they're not coming back," (Pinkney, 1993).

Racial Disparities and Trauma

Although racial disparities and trauma exist in all areas of treatment and healthcare, mental health is an area that should not go overlooked. There are obvious disparities and trauma that exist between Black Americans and whites in relation to mental health and their willingness to seek treatment. Societal factors influence health beliefs and behaviors positively and negatively. Some of these factors function as barriers to seek mental health treatment while others act as motivators (Plowden, 2003). Black American families are more likely to report a lack of financial resources (insurance coverage, cash, etc.) in comparison to white counterparts (Cheatman, Barksdale & Rodgers, 2008). This is extremely important because individuals who lack such resources encounter great difficulty when attempting to access care (Cheatman, Barksdale & Rodgers, 2008). As a result of the disparities and trauma in availability and quality of mental health care services for African Americans, they "bear a disproportionately high disability burden from mental health disorders" (Allen, Davey & Davey, 2010). The differences are not just exclusive to adults. Black American children and adolescents are more likely than white Americans to have unmet needs for mental health services (Cummings, Ponce, & Mays, 2010). The mental health needs of Black Americans, in entirety, remain largely unmet (Chow, Jaffee & Snowden, 2003).

Causes of Mistrust and Disparities

The disparities and trauma that exist are not a phenomenon that randomly happened but instead they are byproducts of a system of events, circumstances and variables consistently interacting. There are three major barriers to health care that affect all Americans including: lack of health insurance, lack of a usual source of care and perception of need (Cheatman, Barksdale & Rodgers, 2008). When these factors are missing, or neglected health is affected. Unfortunately, these factors are being neglected more in Black American communities (Plowden, 2003). It is these factors and others that are responsible for the racial disparity in mental health treatment and the seeking of mental health. Oftentimes the reasons for the disparity in mental health seeking and treatment have been attributed to alternative coping strategies and Black Americans' attitudes towards services (Buser, 2009). Maladaptive coping strategies such as substance abuse are common. Most clients who report using do so to "stop the pain" or "to not feel". To this end, there is an increase in substance use disorders, especially during the COVID pandemic and racial injustices.

Substance Use Disorders

Research has documented relationships between self-reports of discriminatory experiences and reports of physical and mental health concerns (e.g., stress, anxiety, depression; Banks, Kohn-Wood, & Spencer, 2006; Gibbons et al., 2010; Stock et al., 2011). One-way Black Americans have learned to mitigate constant race and inequality related stressors is to engage in unhealthy coping behaviors. In particular, Black Americans may turn to illicit substances to manage the long- and short-term outcomes of racial and psychological distress. Moreover, Black Americans may seek, what they deem as beneficial, the immediate psychological outcomes of illicit substances to reduce the effects of stress (Chen et al., 2018). For example, Black Americans who report more experiences of discrimination are more likely to consume tobacco and alcohol as well as report lifetime use of marijuana or crack (Gibbons et al., 2010). Overall substance use rates of Black Americans are lower or comparable to that of white Americans of the same age. However, patterns of substance use have changed over time for Black Americans, with current concerns being an increase in marijuana and opiate use.

Among all illicit substance use, marijuana is the most used substance by Black Americans (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Marijuana use has been linked to perceived racial discrimination in that Black Americans who disclosed experience of racial discrimination were nearly 100 times more likely to engage in marijuana use in their lifetime compared to Black Americans who denied having perceived racial discrimination (Assari et al., 2019).

The Substance Abuse and Mental Health Services Administration identifies the current opioid epidemic as an urgent issue for the Black American population. The opioid epidemic is one of the largest drug epidemics recorded in U.S. history for all racial and ethnic groups. From 1999 to 2017, there were nearly 400,000 overdose deaths involving opioids in the U.S. The opioid misuse rate among Black American is comparable to the national population rate of about four percent (SAMHSA, 2020). Equally important, Black Americans' rates of death by opioid overdose nearly doubles that of White Americans (Griffith et al., 2018). Out of the 1.2 million Black Americans with opioid use disorder, almost 92% of abusers misuse prescription pain relievers (NSDUH, 2018). The remaining percentage of users are associated with heroin and a lower portion of about 35,000 are combination users of heroin and misuse of prescription pain relievers (NSDUH, 2018). With the majority of users misusing prescription pain relievers, findings from the NSDUH (2018) study revealed that the majority (49.4%) were purchased, given, or took from friends or family members. The second largest area (37.5%) were received through prescriptions or stole from a healthcare provider. The majority of Black Americans continue to obtain from friends/relatives and from healthcare providers underscoring the need for ongoing education of practitioners, appropriate pain management, and partnership with states to monitor opioid prescribing (NSDUH, 2018).

The majority of attention has focused on White Americans however Black American communities are experiencing dramatic increases in opioid misuse and overdose deaths. The rate of increase of Black/African American drug overdose deaths between 2015-2016 was 40 percent compared to the overall population increase at 21 percent. This exceeded all other racial and ethnic population groups in the U.S. (Rossen et al., 2019). Black Americans are less likely than Whites to complete addiction treatment, largely due to socioeconomic factors. Despite this information, large gaps across the intervention spectrum (i.e., prevention, treatment, and continuing care) still exist for Black Americans.

Barriers to Treatment

While substance use treatment has been proven effective in reducing alcohol and other drug use, treatment is vastly underutilized. Interestingly, Black Americans have similar or higher rates of obtaining treatment compared to white Americans, though they are also more likely to be referred to these services because of their interaction with social services systems (e.g., criminal justice system; Evans-Polce, Doherty, & Ensminger, 2014). Despite how Black Americans enter treatment, one of the issues faced is a lack of culturally competent treatment. Within these systems of care, the number of Black American behavioral health providers make up a small portion of the provider workforce (Mental Health America [MHA], 2020).

The past few years have seen a favorable shift in Black Americans' attitudes towards seeking behavioral health services. Despite these gains, fear of stigma and judgment continues to play a major role in initiating treatment services (MHA, 2020). This is especially true in the Black American community. Black Americans have been shown to hold more negative attitudes towards mental health and mentally illness than whites (Cruz et al., 2008). Stigma in the Black family and community also plays a role in dissuading Black Americans from seeking behavioral health care (Buser, 2009). As well, individuals are fearful of the *consequences* of being associated with mental health treatment or mental illness. For example, research has shown that employers are less likely to hire individuals with a known mental illness and landlords are less likely to lease to individuals for the same reason (Strauser, Ciftci & O'Sullivan, 2009).

Black Americans' entry into substance abuse treatment have not safeguarded them from the historical trauma and dehumanization within the medical system that fosters distrust and reduces help-seeking behavior. Mistrust of healthcare providers is extremely influential to Black Americans seeking substance abuse treatment. The "Tuskegee Study of Untreated Syphilis in the Negro Male" has had a lasting impact on the Black American community (Buser, 2009). From these experiments and more instances, can Black Americans have developed a generalized suspicion or distrust of institutions that are primarily White American such as mental health services (Buser, 2009). Research has shown some Black Americans believe that the Tuskegee experiment/study is still representative of current medical research. This mistrust holds true especially when Black Americans are being treated by white professionals (Buser, 2009).

In addition to the Tuskegee experiment, Black Americans may have negative attitudes towards seeking medical care, which can explain their mistrust of white clinicians and subsequently lower use of behavioral health services, especially in times of need (Diala et al., 2001). Previous literature indicates differences in diagnosis and prescription patterns which may have also contributed to the mistrust Black Americans have towards the mental health system. For instance, there is evidence that Black Americans are more likely to be diagnosed with schizophrenia and paranoid personality disorder than whites. In these findings it has been noted that white clinicians exhibited this overdiagnosing pattern to a greater degree. Racial bias may be a part of these diagnosis differences and clinicians may hold racial stereotypes about mental illness (Buser, 2009).

Coupled with helping professionals' biases and misconceptions of Black Americans, Black Americans face disparities in health insurance coverage, another common barrier to the Black American community when seeking substance use treatment (Turner & Wallace, 2003). While the Affordable Care Act has made substantial gains to help insure more Black Americans, disparities continue to persist. For instance, in 2018, 11.5% of Black Americans were uninsured compared to that of 7.5% uninsured white Americans (MHA, 2020).

What Can Be Done

Black Americans are a unique population to work with and one must take into account their unique cultural characteristics when working with them. Development of appropriate interventions and outreach is vital and should be dependent upon understanding critical social factors that influence health-seeking behavior (Plowden, 2003). Black Americans are not heterogeneous in nature and an array of biopsychosocial factors should be considered. Clinicians should actively dialogue with patients about perceived barriers and tailor treatment in a way that overcomes those (Cruz et al., 2008). One such factor is employment assistance. Unemployment can be a significant stressor and in turn increase the risk of relapse (Watkins & NAADAC, 2020). Similarly, housing insecurity and homelessness can also contribute to stress and increase the risk of relapse. Providing resources such as job training and access to government-funding housing may support sustained recovery and maintenance.

Another treatment consideration is religion and spirituality. Research suggests that a high degree of religion and/or spirituality increases resiliency in Black Americans (SAMHSA, 2009). Black churches have led health promotion with the Black American community. Integrating faith-based approaches into substance use treatment may be a vital component of recovery. As well, research has found that Black Americans are more likely to seek mental health assistance from religious leaders than from mental health professionals (Buser, 2009). With this knowledge, clinicians should advocate to work collaboratively with community churches and religious leaders, explaining the importance of mental health and appropriate mental health treatment. Black American clergy have a critical role in the delivery of mental health care services for parishioners and their families. Their significance is evident because Black Americans tend to first seek the support of ministers during personal emotional distress and crises. Unfortunately, in some cases, leaders are struggling to meet the needs of their members because they are without the necessary clinical skills to appropriately assess, diagnose or treat some mental illnesses. Clinicians should not use this information as a reason to boast about their skills but instead as motivation to build a more collaborative partnership with Black American church leaders to be more effective in reaching Black Americans. It is in churches where messages about seeking and receiving mental health treatment have the potential to be shaped by the influential interpersonal social interactions (Allen, Davey & Davey, 2010).

Finally, some models of addiction and addiction treatment may be inappropriate for use with Black Americans. Currently, there is a paucity of research and treatment modalities specifically designed for Black Americans with substance use concerns. Additionally, studies have shown that some African Americans who are seeking to utilize mental health treatment prefer an African American counselor (Duncan, 2003). However, there is a significant underrepresentation of Black behavioral health providers trained to deliver these needed services. While these considerations are important to include, the onus of developing and implementing culturally affirming and responsive interventions for Black Americans does not fall exclusively on the Black American behavioral health workforce.

There needs to be work done to assist in removing the stigma associated with mental health treatment. Two approaches that can assist with reducing the stigmatization of mental health treatment and illness are interpersonal contact and education. Interpersonal contact can produce the greatest improvement in perception. This approach aims to have individuals increase the amount of positive time spent with individuals who are stigmatized. The increased positive time is expected to decrease the negative stigmas associated with the individual. Clinicians should be proactively working against public and self-stigma for individuals with mental illness and/or receiving mental health treatment. The other approach is education strategies, which are aimed to dispel commonly held myths regarding mental illness and treatment by presenting factual information. The goal should be to not only educate clients but the clinicians and community. There is one particular theory that incorporates interpersonal contact and education, and that is Critical Race Theory (CRT). CRT looks at reforming white-washed education and cultural competency. CRT analyzes the role of race and racism in perpetuating social disparities between dominant and marginalized racial groups (DeCuir & Dixson; Ladson-Billings; Ladson-Billings & Tate, 1995). CRT's purpose is to unearth what is taken for granted when analyzing race and privilege, as well as the profound patterns of exclusion that exist in U.S. society (Parker & Villalpando, 2007). Therefore, CRT can play an important role when higher education institutions work towards becoming more diverse and inclusive.

Critical Race Theory

In November 2008, Barack Obama, a Chicago native, and U.S. Senator became elected as the country's first African American President of the United States. This presidential election sparked much discourse around the nation, so much so that the national media proclaimed that it had entered a "post-racial" era (Howard & Navarro, 2016; McCoy & Rodricks, 2015; Van Cleve & Mayes, 2015). Subsequently, the historic moment led many to believe that racism had been entirely effaced at the institutional level, and was now only present at the individual level, thus creating a new spark of colorblindness. The color blindness effect was exacerbated, but America subsequently faced many controversies regarding racism and prejudice, particularly given the police killings of multiple unarmed black men (McCoy & Rodricks, 2015).

Critical Race Theory (CRT) is a movement that consists of activists and scholars dedicated to studying and transforming the relationship between race, racism, and power (Delgado & Stefancic, 2017). Within CRT, social situations are not only defined and understood, but activists attempt to change disparities and inequalities. It emerged from a scholarship that sought to understand White supremacy and its oppression of people of color

(Howard & Navarro, 2016; McCoy & Rodricks, 2015; Van Cleve & Mayes, 2015). Theory activists are not afraid to challenge the dominant systems of racial oppression. Racial superiority can be found within America's criminal justice system through "invisible racism" (Howard & Navarro, 2016). With racism being "indivisible" to society, many believe that racism no longer exists due to the illusion of it being an "isolated" incident of one person's misfortune. Research suggests that when oppression such as racism, no longer seems like oppression to the victim, the racism appears as isolated encounters such as the case of Kalief Browder, a black male done unjustly by the criminal justice system for crimes he did not commit (McCoy & Rodricks, 2015).

Colorblindness. Often, colorblindness is referred to as a lens that one may look through. Consequently, color blindness is also a lens that often dismisses the role of racial discrimination. Research suggests that colorblind logic is deeply rooted in America (Van Cleve & Mayes, 2015). Many scholars admit that the system is racialized, but the system fails to identify race and racism as a core concern (McCoy & Rodricks, 2015). Even in recent years, the criminal justice system, which houses many Black Americans who need substance abuse treatment, has taken a precipitous drop; however, many people of color never have trusted nor believed in the system (Van Cleve & Mayes, 2015).

Additionally, colorblindness has led to many disadvantages and inequalities, thus creating a cycle of injustice within America's criminal justice system (Van Cleve & Mayes, 2015). Scholars have suggested that race is constructed on every level of analysis. The different levels of analysis are the micro-level features of unconscious decision making, to the meso-level engine of cultural meaning-making, and finally, the macro-level fixtures that define institutions and social structures (Van Cleve & Mayes, 2015). Criminal justice research often minimizes race and identifies race as merely a control variable, thus creating colorblindness within the many systems of America. (McCoy & Rodricks, 2015). For instance, many Black American men often find themselves behind bars for self-medicating with illegal substances. Consequently, many of the mental health needs are overshadowed by criminal records and negative stigmas.

W. E. B. Du Bois reminded us that former slaves had a brief moment in the sun before they were returned to a life without freedom (Alexander, 2012). After the Civil War, slaves were released from captivity; however, Black Americans still realized they were not free. By not having the right to vote and having zero protection by laws nor law enforcement, slavery seemed to exist still. Even after constitutional amendments were put into place, it seemed as impotent as the Emancipation Proclamation due to white backlash and reconstruction of laws that oppressed Blacks in America (Alexander, 2012). Jim Crow laws had many parallels to slavery for many rights of African Americans were denied. Equality and justice often went overlooked to create and uphold a system of racial caste (Alexander, 2012). Each year, during Black History Month, success stories are told across the nation that give the misperception that equality exists. As a result, many believe that no caste system in the United States exists but equal opportunity, completely dismissing barriers faced by Black Americans.

Since this nation was founded, Black Americans have been controlled by institutions such as slavery and Jim Crow laws. The newest institution that has gained control is the criminal justice system, which is the force behind mass incarceration for many Black American males (Alexander, 2012). This systemic issue has been achieved mostly by appealing to lower-income whites who are passionate about ensuring that they are not found at the lower totem pole of America's social class system. As a result of the Civil Rights Movement, policies such as affirmative action and federal civil rights legislation were put into place, but in the midst of this success, a new system such as mass incarceration was quietly planted, replacing the old crumbling Jim Crow laws (Alexander, 2012). Years of oppression has led to Black American males to be unconsciously comfortable with the lack of freedom. The oppressed often internalize the oppressor's guidelines and are fearful of challenging them (Freire, 2018). Oppression in American is deeply rooted and to surmount the situation of oppression, African Americans, but recognize the source from which is coming (Freire, 2018).

CRT and Counselor Education

Programs have typically focused on enhancing trainees' multicultural competence (American Counseling Association, 2014; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). Few programs have extended multicultural constructs to include topics such as racism, discrimination, police brutality, white privilege, white fragility, historical trauma, intergenerational trauma and additional marginalized groups such as LGBTQIA, Hispanics and Native Americans. Counselor educators' focus on these

concepts is typically designed to help either white students develop a greater awareness or trainees examine these constructs in society at large (Haskins, N. and Singh, A., 2015).

Cultural Awareness and Competency

The shared understanding and knowledge of cultural belief systems add to the creation of meaningful relationships. Cultural competency requires counselors and counselors in training to reflect on the importance of the person of the counselor and how this impacts relationships with clients. Self-awareness and affective empathy are two categories of personal development that are important to consider in cultural competency (Collins & Arthur, 2005a), which is important for the counselors' connection with the client. Counselors must be sensitive to their approach in treating ethnic populations. If pre-existing disparities exist between counselor and client, they may impair the counselor's ability to provide the highest quality of service.

Franklin et al. (2006) argued that counselors often have little or no firsthand experience of minorities. Some may have known Hispanic or Black students in their school or work settings, but have never been to their home, or interacted with them in social settings. This means that counselors are unaware of the differences between their clients' backgrounds, but in their eagerness to practice effective therapy, they often unwittingly make errors (Franklin et al., 2006). For these reasons, it is important to increase minority representation among doctoral students in counseling.

Cultural awareness represents an understanding of racial microaggressions' impact on people of color (Franklin et al., 2006). The non-optimal climate of race-related experiences may impact the functioning and engagement of minority graduate students. Racial microaggressions among Black Americans have been the focus of a number of researchers over the past decade. Researchers mainly focused on how educators can perpetrate microaggression that harms students and undermines learning (Franklin et al., 2006). Consequently, barriers are created that prevent non-white people from accessing educational and other health related services.

Black American students have encountered unique experiences with racial microaggressions. These are often attributed to the stereotypes and prejudices typically associated with their group affiliations. For example, the micro-aggressor usually expresses fear of violent behaviors of Black American males. Allen et al. (2013) examined the shared experiences/effects of racial microaggressions experienced by Black American to their well-being, self-concept, and racial identity development. They used CRT as the theoretical framework and as a basis for their discussion. The CRT framework uncovered valuable information concerning the how and why people of color experience subordination through social and institutional racism. The researchers explored racial microaggressions through the lens of district, school, and teacher levels.

Utilizing an extensive literature search to explore racial microaggressions, Allen et al. (2013) concluded that Black American students absolutely experienced district, school level, and teacher level microaggressions in urban schools. They recommend that school districts seek to empower and engage educational stakeholders in the processes of developing cultural competency within America's urban schools and communities. The key premise is that with the incorporation of a culturally affirming education, districts, schools, and teachers could move toward cultural competency. In an effort to do this, it is recommended that school districts and stakeholders assess the overall cultural climate in the classroom and support positive relationship building with students.

Stambaugh and Ford (2012) examined microaggressions perpetuated among Blacks, and low-income individuals identified as gifted students. The researchers hypothesized that gifted individuals are subject to microaggressions based on their unique characteristics. The researchers found that microaggressions were perpetuated when gifted individuals were Black or low income. The authors recommend counseling for culturally different and low-income gifted students. The premise is that when any individuals differ significantly from the general population in terms of beliefs, ability, cultural differences, or race or ethnicity, they become more susceptible to being misunderstood and microaggressions (Stambaugh & Ford, 2015).

Mental health was once an overlooked component of one's overall health, but it has recently been given more attention and respect. In recent years mental health has been given more consideration in regard to its effect on not just physical health but an individual's overall well-being. Good mental health can be a contributing factor to an increased life expectancy and fewer physical health concerns, but poor mental health can be a catalyst to declining health and an early death. Regrettably there are racial disparities and trauma mental outcomes, treatment and resources.

Mental illness is something that affects millions of individuals in America but unfortunately it impacts one population more drastically than it does another which can have trickling effects on how the rest of society operates.

Haskins and Singh, 2014 created a detailed summary checklist (see Appendix) to guide the evaluation of CRT integration into pedagogy. Their checklist contains:

- Ways to examine one's individual pedagogy and the curriculum.
- Guide counselor educators to use a CRT lens to collaboratively identify the needs of students of color in counselor training and provide continuing education in the most effective ways to meet these needs.
- Evaluate the development of teaching materials and the initiation of faculty dialogues on ways to address the embedded racism within the counseling curriculum and overall counselor training experiences for all students.

Conclusion

This paper discussed racial disparities, trauma and mental health and substance abuse, creating multiculturally competent counseling educators to treat Black Americans effectively, and utilizing CRT as the theoretic framework in revamping curriculum and conversations within counselor educator programs. CRT was creating during the mid-1970s and emerged from the early work of Derrick Bell and Alan Freeman, who were discontent with the slow pace of racial reform in the United States. The various tenets of CRT can be used to uncover the ingrained societal disparities in higher education that support a system of privilege and oppression. With recent events in the United States, Black Americans are calling for reform in every environment, workplace, and institution. Recent events have also caused many in recovery to either relapse or work harder to maintain sobriety due to increased isolation, fear, great losses in the form of unemployment, financial, connections, death and sickness. Having counselors and counselor educators who are competent in multiculturalism and who are able to hold safe spaces to Black Americans is more important than it has ever been. CRT's relevance gives a framework and objectives to begin the discussion and make equitable and long-term changes. CRT is no longer a new theological framework that can be questioned. Numerous studies have shown its effectiveness however many scholars focus on the two tenets of counter-storytelling and permanence of racism (DeCuir & Dixson, 2004; Ladson-Billings, 2005). Yet using all of the tenets will create authentic counselor educators who are able to debunk, unmask and uncover the continuity of white supremacy in our curriculum and programs.

When thinking about the need for change, administrators should ask themselves how the current racial climate continues to promote division and a racist structure even within the counselor education programs. Are we having solution-focused discussions with current and past Black students to access individual experiences'? We can no longer continue to focus only on enrollment numbers when the faculty does not match the student demographics. Therefore, it is important to utilize CRT's five tenets to help reveal racial inequity. Given that all five tenets address different, yet interconnected themes, they help unearth the various ways in which institutions reinforce racism. In addition, it is necessary for academic institutions, counselor education programs, students and alumni work collaboratively. If all sides do not work together in making the institution more inclusive, all the work will be done in vain.

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APPENDIX

Checklist for Integration of Critical Race Theory (CRT) Into Counselor Education Pedagogy:

- ❑ Acknowledge that racism exists and is embedded in the counseling curriculum via color blindness and other White hegemonic beliefs and norms, and then identify the ways in which "color blindness" is present in the counseling curriculum.
- ❑ Assess one's racialized experiences and the influence of these experiences on biases, beliefs, and values, and seek out opportunities to enhance one's understanding of the ways in which racism influences mental health and counselor training
- ❑ Explore the impact of privilege related to race/ethnicity and its intersection with other identities on one's pedagogical training.
- ❑ Practice identifying and understanding how master racism narratives and other oppression narratives (e.g., sexism, heterosexism) influence students of color and the counternarratives students of color have of their experiences.
- ❑ Examine the ways that White privilege and dominant cultural norms reward students with privilege and disadvantage students from historically marginalized backgrounds.
- ❑ Plan for and intentionally integrate the needs of trainees from diverse backgrounds into class learning, as well as nontraditional perspectives on counseling and healing.
- ❑ Initiate conversations with program, department, and university faculty about how to integrate CRT into faculty decisions about students (e.g., attending to issues of privilege and intersectional identities in activities such as admissions, advising, and supervision).
- ❑ Use CRT to critique the materials used in teaching (e.g., textbook selection, class lectures, exams, experiential activities, grading).
- ❑ Identify how Whiteness affects current course content and teaching strategy selections. (Haskins, N. and Singh, A., 2015)