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Clinicians' Experiences of Using Schema-Focused Therapy in Black Americans with Panic Disorder

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Walden University
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Abstract

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B. Th., Pontifical Urban University, 2007

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

Black Americans have a history of racism, oppression, subjugation, and discrimination, which could increase the risk of developing panic disorder. Because panic disorder and other chronic psychological problems resist Beck's short cognitive therapy and other interventions that overlook the roots of psychological problems, schema-focused therapy has been adopted more conveniently over the most recent years for their effective treatment. In this study, clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder was explored. The concept that grounded this study was the integrated schema-focused model, a convenient clinical model that integrates several models of schema therapy. Generic qualitative data were collected through semistructured audio interviews with clinicians (n =14) to uncover their experiences of schema-focused therapy with Black Americans with panic disorder. Thematic analyses of the data were performed manually to develop themes and meanings. The study results indicated that schema-focused therapy is effective with Black Americans with panic disorder. The results also revealed several early maladaptive schemas and modes associated with panic disorder in this population, highlighted helpful and unhelpful strategies for this population, and underscored challenges clinicians and clients face during the therapy and ways to manage them. Some findings of the study were unique, and future research needs to validate their association with panic disorder in Black Americans. The current study advances positive social change through the understanding of strategies and practices of effective schema-focused therapy in Black Americans with panic disorder.

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Dedication

I dedicate this work to the Blessed Virgin Mary, mother most lovable. Also, I dedicate this work to my late father, Mr. Patrick Otumdi Akanaefu. May he continue to rest in the bosom of the Lord.

Acknowledgments

I express my profound gratitude to God almighty for his protection, wisdom, and providence throughout this dissertation journey. My sincere thanks go to my family members for their prayers and support to me in this journey. I also express my special thanks to Dr. Perry Ethel for her untiring efforts in moderating this dissertation as the chair of my dissertation committee. She was exceptional as a moderator. Her commitment, encouragement, and comprehensive feedback were second to none. Additionally, I remain indebted to Dr. Patti Barrows for her thorough and insightful feedback. She was also committed to this task. I immensely thank all the authors whose research and ideas served as sources to this dissertation. I cannot thank them enough for their ingenuity. Finally, I thank all who in one way or the other helped to make this study a success. May God in his infinite goodness reward you abundantly.

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Chapter 1: Introduction to the Study

Introduction

Studies have shown that panic disorder among Black Americans is a significant mental health problem (Erving et al., 2019; Jones et al., 2020; Kisely et al., 2017; Nguyen et al., 2020; Thomas et al., 2022). However, panic disorder, like other chronic mental health problems, resists several treatment approaches, including Beck's short cognitive therapy and other earlier-developed interventions (Bach et al., 2018; Oguz et al., 2019; Peeters et al., 2021). Consequently, schema-focused therapy has been adopted more conveniently over the most recent years for effective treatment of panic disorder and other chronic psychological problems (e.g., Kianipoor et al., 2020; Mammad et al., 2017; Oguz et al., 2019; Peeters et al., 2021; Petrowski et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018; Tariq et al., 2021; Yan et al., 2018; Yigit et al., 2018; Zadahmad & Torkan, 2016). In this study, I explored the use of schema-focused therapy with Black Americans with panic disorder. I explored a sample of clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder and the meaning these clinicians ascribe to their experiences. The knowledge generated from this research includes new insight, informing clinicians about effective techniques, strategies, and practices of schema-focused therapy with Black Americans with panic disorder.

This chapter begins with an overview of the research context, the background of the study, and the research problem statement providing a logical argument on why clinicians' experiences of using schema-focused therapy with Black Americans is a gap in the research literature. Following this section are the statement of purpose, which

centers on how the current study will address the problem; the research question, which frames the focus of the study and sets its boundaries and points; and the conceptual framework, explaining and justifying the study. Also, included in this chapter are the nature of the study in which the summary of the detailed description of the research design and methods is presented; operational definitions of key terms, and assumptions and biases containing the conditions taken for granted without which the research would be pointless. In this chapter, I also described the scope and delimitations of the study, providing the scope of the study in terms of participants, designs, time, and locations; the study limitations; and the significance of the study in the last section. The chapter ends with a summary and conclusion.

Background

As a racial minority group, Black Americans, including African Americans, Caribbean Blacks, and African immigrants, have a history of racism, oppression, subjugation, and discrimination, which could increase the risk of developing panic disorder. These risk factors include living below the poverty line, major life stress, lower education, low household income, having two or more chronic conditions, depression, poor quality of life, traumatic events, and substance use (e. g., Benner et al., 2018; Brown, 2019; Carter et al., 2021; English et al., 2020; Jones & Neblett, 2017; Kijakazi, 2019; Lanier et al., 2017; Lavner et al., 2021; Manduca, 2018; Oh et al., 2021). Correspondingly, research has revealed that panic disorder is a significant public health problem among Black Americans (Erving et al., 2019; Jones et al., 2020; Kisely et al., 2017; Nguyen et al., 2020; Thomas et al., 2022). However, several criteria (e.g.,

suicidality, high level of avoidance, dissociation, depersonalization, rumination, heightened unrealistic fear of dying, going crazy, and impulsivity) for panic disorder and other chronic disorders, such as personality disorder, obsessive-compulsive disorder (OCD) and depression are resistant to Beck's cognitive therapy and other interventions that overlook the roots of psychological problems (Albanese et al., 2016; Bach et al., 2018; Dadamo et al., 2016; De Klerk et al., 2017; Peeters et al., 2021; Rameckers et al., 2021; Young & Lindemann, 1992). In contrast, schema-focused therapy goes deeper than most cognitive therapies to focus on how symptoms and problems have developed and how they are currently maintaining the problem (Taylor et al., 2017). Schema-focused therapy recognizes that core maladaptive schemas developed in childhood due to unmet psychological needs (e.g., connectedness, worthiness, autonomy, stability, and safety) can have lifelong implications (Bach et al., 2018).

Consequently, schema-focused therapy has proved promising for the effective treatment of patients with resistant chronic psychological problems (Mammad et al., 2017; Peeters et al.; Rameckers et al., 2021; Tariq et al., 2021; Yan et al., 2018; Yigit et al., 2018; Zadahmad & Torkan, 2016). For instance, Rameckers et al. (2021) conducted a meta-analytical study to compare the "Big-4" psychological treatments for personality disorders (schema-focused therapy, dialectical behavioral therapy, transference-focused therapy, and mentalization-based treatment). Among other things, the results revealed that schema-focused therapy had the largest change for the most treatment-resistant criteria, including anger, impulsivity, suicidality, and dissociation. Tariq et al. (2021) conducted a meta-analysis of the strength of the association between schemas and anxiety

symptoms in individuals from 10 to 29 years old. They found a strong association between anxiety and early maladaptive schemas (EMSs), including the schema domains of disconnection/rejection, impaired autonomy/performance, and other-directed. Mammad et al. (2017) also investigated the association of anxiety problems with EMSs in university students and found that the activation of specific schemas, including emotional deprivation, social isolation, enmeshment, vulnerability, incompetence, and insufficient self-control, influenced the development of anxiety disorders. Similarly, Peeters et al. (2021) found a significant decrease in anxiety symptoms in their study in which individuals with anxiety disorders, who resisted CBT treatment guidelines, were treated with the combination of schema therapy, exposure therapy, and response prevention.

Similarly, studies have revealed a significant correlation between schemas and panic disorder, suggesting the effectiveness of the schema-focused model for patients with panic disorder (e.g., Kianipoor et al., 2020; Oguz et al., 2019; Petrowski et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018; Yan et al., 2018). For instance, Oguz et al. (2019) investigated the similarities and differences between a healthy control group and the clinical groups of OCD and panic disorder in relation to three schemas: metacognitive beliefs, emotional schemas, and cognitive flexibility. The study findings indicated that clinical groups scored higher than the control group on the metacognitive beliefs of uncontrollability, danger, and the need to control thoughts. The clinical groups also scored significantly higher than the control group on the emotional schemas of uncontrollability, comprehensibility, rumination, dissimilarity, dangerousness, and guilt.

In contrast, the healthy control group scored higher than the clinical groups on cognitive flexibility. Shibuya et al. (2018) explored the therapeutic effects of the schema therapy technique of imagery rescripting and the conventional CBT on individuals with panic disorder. The authors found a significant reduction of panic disorder severity only with imagery rescripting.

Many studies also exist regarding using the schema-focused model for Black Americans (e.g., Abrams et al., 2018; Allen et al., 2019; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Liao et al., 2020; Mahbubani, 2022; Sims et al., 2019; Watson-Singleton, 2017). Additionally, extensive studies have highlighted clinicians' experiences of using schema-focused therapy for chronic psychological problems (Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Ten Napel-Schutz et al., 2017). For instance, De Klerk et al. (2017) examined patients' and therapists' perspectives on schema therapy for personality disorders. They found that, similar to patients, therapists found some aspects of the schema therapy procedure helpful (e. g., imagery rescripting technique, schema mode model, and the therapeutic relationship in schema therapy). However, therapists perceived some other aspects as unhelpful, including the difficulty in managing the therapeutic relationship, getting used to a new kind of therapy, and keeping treatment focused on personality problems.

None of these studies focused on clinicians' experiences of using schema-focused therapy with Black Americans who have panic disorder (e.g., Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Ten Napel-Schutz et al., 2017). Therefore, in this study, I explored clinicians' experiences of using schema-

focused therapy with Black Americans with panic disorder and the meaning these clinicians ascribe to their experiences. The knowledge generated from this research includes new insight, informing clinicians about effective techniques, strategies, and practices of schema-focused therapy with Black Americans with panic disorder.

Problem Statement

Research has revealed that panic disorder is a public health problem among Black Americans and that panic disorder is among the chronic mental problems resistant to Beck's short-term cognitive techniques and other focused interventions (Bach et al., 2018; De Klerk et al., 2017; Erving et al., 2019; Jones et al., 2020; Kisely et al., 2017; Nguyen et al., 2020; Peeters et al., 2021; Rameckers et al., 2021; Thomas et al., 2022). Research has also indicated that schema-focused therapy has been adopted more conveniently in the past 10 years to treat panic disorder, and a significant correlation between schemas and panic disorder suggest that the schema-focused model provide effective treatment for patients with panic disorder (Demir & Soygut, 2015; Kianipoor et al., 2020; Kwak and Lee, 2015; Oguz et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018; Peeters et al., 2021; Petrowski et al., 2019; Yan et al., 2018). Schema therapy has also been adopted for Black Americans (e.g., Abrams et al., 2018; Allen et al., 2019; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Liao et al., 2020; Mahbubani, 2022; Sims et al., 2017; Watson-Singleton, 2017). However, none of these studies addressed clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder (e.g., Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Ten Napel-Schutz et al., 2017). Therefore, the specific research

problem that I addressed in this study was clinicians' experiences of using schema-focused therapy in Black Americans who have panic disorder. I addressed the study problem by exploring clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder, including the schema techniques used, the major schema domains and modes addressed, and the extent the therapy met clients' needs. Other clinicians' experiences that I explored in this study included the benefits clients gained in schema-focused therapy, the aspects of the therapy most helpful to clients, and the aspects emotionally confronting to clients and therapists.

Purpose of the Study

The purpose of this qualitative study was to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. Schema-focused therapy is a treatment approach that integrates aspects of interpersonal therapy, experiential therapy, and psychoanalysis within a cognitive-behavioral structure to address chronic psychological problems resisting Beck's cognitive therapy and other focused interventions. Schema-focused therapy focuses on maladaptive schemas impacting people's perceptions of themselves, others, and the world and their interpersonal relationships (Young, 1990). Panic disorder is a chronic anxiety problem consisting of recurrent panic attacks without real danger. Panic attacks are characterized by a sudden surge of intense fear or intense discomfort, loss of control, and physical symptoms, such as fast heartbeat, sweating, shivering, chest pain, and feelings of choking and dizziness (Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al., 2021). Other panic attack symptoms include nausea or abdominal distress, derealization,

depersonalization, chills or hot flushes, fear of dying, numbness or tingling sensation, lighted head, and faint (Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al., 2021). I underscored clinicians' experiences of using schema-focused therapy with Black Americans, the meaning clinicians ascribed to these experiences, and consequently obtained an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy with Black Americans with panic disorder.

Research Question

The research question that I answered in this study was: What are clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder?

Conceptual Framework

The concept that I used to ground this study was the integrated schema-focused model. The integrated schema-focused model is a convenient clinical model that integrates several models of schema therapy, including 18 EMSs, schema modes, and maladaptive emotional schemas (McGinn & Young, 1996; Young & Lindemann,1992). Young (1990, 1999) developed a schema-focused model to conceptualize and treat chronic psychological problems (e.g., personality, anxiety, and mood disorders) that resist Beck's short-term cognitive therapy. The 18 EMSs are grouped into five domains (Galum & Soygut, 2022). These domains include: disconnection and rejection (abuse/mistrust, (abandonment/instability, emotional deprivation, social isolation/alienation, and shame/defectiveness); impaired autonomy and achievement (dependence/incompetence, vulnerability to harm and illness, enmeshment/undeveloped self, and belief in inevitable failure); impaired limits (insufficient self-control and

grandiosity/entitlement); other-directedness (self-sacrifice/overresponsibility, subjection, approval-seeking); and hypervigilance and inhibition (unrelenting standards, pessimism and negativity, punitiveness, emotional inhibition).

Over 80 schema modes have been identified. They are divided into four domains: vulnerable child modes (e.g., neglected child, terrified child, abused child, desperate child, humiliated child, angry child, and impulsive child); parent modes (punitive parent mode, guilt-inducing parent mode, and anxiety-inducing parent mode); and healthy modes (authentic child, contented child, happy child, and creative child); and coping modes. It is important to underscore that Young and Lindemann (1992) identified three schema coping styles to respond to EMS activations: schema avoidance (flight), schema overcompensation (fight), or schema rigidity or surrender (freeze). Additionally, Edwards (2022) identified repetitive, unproductive thinking as the fourth category of schema coping mode. Coping modes are generally dysfunctional and perpetuate schemas as individuals. Another important concept is maladaptive emotional schemas. Emotional schemas are a group of schema modes whose model emphasizes emotional interpretations and the need to validate the emotions, make sense of the emotions, normalize the emotions, expand the meaning or modify beliefs about the emotion. Maladaptive emotional schemas include rumination, denial, duration, validation, uncontrollability, guilt, weakness, avoidance, rationality, acceptance, dissimilarity, validation, comprehensibility, and dangerousness (Leahy, 2019; Oguz et al., 2019; Sardarzadeh, 2017; Wupperman, 2019). Schema coping modes are also a group of

schema modes individuals employ to avoid, control, or block the pain resulting from schema triggers, leading to problems in life and relationships.

Additionally, schema therapy techniques adopted to deal with maladaptive schemas include imagery rescripting, limited reparenting, attunement, behavior-pattern breaking, schema diary, chairwork, cognitive restructuring, psychoeducation, and flashcards (Dadomo et al., 2016; Jing, 2018; Gülüm & Soygüt, 2022; Videler et al., 2017; Young et al., 2003). These techniques are relational, cognitive-behavioral, and experiential procedures. For instance, imagery rescripting helps clients re-experience traumatic events crucial for forming maladaptive schemas in a controlled manner so that these events and their experiences acquire different meanings and emotional values (Jing, 2018). Chairwork is an experiential technique that helps clients distinguish and experience feelings and needs associated with their schema modes (Videler et al., 2017).

Early maladaptive schemas, schema modes, schema coping styles, maladaptive emotional schemas, and schema techniques are essential concepts that will provide guidelines for the exploration of the clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. I used these concepts as guidelines for my review of previous studies on the key related variables and concepts, the type of data I collected for the study, and the data collection methods, including semistructured interviews and data analysis. Also, the research problem, the study purpose, and the research question were generated through the conceptual framework. Clearly, these three study stages center on clinicians' experiences of using schema-focused therapy and so align with the schema-focused model, the conceptual framework.

Nature of the Study

In this study, I used a generic qualitative approach to uncover clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder and the meaning clinicians attribute to them. I obtained an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy for Black Americans with panic disorder (see Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). Additionally, the approach aligned with the study purpose statement and consequently with the conceptual framework (the schema-focused model) and problem statement of the study. Precisely, the word *explore,* which signals the purpose of this study, implies basic qualitative research (see Creswell & Creswell, 2018).

I collected data through semistructured interviews with clinicians regarding their experiences of using schema-focused therapy in Black Americans with panic disorder, the interpretations of their experiences, and the meaning they attribute to these experiences. I used audiotaped interviews as the primary source of data collection for the current study. Thus, data points for the current study included a semistructured interview guide with questions that I used to answer the research question. Fieldnotes were used for data collection to answer the research question. I performed thematic data analysis on the information received manually. Precisely, I organized the data into codes, categories, and themes. I saved the data on a separate hard drive and protect all data with an adequate password.

Definitions

Schema-Focused Therapy: A treatment approach that integrates aspects of cognitive-behavioral therapy, interpersonal therapy, experiential therapy, transactional analysis, object relations theory, mentalized-based therapy, dialectical behavior therapy, and positive psychology to address chronic psychological problems (Back et al., 2018; Taylor & Arntz, 2016). It focuses on maladaptive schemas impacting people's perceptions of themselves, others, the world, and interpersonal relationships (Young, 1990).

Schemas: Subjective perceptions, meanings, emotions, and actions individuals give to an experience. Therefore, schemas serve as mental templates for filtering and organizing information and experiences, including emotions, thoughts, and behavior (Boterhoven de Hann, 2019; Demir & Soygut, 2015) Schemas form the core of one's self-perception and conception of the environment and do not usually prompt questioning. Consequently, people take schemas for granted as prior truth.

Anxiety: A general feeling of apprehension or anticipation for possible future danger. Because different objects and situations induce anxiety, different anxiety problems exist, including panic disorder, general anxiety disorder (GAD), specific phobias, and separation anxiety (Tariq et al., 2021). However, they share similar symptoms, such as physiological symptoms (increased breathing rate, temperature, and heart rate), avoidance behavior, and anxious thoughts (Tariq et al., 2021).

Panic Disorder: A chronic anxiety problem consisting of recurrent panic attacks in the absence of real danger (Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al.,

2021). Two important criteria for panic disorder are recurrent and unexpected panic attacks and the existence of one or more persistent panic attack-related conditions for at least 1 month (American Psychiatric Association [APA], 2022). Such panic attack-related conditions include behavioral changes (e.g., avoiding situations that might trigger the attack), and persistent worry or concerns that one will have another attack. Additionally, the panic attack must not result from other potential causes, such as social phobia, post-traumatic post disorder (PTSD), obsessive-compulsive disorder (OCD), separation anxiety, and physiological effects of substance use or a medical condition (APA, 2022).

Panic Attacks: A sudden surge of intense fear or intense discomfort, loss of control, and physical symptoms, including fast heartbeat, sweating, shivering, chest pain, feelings of choking and dizziness, nausea or abdominal distress, derealization, depersonalization, chills or hot flushes, fear of dying, numbness or tingling sensation, lighted head, and faint (APA, 2022; Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al., 2021). Basic panic attack diagnostic criteria include a period of intense fear or discomfort and a sudden appearance of at least four of these symptoms, which reach a peak within 10 minutes (APA, 2022; Olaya et al., 2020).

Agoraphobia: The fear or anxiety about being in situations or places (e.g., public transportation, being open spaces, standing in line or being in crowd, presenting a public speech) where a panic attack may occur and from which escape might be difficult and immediate help might be unavailable (APA, 2022). Additionally, the agoraphobia situations must be actively avoided, and fear, anxiety, or avoidance must persist for at least 6 months for one to be diagnosed with agoraphobia. Also, the fear, anxiety, or

avoidance does not result from other potential causes, such as specific phobia, OCD, PTSD, and separation anxiety (APA, 2022).

Black Americans: A racial group in the United States that includes a heritage of the Caribbean or West Indian (e.g., Haitian or Jamaican), African (e.g., Biafra, Ghana, and Kenya), African Americans, and other Black non-American descents (Gina et al., 2016).

Risk Factors: Variables that increase the risk of developing a health problem. Risk factors are not the main cause of a health problem, but variables correlated with the disorder (Rashedi et al., 2020). Thus, risk factors predispose individuals to specific disorders, thereby increasing the probability of developing those disorders. For instance, having abusive parents or being neglected as a child might predispose the individual to an anxiety problem.

Assumptions

I made three primary assumptions in this study. Firstly, more schema modes than reported in the literature are associated with panic disorder. This assumption was based on the new category of schema coping mode (known as repetitive, unproductive thoughts), identified most recently (Edwards, 2022). Most of these schema coping modes have basic characteristics associated with panic disorder, including overanalyzer, denial ruminator, worrying overcontroller (e.g., catastrophizer and threat image ruminator), and pessimistic or depressive ruminator. Moreover, most of these coping schema modes are responses to the EMSs associated with panic disorder. For instance, the pessimistic or depressive ruminator involves repetitive thoughts associated with the EMSs of

abandonment, incompetence/dependence, and social isolation (Edwards, 2022). The catastrophizer is a coping mode in response to the vulnerability to harm schema.

My second assumption was that more EMSs than reported in the literature are associated with panic disorder. This assumption was based on the observation that the same schema mode can be triggered by different EMSs (Arntz et al., 2021). For instance, the guilt-inducing mode found to be associated with panic disorder can be triggered by self-sacrifice, which is associated with panic disorder in the literature. However, the same schema mode can be triggered by negativity and pessimism schema, which is yet to be associated with panic disorder.

My third important assumption was that Black Americans with panic disorder are far greater than White Americans and other ethnic groups, contrary to what is reported in the literature. This assumption is based on previous research, which has shown that Black Americans with panic disorder are more likely to avoid questions related to panic disorder. For instance, Black Americans avoid such questions as: Have you ever in your life had an attack of fear or panic when all of a sudden you felt very frightened, anxious, or uneasy) when completing questionnaires on mental health problems (Levin et al. (2013). Similarly, Black Americans with panic disorder are more likely to be misdiagnosed with another serious mental health problem (Bell et al., 2016).

Scope and Delimitations

This study focused on clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder and the meaning clinicians ascribed to these experiences. Based on these experiences, I sought to obtain an in-depth understanding of

techniques, strategies, and practices of effective schema-focused therapy for Black Americans with panic disorder. The Black American population for this study included Caribbean Blacks (e.g., Haitian or Jamaican), Africans (e.g., Biafra, Ghana, and Kenya), African Americans, and other Black non-American descents (Gina et al., 2016). The conceptual framework for the study was the schema-focused model, an integrative model that includes EMSs, schema modes, coping modes, maladaptive emotional schemas, and schema techniques.

A generic qualitative approach was used to uncover clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder, and the meaning clinicians attributed to these experiences. The phenomenological methodology was not used in this study because the study did not focus on the shared living experiences of Black Americans with panic disorder but on clinicians reporting their experiences of using schema-focused therapy with Black Americans with panic disorder and the interpretation and meaning clinicians ascribed to these experiences (see Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). A nonprobabilistic and purposive sampling strategy was used to choose participants carefully (see Queirós & Almeida, 2017). Additionally, participants were limited to 14 male and female clinicians in the United States of America practicing schema-focused therapy. Each respondent received an audiotaped semistructured interview regarding their experiences of using schema-focused therapy in Black Americans with panic disorder. The clinicians selected were from different sections of the state to prevent bias.

Additionally, the data collected were limited to schema-focused therapy performed since 2017. I manually performed thematic data analysis, a flexible analytical method to derive the central themes from data, on the information received. It is imperative to underscore that the opportunistic sampling strategy, the small number size, and other limitations of a qualitative study impacted the representativeness of the sample and the generalizability of the study findings. However, the study interpretations and conclusions would be suggestive for other contexts and so are transferable to similar contexts (see Ghafouri & Ofoghi, 2016; Nassaji, 2020).

Limitations

One limitation of this study was the difficulty of accessing clinicians' performance on schema-focused therapy with Black Americans with panic disorder. This limitation reduced the opportunity to recruit clinicians with the best schema-therapy records for Black Americans with panic disorder (see Hughes et al., 2022). Another limitation of this study was the impossibility of exploring how schema-focused therapy addressed some schemas among Black Americans. There are several schema modes in addition to EMSs and emotional schemas. It was not possible to obtain information regarding all these schemas during the interview on the experiences of schema-focused therapy in Black Americans with panic disorder. The length of time individuals had undergone schema-focused therapy might have also prevented a vivid recall of the therapy experience (see De Klerk et al., 2017; Tan et al., 2018). Additionally, there was no participants' demographic information (e.g., states, ethnicity, and age). Such

knowledge might have been useful in gaining a better understanding of the participants' backgrounds and biases.

Using Zoom video with the camera off to collect data was another limitation of the current study. While this method made participants more anonymous, encouraging them to be more objective, it prevented the ability to observe participants' physical expressions during the interview. In this way, a wealth of useful knowledge about the study was omitted. Similarly, the researcher's bias (e.g., unconsciously influencing the interviewee's response by showing approval or disapproval with a smile, frown, or other body gestures) might have reduced the objectivity of the study findings (see Ghafouri, & Ofoghi, 2016; Nassaji, 2020). Consequently, a nonprobability sampling strategy was used for this study to choose participants carefully to reduce interview biases (see Queirós & Almeida, 2017). However, this opportunistic sampling strategy impacted the representativeness of the sample. Also, in qualitative research, respondents are small in number, and the study results were interpretive (Nassaji, 2020). Consequently, the findings of this study are not generalizable. Rather, the study interpretations and conclusions are only transferable to other similar contexts (Ghafouri, & Ofoghi 2016; Nassaji, 2020).

Significance

As already indicated, panic disorder is a significant health problem among Black Americans, and schema-focused therapy has been adopted for several chronic mental health problems, including panic disorder. Schema-focused therapy has also been used with the Black American population. However, the research literature has not addressed

clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder. Therefore, this study is significant in that it provides clinicians' perceptions of using schema-focused therapy with Black Americans with panic disorder and the meaning clinicians attribute to these perceptions. Additionally, uncovering these experiences helps to obtain an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy in Black Americans with panic disorder, enhance knowledge in professional practices regarding using schema-focused therapy for Black Americans with panic disorder and improve the implementation of schema-focused therapy with the population. For instance, considering clinicians' perceptions about which aspects of schema-focused therapy with Black Americans with panic disorder are unhelpful and their recommendations will lead to an effective schema-focused therapy with this population. Consequently, this study has several implications for positive social change, including improving schema-focused therapy among Black Americans with panic disorder and enhancing the mental health of Black Americans and their trust in health services.

Summary

Based on the previous literature, this research sought to fill the gap of exploring clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder. In the current study, I used a generic qualitative method to explore with a sample of male and female clinicians (n = 12) their experiences of using schema-focused therapy with Black Americans with panic disorder and the meaning these clinicians ascribe to their experiences. The knowledge generated from this will help therapists

improve the implementation of schema-focused therapy with Black Americans with panic disorder. Because this is a qualitative study, the study findings are not generalizable. However, the study interpretations and conclusions would be suggestive and transferable to other similar contexts (Ghafouri & Ofoghi, 2016; Nassaji, 2020). The focus of the next chapter is on an in-depth review of related literature that systematically reveals how clinicians' experiences of using schema-focused therapy with Black Americans is a gap that is justified, grounded in the literature, original, and amenable to scientific study.

Chapter 2: Literature Review

Introduction

In this chapter, I present an overview of the research conducted on schema-focused therapy among Black Americans with panic disorder to highlight the research gap in the literature appropriate for the current study and the relevance of the study problem. The problem that I addressed in this study was clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. The schema-focused model has been used more frequently to conceptualize and treat personality disorder characteristics than any other psychological problem since its development (Bach & Farell, 2018; Bach et al., 2018; De Klerk et al., 2017; Kunst et al., 2020; Young & Lindemann, 1992; Young, 1999; Tan et al., 2018). Recently, research has shown a significant association between schemas and anxiety disorders (Mammad et al., 2017; Peeters et al., 2021; Tariq et al., 2021; Thiel et al., 2016; Yigit et al., 2018; Zadahmad & Torkan, 2016). Precisely, recent studies have suggested that a focus on schema may provide effective treatment for patients with panic disorder because such patients usually present high levels of maladaptive schemas resisting Beck's cognitive therapy and other focused interventions (Demir & Soygut, 2015; Kianipoor et al., 2020; Kwak & Lee, 2015; Oguz et al., 2019; Peeters et al., 2021; Petrowski et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018). Research has also revealed that panic disorder is a significant public health problem among Black Americans (Erving et al., 2019; Hofmann & Hinton, 2014; Jones et al., 2020; Kisely et al., 2017; Nguyen et al., 2020; Thomas et al., 2022) and highlighted the application of the schema-focused model for Black Americans (e.g.,

Abrams et al., 2018; Allen et al., 2019; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Liao et al., 2020; Mahbubani, 2022; Sims et al., 2019; Watson-Singleton, 2017). Research has also highlighted clinicians' experiences of using schema-focused therapy for chronic psychological problems (Beterhoven de Haan & Lee, 2014; Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Tan, 2015; Ten Napel-Schutz et al., 2017).

However, none of these studies addressed clinicians' experiences of using schema-focused therapy among Black Americans with panic disorder (e.g., Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Ten Napel-Schutz et al., 2017). To fill this gap, the study problem I addressed was clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. The purpose of the current study was to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. I explored clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder, and the meaning clinicians ascribe to these experiences. The findings from this study include an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy for Black Americans with panic disorder.

In this overview of the existing body of literature on clinicians' experiences of using schema-focused therapy among Black Americans with panic disorder, I concentrate on several themes related to the research question. These themes include the history of the application of schema-focused therapy, schemas associated with panic disorder, schema-focused therapy with Black Americans, panic disorder as a major health problem

among Black Americans, risk factors for panic disorder in Black Americans, and clinicians' experiences of using schema-focused therapy. Additionally, I present the conceptual framework of the current study, namely, the schema-focused model. This section includes discussion ofEMSs and their domains, schema modes, schema coping styles, and schema-focused therapy techniques. The chapter ends with a summary of the key findings from the literature, highlighting the literature gap and the relevance of the study.

Literature Search Strategy

I conducted a thorough search of the literature on clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder through the electronic library databases at Walden University. The keywords used for this literature search included *panic disorder, schema-focused model, integrative-schema model, schema-focused therapy, imagery rescripting, schema diary, emotional schema, chairwork, behavior pattern break, cognitive restructuring, early maladaptive schemas, EMSs, clinicians' perceptions of schema-focused therapy, clinicians experiences of schema-focused therapy, therapists' experiences of schema therapy, therapists' perception of schema therapy, practitioner's perceptions of schema therapy, epidemiology, African Americans,* and *Black Americans.* Similarly, the databases that I searched included PsycARTICLES, PsycINFO, PsycETRA, PsycBOOKS, SAGE Journals, Google Scholar, Thoreau Multi-database Search, and EBSCO.

Conceptual Framework

The concept that I used to ground this study was the integrated schema-focused model, a clinical model that integrates important concepts and models, including EMSs, schema modes, schema coping styles, schema domains, and schema therapy techniques (see McGinn & Young, 1996; Young & Lindemann,1992). The integrated schema-focused model is associated with Young (1990, 1999), who expanded on Beck's cognitive therapy to conceptualize and treat chronic psychological problems (e.g., personality, anxiety, and mood disorders) that resist Beck's cognitive therapy. Schema modes and EMSs are central to the schema-focused model because they are the basis for case conceptualization and a guide to schema therapy practice (Edwards, 2022). In this section, I will focus on EMSs, schema modes, schema coping styles, and schema techniques as essential concepts providing guidelines for the exploration of the clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder and reviewing previous studies on the key related variables and concepts. I will also explore the application of the schema-focused model to panic disorder.

Early Maladaptive Schemas and their Domains

EMSs are broad and pervasive dysfunctional patterns of emotion, thoughts, and behavior regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime (Young, 1999; Young & Lindemann, 1992; Young et al., 2003). Individuals develop EMSs when core emotional needs are deprived during childhood. These emotional needs include a secure attachment to others (e.g., safety, secure base and exploration, acceptance and empathy, stability, nurturance,

and emotional needs); competence, autonomy, and sense of identity; freedom to express valid needs and emotions; the ability to be spontaneous and playful; and realistic limits and self-control (Young et al., 2003). Aversive childhood experiences, including the unresponsiveness of parents or caregivers, abuse, racial discrimination, and traumatic life events, are the source of unmet core emotional needs that consequently lead to EMSs.

Early Maladaptive Schema Domains

Eighteen EMSs have been enumerated and grouped into five categories or domains (Galum & Soygut, 2022). These domains include disconnection and rejection, impaired autonomy and achievement, impaired limits, other-directedness, and hypervigilance and inhibition.

Disconnection and Rejection. The domain of disconnection and rejection is associated with the core emotional need for secure attachment. It includes schemas that disrupt connection with others and hamper secure attachment relationship formation. Individuals with schemas from this domain do not usually develop or maintain healthy intimate, family, or social relationships. Such individuals have a higher degree of relationship conflicts because these schemas disrupt the expectations that their emotional needs and the need for stability, security, and safety will be fulfilled in relationships (Young & Lindemann,1992). Childhood dynamics associated with this schema include loneliness, detachment, explosiveness, abuse, and rejection. This schema category contains five EMSs: emotional deprivation, instability and abandonment, abuse and mistrust, shame and defectiveness, and social isolation and alienation (Galum & Soygut, 2022). For instance, social isolation and alienation schema includes thoughts or feelings

that one is outwardly undesirable to others (e.g., ugly, sexually undesirable, low in status, poor in conversational skill, dull), isolated from the world, different from others, and does not belong to any group or community (Boudoukha et al., 2016; Young & Lindemann, 1992). The schema of abuse and mistrust involves the expectations that others are usually harmful, including having the tendency to lie, cheat, humiliate, hurt, abuse, manipulate, take advantage, or explode with violence and anger (Boudoukha et al., 2016; Boudoukha et al., 2016).

Impaired Autonomy and Achievement. This schema category involves expectations about oneself and the environment interfering with one's belief in one's ability to survive and function independently (Young & Lindemann, 1992). Thus, the schema domain includes schemas that make it difficult to develop a strong sense of self and function in the world as an adult. This schema is often present as pervasive passivity. The core emotional needs associated with this schema domain include the need for autonomy, competence, and a sense of identity. There are four EMSs within this schema category: dependence/incompetence, vulnerability to harm and illness, enmeshment/undeveloped self, and failure (Galum & Soygut, 2022). For instance, the schema of enmeshment/undeveloped self involves excessive emotional closeness and involvement with significant others, resulting in an undifferentiated self and a lack of normal social development (Boudoukha et al., 2016; Young & Lindemann, 1992). The failure schema is the belief in one's fundamental inadequacy compared to others in areas of achievement, including career, education, music, and sports (Boudoukha et al., 2016;

Young & Lindemann, 1992). Thoughts related to this schema include believing that one is stupid, inept, and ignorant.

Impaired Limits. The schema domain of impaired limits includes schemas that affect self-control or internal limits, making it difficult to respect the rights of others, boundaries, and limits and meet one's personal goals. This schema domain develops within families with the parenting style of permissiveness and indulgence. The core emotional needs associated with this schema domain are realistic limits and self-control. Two EMSs are within this schema category: grandiosity/entitlement/self-centeredness and lack of self-control/self-discipline. The schema of self-centeredness or grandiosity involves the self-perception that one should have whatever one wants regardless of its cost to others and without empathy toward others' needs (Young & Lindemann, 1992). The lack of self-control schema involves excessive difficulties in exercising sufficient self-control and frustration tolerance in the expression of one's emotions and impulses or in achieving one's personal goals (Boudoukha et al., 2016; Young & Lindemann, 1992).

Other-Directedness. This schema category includes schemas that lead one to prioritize the needs of others over one's needs. Thus, the schema domain involves inordinate suppression, restriction, or ignoring of one's emotions, decisions, preferences, and needs to prioritize others' needs and preferences. The core needs associated with this schema domain are the freedom to express valid needs and emotions. This schema domain contains four EMSs: subjugation, overresponsibility/self-sacrifice, emotional inhibition, and approval-seeking. For instance, the subjugation schema involves the perception that one's desires are not as valid or important as the other, leading to the

excessive surrendering of control over one's decisions and preferences, usually to avoid anger, retaliation, or abandonment.

Hypervigilance and Inhibition. This schema domain involves schemas that prioritize avoiding failure or mistakes through alertness, rules, and disregarding desires or emotions. It contains three EMSs: unrelenting standards, pessimism and negativity, and punitiveness. For instance, unrelenting standards involve striving relentlessly to meet high standards or expectations of oneself or others at the expense of happiness, pleasure, relaxation, spontaneity, playfulness, health, satisfying relationships, and accomplishment (Boudoukha et al., 2016; Young & Lindemann, 1992). The punitiveness schema is the belief that people should be harshly punished for making mistakes. Individuals with this schema tend to be angry, intolerant, punitive, and impatient with the self or others for not meeting up to expectations or standards (Young et al., 2003).

Schema Modes and their Domains

According to Young's schema theory, specific stimuli can activate EMSs, leading to behavioral, cognitive, and emotional responses, which will dominate an individual's information processing (Young et al., 2003). Schema modes are distinct states of feeling, behaving, and thinking activated in the present in response to how the individual copes with the threat of EMSs (Arntz et al., 2021). Therefore, a schema mode is the combination of activated EMS and how one copes with them (Beterhoven de Haan et al., 2019). Compared to EMSs, schema modes are momentary and can be either adaptive or disruptive in response to current events (Dadomo et al., 2016; Beterhoven de Haan et al., 2019; Young et al., 2003). Suffice it to underscore that the same EMS (e. g.,

shame/defectiveness) can underlie different types of problems (e.g., depression, approval-seeking, self-sacrifice, perfectionism). However, the type of schema mode activated for responding or coping with the EMS determines which of these problems will be expressed (Arntz et al., 2021). Similarly, the same problem (e.g., depression) can result from different EMSs (e.g., abandonment and shame/defectiveness). Over 80 Schema modes have been identified. They are divided into four domains or categories: Unheathy child modes, parent (or inner critic) modes, healthy modes, and coping modes (Dadomo et al., 2016; Edwards, 2022).

Unhealthy Child Modes. These are vulnerable and angry or unsocialized child modes, which are unhealthy emotional states associated with unmet childhood needs. Thus, individuals with maladaptive child modes think, feel, and behave like children when their needs are not met. For instance, individuals with this mode show intense and dysregulated emotions, including anger, shame, sadness, hopelessness, helplessness, loneliness, depression, and anxiety when their needs are not met (Arntz et al., 2021; Dadomo et al., 2016, Edwards, 2022). The schema modes strongly experience most EMSs and encompass most psychological problems patients experience. Additionally, many other modes belonging to other domains of schema modes are derived from vulnerable child modes. Therefore, the vulnerable child modes provide the most apparent manifestation of unmet needs and are regarded as schema therapy's core mode (Back et al., 2018; Dadomo et al., 2016). Vulnerable child modes include neglected or lonely child, rejected child, deprived child, terrified child, abused child, desperate child, humiliated and inferior child, and subordinate child (Arntz et al., Bach et al., 2018;

Edwards, 2022). Other vulnerable child modes include victimized child, over-diligent child, confused child, constrained child, lying child, sulking child, and dependent child (Arntz et al., 2021; Edwards, 2022). Angry or unsocialized child modes includes angry child, enraged child, impulsive or undisciplined child, defiant child, stubborn and rebellious child, aggressive child, grandiose child, deceptive child, and spoilt or entitled child. Each unhealthy child mode is associated with underlying EMS. For instance, the EMSs associated with activating the neglected child schema mode include defectiveness/shame, emotional deprivation, social isolation, and abandonment; the abandoned child mode is associated with abandonment schema; etc. (Arntz et al., 2021; Edwards, 2022).

Parent or Inner Critic Modes

These are dysfunctional modes involving the internalization of punitive, anxiety-inducing or demanding, and guilt-inducing messages or voices from parents or other authorities (Bowker, 2021; de Hann et al., 2019; Edwards, 2018). Precisely, individuals in this schema mode treat themselves the way their parents or other authorities did during their childhood (Bowker, 2021; Young et al., 2003). Such internalized critical messages or voices include: “I am worthless, empty, unimportant, unwanted, inadequate, unworthy.” Individuals with this schema mode usually anticipate internalized negative and critical voices from others, thereby undermining positive responses from them and sabotaging their interpersonal relationships (Edwards, 2022; Teyber & Teyber, 2017). They project onto others these internalized messages (e.g., seeing others as rejecting, neglectful, abandoning, blaming, punitive, abusive, controlling, overprotective,

demanding, unpredictable, dismissing, or hurting). Critical, demanding voices also lead one to the other extreme of being bossy, punitive, controlling, blaming, and judgmental toward others.

Parent modes have three types: punitive, guilt-inducing, and anxiety-inducing or demanding messages. Punitive parent modes are the demeaning voices emphasizing that the individual is worthless, useless, inadequate, empty, unimportant, unwanted, too needy, too demanding, too dependent, etc., for expressing one's needs or for making mistakes. Consequently, people with this schema mode have strong inhibitions to expressing their needs and feelings or an exaggerated sense of responsibility when things go wrong (Bowker, 2021; Teyber & Teyber, 2017). Guilt-inducing parent modes are internal critical voices that blame one for disappointing others and not living up to the ideals. Anxiety-inducing or demanding parent modes are inner critical voices demanding excessively high standards of achievement and self-control and condemning emotional expressions and spontaneous actions. People with this schema are always under pressure and anxiety to meet excessively high standards.

Healthy Schema Modes

Two types of healthy schema modes have been identified: healthy child modes and healthy adult modes. There are no EMS activations or adaptive functioning in both types of healthy schema.

Healthy Child Modes. These schema modes are healthy emotional states in which childhood core needs are met. One important healthy child mode is the authentic child schema mode, which involves engaging authentically with life, being in touch with

the true self, and expressing the true self (Edwards, 2022; Rivera et al., 2019). The authentic child is central to healthy child modes. Other healthy child modes include contented child (e.g., feeling connected, loved, protected, safe, fulfilled, and valued), happy child (e.g., self-confidence, optimism, spontaneity, joy, and positive affectivity), playful child (e.g., spontaneous playfulness and fun), and creative child (e.g., natural curiosity and creativity). A primary goal of schema therapy is to recover and strengthen clients' experience of this mode (e.g., restoring a lost emotional self).

Healthy Adult Modes. These schema modes represent how a full and mature functioning person thinks, feels, and behaves. According to Bernstein (2020), a healthy adult schema mode is the strength to function and meet our needs in healthy and adaptive ways. Healthy adult modes consider strengths and weaknesses realistically. Bernstein (2020) identified 16 positive qualities of healthy adult schema modes and grouped them into four factors. Each factor of the healthy adult is attainable through the qualities or strengths contributing to its overall strength. The first healthy adult factor is self-directedness, and it is the strength to focus on the course of one's life. Individual strengths contributing to the general strength of this factor are identity, self-awareness, self-assertion, self-confidence, and imagination (Bernstein, 2020).

The second healthy adult factor is self-regulation, which is the strength to regulate impulses, emotions, thoughts, and behavior. Specific strengths contributing to the general strength of self-regulation include emotional balance and resilience, self-control, self-care, and reality testing or appraising if one's ideas, feelings, and perceptions are real, objective, and rational (Bernstein, 2020). The third healthy adult factor is connection,

which is the strength to engage in meaningful, mutual relationships. This factor contains four strengths: empathy, compassion, humor, and responsibility or taking one's roles and obligations seriously and being reliable and trustworthy (Bernstein, 2020). The fourth healthy adult factor is transcendence, which is the strength to pursue higher meanings in life and relationships. Strengths contributing to the overall strength of transcendence are wisdom, thankfulness, knowledge, learning from experience, and having good judgment (Bernstein, 2020).

Schema Coping Modes

As noted earlier, the schema mode is the present state of feeling, thinking, and behaving in response to EMS activations and how one is coping with these reactions Thus, a person's coping style with responses to the EMS activation results in the schema mode. Young and Lindemann (1992) have identified three schema processes or coping styles to respond to EMS activations: schema avoidance, schema overcompensation, or schema rigidity or surrender. Another way to describe these coping styles is flight (avoidance), fight (overcompensation), and freeze (surrender or rigidity). Edwards (2022) identified repetitive, unproductive thinking as the fourth category of coping mode. In any case, these coping modes are generally dysfunctional and perpetuate schemas as individuals employ them to avoid, control, or block the pain resulting from schema triggers, leading to problems in life and relationships.

Schema Surrender. In this coping category, the individual surrenders or freezes to an EMS activation by accepting the EMSs as if they were true (e.g., I am unlovable, worthless, empty, unimportant, unwanted, inadequate, defective). According to schema

theory, schema surrender leads to vulnerable child modes and parent modes (Arntz et al., 2021; Young et al., 2003). For instance, surrendering to the abandonment EMS results in abandoned child mode; surrendering to punitiveness EMS leads to the punitive parent mode. The coping styles of surrendering to schemas are grouped into seven: compliance surrender, helpless surrender, self-sacrificer or rescuer, self-pity victim, reassurance seeker, passive resistor, and rolling stone (Dadomo et al., 2016; Edwards, 2017; Edwards, 2022; Simpson et al., 2018; Simpson, 2020). For instance, compliant surrender is the coping mode in response to EMS activation in which one focuses on meeting others' needs at the cost of one's needs because one wants to avoid rejection due to negative beliefs that one is unlovable, unworthy, or because one is afraid of conflict.

Schema Avoidance. This coping mode category involves flight, avoiding, or escaping EMS activation cognitively (e.g., distracting painful thoughts from coming to consciousness), emotionally (e.g., terminating relationships with others), and behaviorally (e.g., avoiding people, places, events, discussions, etc. that trigger the pain of the EMSs). Avoidance strategies include detached protector, avoidant protector, angry protector, deceptive protector, and self-soother (Dadomo et al., 2016; Arntz et al., 2021; Edwards, 2022). In the detached protection, individuals suppress their feelings, needs, and other pains associated with the EMS activation, withdraw emotionally from others, and do not connect with others. Individuals with this coping mode usually avoid discussing their feelings, pretend to be self-sufficient, and suffer from boredom, emptiness, and resentment. Avoidant protector, the next coping mode in the avoidant

category, involves the behavioral avoidance of situations (e.g., people, places, activities, topics, conversations) that trigger the pain of the EMS activation.

Angry protector is a mode of responding to the EMS activation in which individuals use the wall of anger to prevent others from hurting them. Deceptive protector is characterized by using lies to escape from blame and shame. In deceptive protection, deceit is not deliberate and strategic (Edwards, 2017). In this way, deceptive protector differs from conning and manipulation. In the detached self-soothing mode, individuals actively engage in behavior that soothes or distracts from the unpleasant feelings of the EMS activation. Such behaviors are often addictive or compulsive (Young et al., 2003). They include spending time excessively on unproductive activities, including computer gaming, watching television, fantasizing, overeating, watching pornography, masturbation, taking recreational drugs, or self-medication. Other behaviors include excessive concentration on adaptive behaviors (e.g., working at home or in office), neutralizing disturbing intrusive thoughts and images, and passively or actively planning suicide (Edwards, 2022).

Schema Overcompensation. This is a coping mode category in which individuals fight to challenge the underlying EMS by adopting overcompensating cognitive and behavioral styles that are opposite to EMS activations (Arntz et al., 2021; Young & Lindemann, 1992). This coping style may ultimately backfire as individuals end up in the exact situation they are fighting to overcompensate because the process of overcompensation may lead to striving for power, control, dominance, and superiority over others. For instance, self-aggrandizers and narcissistic adults overcompensate their

underlying emotional deprivation schema. However, because of their dominance and control, such individuals end up alienating friends and reverting to a state of emotional deprivation (Young et al., 2003; Young & Lindemann, 1992). Overcompensatory coping modes include social overcompensator, strong and independent overcompensator, comic protector, rolling stone, pollyanna overcompensator, attachment seeker, overcontroller, detached self-stimulator, and externalizing overcompensator (Edwards, 2022).

Repetitive, Unproductive Thinking. Edwards (2022) identified repetitive, unproductive thinking as the fourth category of coping mode. The coping mode involves a repetitive rehearsal of thoughts and images without any productive planning or problem-solving. Edwards (2022) listed five repetitive, unproductive coping styles: overanalyzer, denial ruminator, worrying overcontroller, pessimistic or depressive ruminator, and angry ruminator. For instance, overanayzer involves repetitive thoughts that focus on self-doubt or self-questioning, including questioning the meaning of life. The denial ruminator is characterized by thought rehearsals that focus on denied reality (e.g., daydreaming, repetitive regretful thoughts regarding how acting differently would have saved a situation, etc.). The denial ruminator becomes the grief ruminator when the event that one wishes would have been prevented is the death of a loved one (Karantzas et al., 2022; Smith & Ehlers, 2020).

Schema-Focused Therapy Techniques

The overarching procedures for schema-focused therapy include schema identification schema (identifying schema modes and underlying EMSs), schema work to resolve identified problematic schemas, and schema change to help clients experience a

functional schema mode (Dadomo et al., 2016; Young & Lindemann, 1992). Different schema therapy techniques have been adopted to deal with maladaptive schemas through these stages. They include schema-focused questionnaires, schema-focused life history, schema psychoeducation, imagery rescripting, limited re-parenting, empathic confrontation, attunement, behavior-pattern breaking, schema diary, chairwork, and cognitive restructuring (Jing, 2018; Videler et al., 2017).

Schema Identification Techniques

Identifying the problematic schema mode and its underlying EMS is the first of schema-focused therapy**.** Techniques, including clients' interviews, schema-focused questionnaires, schema-focused life history, and guided imagery, are essential for assessing and identifying clients' past childhood experiences (Young & Lindemann, 1992). Schema-focused questionnaires confirm the initial information gathered through the client's interview. A schema-focused life history could be used to follow up with questions related to the schema-focused questionnaire.

Schema Work and Schema Change Techniques

At the stage of schema work, therapists rework and resolve the client's identified problematic schemas. Additionally, schema change is the stage during which therapists help clients experience healthy schema modes. Clients can use the same techniques to transition from the schema work stage to schema change. This observation means that same techniques can be adopted for both stages. These techniques include relational techniques (e.g., limited reparenting, attunement, and empathic confrontation), experiential procedures (chairwork and imagery rescripting), and cognitive-behavioral

interventions (e.g., psychoeducation, schema diary, flashcards, relaxation training, homework, and rewarding adaptive behavior).

Relational techniques help schema-focused therapists provide a safe haven that offers clients the security to affirm and express their needs, desires, and feelings abusive or punitive parent suppressed during childhood. In these therapeutic relationships, clinicians offer healthy countertransference to clients' transference and consequently help clients attain emotional-relational corrective responses (Dadomo et al., 2016). For instance, limited reparenting involves positive countertransference, including providing care, warmth, and acceptance to meet clients' core needs within therapy (Jing, 2018). In the empathic confrontation, clinicians simultaneously validate schemas and coping modes as an understandable outcome of clients' history (attunement) and draw clients' attention to the present adverse consequences of the maladaptive schemas (Dadomo et al., 2016; Jing, 2018; Gülüm & Soygüt, 2022; Young et al., 2003).

Experiential techniques are schema-focused techniques designed to focus on emotions associated with schema activations behavior-pattern breaking, schema diary, and attunement). For instance, imagery rescripting is designed to change the meaning of events, images, and associated memories crucial for forming maladaptive schemas so that clients re-experience them in a controlled manner and gain reduced emotional distress (Bosch & Arntz, 2021; Jing, 2018; Shibuya et al., 2018). Cognitive-behavioral techniques are designed to help clients understand their modes, coping strategies, and emotional functions; restructure thinking patterns; break maladaptive behavioral patterns; and transform outcomes (Dadomo et al., 2016; Gülüm & Soygüt, 2022). For instance, the

flashcard helps consolidate and rehearse adaptive behavior (Yong & Lindemann, 1992). Schema psychoeducation educates clients about the nature of schema modes and EMSs.

Finally, several studies have shown that the concepts of EMSs, schema modes, schema coping styles, and schema techniques have been conveniently and validly applied to panic disorder. Such studies indicate the validity of the schema-focused model in its application for panic disorder. Additionally, the focus on these four concepts (i.e., EMSs, schema modes, schema coping styles, and schema techniques) are essential guidelines for the exploration of clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder and reviewing previous studies on the key related variables and concepts. These four concepts of the schema-focused model will also provide guidelines for the type of data to be collected for the study and the data collection methods, including semistructured interviews and data analysis. The study framework is also intrinsically connected with the research problem, the study purpose, and the research question because they clearly center on clinicians' experiences of using schema-focused therapy.

The Schema-Focused Model for Panic Disorder

Although a few studies were conducted on the application of the schema-focused model to panic disorder and anxiety problems during the early stages of schema-focused therapy history (e.g., George et al., 2004; Gude & Hoffart, 2008; Gude et al., 2001; Hadley et al., 2001; Hoffart et al., 2002), the therapy model has been adopted more frequently in the past 10 years to treat panic disorder. For instance, in an earlier study, Hedley et al. (2001) examined how EMSs relate to the fear of losing control, body

sensations, and avoidance behavior in individuals (n = 59) undergoing treatment for panic disorder with agoraphobia. The study results revealed that the schema of vulnerability to harm predicted the fear of physical symptoms, beliefs about losing control, and avoidance behavior in individuals with panic disorder with agoraphobia. The result further indicated the vulnerability to harm schema predicted the incompetence and dependence schema in individuals with panic disorder with agoraphobia. In another earlier study, Hoffart et al. (2002) examined schema change in participants (n = 35) with panic disorder and/or agoraphobia and personality disorder using schema therapy that emphasized self-understanding (schema psychoeducation), empathy, and guided discovery. The authors found that clients' self-understanding was associated with a significant reduction of maladaptive schemas and the symptoms of panic disorder and agoraphobia. Also, therapists' empathy had a significant effect only upon symptomatic improvement associated with self-understanding. Guided discovery did not impact the distress.

Recently, empirical studies have shown frequent applications of the schema-focused model for panic disorder in isolation or panic disorder with other chronic problems (e.g., Demir & Soygut, 2015; Kianipoor et al., 2020; Kwak & Lee, 2015; Oguz et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018; Peeters et al., 2021). For instance, Shibuya et al. (2018) explored the therapeutic effects of the schema therapy technique of imagery rescripting and conventional CBT on individuals with panic disorder. The authors found a significant reduction of panic disorder severity only with imagery rescripting. Similarly, Kianipoor et al. (2020) compared the effectiveness of schema emotional schema therapy and mindfulness therapy in reducing cognitive distortions in

women (n = 45) with panic disorder. The study results indicated that both therapies reduced the women's cognitive distortions while maintaining similar levels of effectiveness.

Furthermore, Kwak and Lee (2015) examined how early maladaptive schema maintains panic disorder and OCD. The authors found that panic disorder is associated with activations in vulnerability to harm schema and self-sacrifice schema. In contrast, participants with OCD exhibited activation in shame/defectiveness schema, social isolation/alienation schema, dependence schema, and failure schema. Similarly, Oguz et al. (2019) investigated the similarities and differences between a healthy control group and the clinical groups of OCD and panic disorder in relation to three schemas: metacognitive beliefs, emotional schemas, and cognitive flexibility. The researchers found that individuals with panic disorder scored higher than the control group on the metacognitive beliefs of uncontrollability, danger, and the need to control thoughts. The study results also revealed that participants with panic disorder and OCD scored significantly higher than the control group on the emotional schemas. Additionally, Sardarzadeh (2017) also observed that EMSs could predict emotional schemas in panic disorder, social phobia, specific phobia, obsessive-compulsive disorder, post-traumatic stress, and acute stress. Peeters et al. (2021) also found a significant decrease in panic disorder, OCD, GAD, SAD, and PTSD in their study in which individuals with anxiety disorders, who resisted CBT treatment guidelines, were treated with the combination of schema therapy, exposure therapy, and response prevention.

Similarly, many recent studies have also shown a significant association between the schemas-focused model and anxiety disorders without specifically mentioning panic disorder (e. g., Bosch & Arntz, 2021; Mammad et al., 2017; Tariq et al., 2021; Yan et al., 2018; Yigit et al., 2018; Zadahmad & Torkan, 2016). For instance, Mammad et al. (2017) investigated the association of anxiety problems with EMSs in university students and found that the activation of specific schemas, including emotional deprivation, social isolation, enmeshment, vulnerability, incompetence, and insufficient self-control, influenced the development of anxiety disorders. Tariq et al. (2021) conducted a meta-analysis of the strength of association between schemas and anxiety symptoms in individuals from ten to 29 years old. They found a strong association between anxiety and EMSs (r = .059), including the schema domains of disconnection/rejection (r = .50), impaired autonomy/performance (r = .47), and other-directed (r = 0.49).

Literature Review Related to Key Variables and/or Concepts

Key variables and concepts reviewed with the existing body of literature on clinicians' experiences of using schema-focused therapy among Black Americans with panic disorder include panic disorder as a major health problem among Black Americans, risk factors for panic disorder in Black Americans the history of schema-focused therapy application. Other variables and concepts reviewed include schemas associated with panic disorder, the schema-focused model with Black Americans, and clinicians' experiences using schema-focused therapy.

Panic Disorder as a Major Health Problem Among Black Americans

Research has revealed that panic disorder is a significant public health problem among Black Americans (e.g., Erving et al., 2019; Hofmann & Hinton, 2014; Jones et al., 2020; Kisely et al., 2017; Levine et al., 2013; Mendoza et al., 2012; Nay et al., 2013; Nguyen et al., 2020; Sibrava et al., 2013; Thomas et al., 2022). Nguyen et al. (2020) reported that panic disorder is one of the anxiety disorders most prevalent among African Americans. Sibrava et al. (2013) conducted a longitudinal study with African American adults (n = 152) diagnosed with panic disorder with agoraphobia (n = 77), GAD (n = 94), and social anxiety disorder (n = 85) to underscore clinical (e.g., functioning and comorbidity) and demographic characteristics and the probability of recovery over a two-year course. The authors found that the recovery rates of panic disorder with agoraphobia, GAD, and social anxiety disorder were .00, .023, and .07, respectively. The authors further noted that these rates of recovery, especially panic disorder with agoraphobia and social anxiety disorder, were markedly low. This observation indicated that panic disorder and other anxiety disorders have a more chronic course for African Americans, with increased psychosocial impairment and high rates of comorbidity. Therefore, this study supports the position that panic disorder is a significant chronic health problem among Black Americans.

In a meta-analytical study, Kisely et al. (2017) compared the prevalence of common mental health disorders (panic disorder, GAD, OCD, PTSD, and depression) in indigenous populations (e.g., American Indians, Alaska Native peoples) across America with non-indigenous populations (e.g., Caucasians, African Americans, Hispanics) from

the same countries. Among other things, the authors found that the lifetime prevalence of panic disorder, GAD, and depression was significantly higher in African Americans and other non-indigenous populations compared to non-indigenous populations. However, they did not find any significant differences between indigenous and non-indigenous groups in the 12-month prevalence of panic disorder, GAD, and depression.

Erving et al. (2019) and Thomas et al. (2022) examined the Black-White mental health epidemiological paradox (i.e., Blacks have lower mental health problems than Whites, contrary to the expectation that Blacks will have worse mental health outcomes than Whites) across 12 lifetime and past-year psychiatric disorders, including panic disorder, and the paradox consistency with gender and age. Erving et al. (2019) reported that, although the paradox generally extends across lifetime and past-year for women and men, Blacks and Whites experienced similar rates for panic disorders, PTSD, bipolar disorders 1 and 2, dysthymic disorder, substance use disorder for past-year. Specifically, the paradox does not so much apply to panic disorder for the past year. Thomas et al. (2022) found more similarities in mental disorders between older Blacks and Whites compared to younger Blacks and Whites. The findings of the two studies suggested that Black-White differences are less pronounced in panic disorder, especially among older adults. Therefore, the two studies are indicative that panic disorder is a significant health problem among the black population in the U. S.

Similarly, Levine et al. (2013) reported that panic disorder is a lifetime prevalent and significant disorder for African Americans and Caribbean Blacks. Levine et al. (2013) examined, among other things, the demographic correlates of panic disorder

among African Americans, Caribbean blacks, and non-Hispanic White Americans using the National Comorbidity Survey-Replication (NCS-R) and the National Survey of American Life (NSAL). The author observed that panic disorder was a prevalent and significant disorder across a lifetime for African Americans and Caribbean Blacks, and non-Hispanic Whites. However, Non-Hispanic Whites reported higher rates of panic disorder (4.8%) than Caribbean Blacks (4.1%) and African Africans (3.5%). Hofmann and Hinton (2014) also reported similar results regarding panic disorder for Hispanic Americans (4.1%) and African Americans (3.8%). These two studies are similar to an earlier study in which Asnaani et al. (2009) examined the rates of panic disorder, panic attacks, and panic attack symptoms among African Americans, Latinos, Asians, and Whites residing in the United States. Using the collaborative Psychological Epidemiological Studies (CPES), which comprises three major national epidemiological databases (NLAAS, the National Latino and Asian American Study of Mental Health; NSAL, the National Study of American Life; and NCS-R, the National Comorbidity Survey Replication), Asnaani et al. (2009) found that Whites reported the higher rates of panic disorder compared to African Americans and other racial minorities. The authors recommended future studies for a more rigorous investigation into ethnic and racial differences in panic disorder, panic attacks, and panic symptoms.

Clarifying why African Americans and Caribbean Blacks reported lower rates of panic disorder than non-Hispanic White Americans, Levin et al. (2013) maintained that methodological issues related to cultural differences were a significant factor. For instance, many African American and Caribbean Black respondents avoided the

screening question, “Have you ever in your life had an attack of fear or panic when all of a sudden you felt very frightened, anxious, or uneasy.” (p. 8). Not responding to this question might mean that it is not culturally relevant for African and Caribbean Black participants. Similarly, Medoza et al. (2012) observed that Black Americans and other minority ethnic and racial groups are underrepresented in randomized control trials and treatment outcome studies of panic disorder and enumerated several reasons for the underrepresentation. Conducting a study review on minority inclusion in randomized clinical trials of panic disorder with 47 studies, the authors noted that only 21 studies, which account for less than half of the randomized clinical trials, provided information on the ethnic and racial data for their sample. Among the total participants (n = 2687) in the 21 studies, 82.7% were European Americans/non-Hispanic White, whereas Black Americans (4.9%) and other minority groups (12.4%) share the remaining percentage. According to Mendoza et al. (2012), these numbers representing Black Americans and other racial minorities are unacceptably low considering the proportional amounts needed to represent the United States population. Furthermore, Mendoza et al. (2012) indicated specific reasons for such an underrepresentation, including mistrust of the clinical trials and public health services, concerns about receiving inadequate treatment or misdiagnosis; physical accessibility; cultural approaches in response to mental health problems, and researchers’ bias. For instance, African Americans have a cultural memory of abuses, such as the US Public Health Service Syphilis Study at Tuskegee.

Regarding cultural approaches in response to mental health problems, Mendoza et al. (2012) maintained that Black Americans are more likely to correlate panic disorder

symptoms to physical or biological illness than to mental health problems. Consequently, Black Americans are more likely to see a primary care doctor and experience unnecessary hospitalization for panic disorder than seeing a mental health specialist. Cultural barriers also restrict Black Americans from fully expressing symptoms in a way that clinicians can understand, leading to possible underdiagnosis. In this light, research has shown that culture-matched clinicians are more likely to diagnose mental health issues properly (APA, 2022). Researchers' bias toward enrolling Black Americans is another important reason for the underrepresentation of Black Americans in the randomized control trials and treatment outcome studies of panic disorder. Researchers may selectively exclude participants they believe would be poor candidates based on beliefs that minorities may drop out prematurely, be unable to follow directions properly, or fail to follow study rules and procedures (Mendoza et al., 2012). Research may also be carried out in areas not convenient to Black American communities and other racial minorities or where they may not feel welcome (Mendoza et al., 2012).

Levine et al. (2013) also found panic disorder to be highly comorbid with other mental health problems among Black Americans. Using the National Comorbidity Survey-Replication (NCS-R) and the National Survey of American Life (NSAL), Levine et al. (2013) examined the comorbidities of panic disorder with other mental health problems among African Americans, Caribbean blacks, and non-Hispanic White Americans. The researchers found that panic disorder is highly comorbid with other mental health problems, but the comorbidities differ across the three sub-populations. Precisely, panic disorder was most comorbid with eating disorders among African

Americans (17%), followed by Caribbean Blacks (11.3%), and non-Hispanic Whites (5.9%). Panic disorder was also comorbid with internalizing disorders, including GAD, among African Americans (15.8%) and Caribbean Blacks (10.7%), but not as much as with non-Hispanic whites (35.6%).

Additionally, Jones et al. (2020) reported that African American women had more persistent panic disorder than Caribbean women. Jones et al. (2020) examined the ethnic and nativity differences in the prevalence of anxiety disorders (panic disorder, agoraphobia, social phobia, GAD, PTSD), mood disorders (dysthymia, major depressive disorder, bipolar disorders), and substance use disorder, their persistence, and unmet treatment utilization among Black women in the U. S. They found that one in three African American women, one in three Caribbean women born within the U. S., and one in five Caribbean women born outside the U. S. met the criteria for lifetime disorder. They further observed that, similar to Black men, about one-half of women with a disorder within each of these three groups suffer from the persistence of that disorder. They also reported that African American women had more persistent panic disorder and less social phobia than Caribbean women.

Risk Factors for Panic Disorder Among Black Americans

Many studies have implicated different risk factors associated with panic disorder, including discrimination and racial traumas, young and middle adulthood, living below the poverty line, major life stress, lower education, having two or more chronic conditions, smoking and alcohol abuse, traumatic events, and female gender (Carter et al., 2021; De Jonge et al., 2016; Levine et al., 2013; Oh et al., 2021; Olaya et al., 2018).

For instance, using cross-sectional data from a nationally representative sample of non-institutionalized adults (*n* = 4569), Olaya et al. (2018) investigated the prevalence of panic attacks and panic disorder over the lifespan and the moderating role of age and other risk factors. The authors found that panic disorder was most prevalent (9.5%) among adults between the ages of 30 and 39, the highest prevalence rate of panic disorder (3.3%) occurred in adults aged 40 to 49, and individuals aged 80 and above presented the lowest rate of panic disorder and panic attack. In addition to young and middle adulthood, the authors also reported that depression and poor quality of life were significant correlates of panic disorder and panic attacks. Similarly, essential correlates of panic attacks without panic disorder included being female and having two or more chronic conditions. Also, frequent drinking was a significant correlate of panic disorder, and older adults who drink frequently have a higher risk of panic disorder.

Furthermore, Moreno-Peral et al. (2014) reported similar risk factors associated with the onset of panic disorder in a systematic review of cohort studies on the risk factors for the onset of panic disorder and GAD in the general adult population. Moreno-Peral et al. (2014) also observed that risk factors for panic disorder were associated with age (20-54yrs), female gender, smoking, and alcohol problems. They also reported that family income, other anxiety disorders, other mental health problems (e.g., sleep disturbance, personality disorders), and parental and history of mental disorders (e.g., panic attack, agoraphobia, specific phobias, and major depression) were associated with the onset of panic disorders. In another study, Newman et al. (2016) examined adults (*n* = 20) with panic disorders, adults (*n* = 20) with GAD, adults (*n* = 11) with comorbid panic

disorder and GAD, and adults (n = 21) with non-anxious control to determine whether panic disorder and GAD could be discriminated through differences in developmental etiological factors including childhood pathology, parental death or separation, and maternal and paternal attachment. The study results indicated that childhood-specific phobia was associated with adult panic disorder, GAD, and mixed GAD and panic disorder; childhood depression was associated with adult GAD; panic disorder participants had excessive attention to attachment-related memories; panic disorder is associated with anxious-ambivalent attachment, whereas GAD is associated with avoidant and anxious-ambivalent (Newman et al., 2016).

These risk factors of panic disorder are inevitably present among Black Americans as a racial minority group struggling with racism, oppression, subjugation, and discrimination (e.g., Benner et al., 2018; Brown, 2019; Carter et al., 2021; Chou et al., 2012; English et al., 2020; Hearld et al., 2015; Jones & Neblett, 2017; Kijakazi, 2019; Lanier et al., 2017; Lavner et al. 2021; Manduca, 2018; Oh et al., 2021). For instance, Chou et al. (2012), Hearld et al. (2015), and Levine et al. (2013) observed that exposure to racial discrimination was a significant risk factor for panic disorder among African Americans, Caribbean Black participants, and other ethnic minority groups, such as Hispanics, Asians. Subsequently, several studies have confirmed that Black Americans often experience racial discrimination leading to chronic stress, traumatic events, and negative mental health (e.g., Benner et al., 2018; English et al., 2020; Jones & Neblett, 2017; Lanier et al., 2017; Lavner et al. 2021).

Additionally, Levine et al. (2013) reported that living below the poverty line was associated with a lifetime risk of panic disorder among African Americans and Caribbean Blacks. Subsequent research has also confirmed that one-third of Black American families live near or below the poverty line and that the median wealth for White American families is ten times that of Black American families (Carter et al., 2021; Kijakazi, 2019; Manduca, 2018). For instance, Carter et al. (2021) underscored that structural racism creates segregated and disadvantaged Black American neighborhoods with concentrated poverty, low education, and high unemployment rates. Studies have also shown that living substantially above the poverty line is associated with high chances of panic disorder among Black Americans because higher levels of socioeconomic status are more likely to live and work in racially diverse settings with more frequent exposures to racial discrimination (Levine et al., 2013).

Hearld et al. (2015) and Levine et al. (2013) also reported that age, smoking, alcohol consumption, and female gender are risk factors for panic disorders in Black Americans. For instance, Levine et al. (2013) found a significant elevation of lifetime panic disorder in African Americans and Caribbean blacks between the age of 35 and 54. Hearld et al. (2015) reported that smoking and excessive consumption of alcohol was a significant risk factor for panic attacks among African Americans, Caribbean Blacks, and other minority groups. Also, being female, especially those who never married, divorced, separated, or widowed, is associated with high chances of 12-month and lifetime panic disorder in Black Americans (Hearld et al., 2015; Levine et al., 2013). However, Levine et al. (2013) reported that the female gender was associated with a higher risk of panic

disorder among African Americans than Caribbean Blacks. Also, Caribbean Black men had higher rates of panic disorder than their women (Levine et al., 2013). This unexpected finding about Caribbean Black men and women might be because the men had a more difficult time finding employment and were more likely to be underemployed than women (Levine et al., 2013). Caribbean Black men might also experience a stressful weakening of family power in the USA, whereas their women enjoy more freedom from traditional general roles and more autonomy in the USA.

The History of Schema-Focused Therapy Application

Expanding on Beck's cognitive therapy and incorporating other theoretical orientations, Young (1990, 1999) developed schema-focused therapy to conceptualize and treat chronic psychological problems (e.g., personality, anxiety, and mood disorders) that resist Beck's cognitive therapy. Precisely, schema-focused therapy is a model that expands on Beck's cognitive therapy to incorporate techniques from objective relation, attachment theory, experiential and emotion-focused techniques, and psychodynamic approaches into a systematic treatment model to modify distorted schemas and achieve correctional emotional experience (Videler et al., 2017). It is imperative to note that Beck's cognitive therapy originally emphasizes three interconnected levels of cognitive distortions through which repetitive themes and schema bias occur in clients' thinking: automatic thoughts, intermediary cognition (consisting of rules, assumptions, and evaluations), and the deepest level of cognition or schemas about the self, others, and the world (encompassing more stable, negative core beliefs) from which distorted beliefs are generated (Beck, 1967; Tecuta et al., 2019).

Additionally, schema-focused therapy primarily emphasizes emotional needs, early life experience, and a therapeutic relationship as a means for therapeutic change, with therapists taking a stance of limited reparenting (Boterhoven de Haan & Lee, 2014; Kopf-Beck et al., 2020). These three aspects are also among the basic features distinguishing schema-focused therapy from CBT (Boterhoven de Haan & Lee, 2014; Kopf-Beck et al., 2020). Other aspects distinguishing schema-focused therapy from CBT include additional application of experiential and emotion-focused techniques (e.g., imagery rescripting and limited reparenting) in the development and maintenance of psychopathology and the use of schema modes, which refer to moment-to-moment emotional, cognitive, physiological states and coping responses (Bach et al., 2018; Kopf-Beck et al., 2020).

During its early stages, schema-focused therapy was most frequently applied to personality disorders, particularly borderline disorder, across different populations, including adolescents, young adults, middle-aged adults, and older adults (e.g., Farrell et al., 2009; Giesen-Bloo et al., 2006; Gude & Hoffart, 2008; Gude et al., 2001; Hoffart et al., 2002; Hoffart & Sexton, 2002; Lobbestael et al. 2005; Lobbestael et al., 2008; Muris, 2006; Nadort et al., 2009; Nordahi & Nysaeter, 2005; Young & Lindemann, 1992; Young, 1999; Western & Arntz, 2007). For instance, Nordahi & Nysaeter (2005) examined the effectiveness of schema therapy using a single case series design of female patients (n = 6) with borderline personality disorder. Essential techniques of schema therapy were schema mode work and limited reparenting. The preliminary case series of the therapy result indicated a significant clinical improvement among five of the six

participants. The result also showed that three participants did not meet the borderline disorder criteria at the end of the therapy. Also, Giesen-Bloo et al. (2006) compared the effect of schema therapy and transference-focused therapy in patients (n = 88) with borderline personality disorder after they received treatment for two sessions per week for three years. The result indicated that three years of schema therapy or transference-focused therapy significantly reduced borderline personality disorder and improved quality of life. The result further revealed that schema therapy was more effective than transference-focused therapy in reducing abandonment fear, identity disturbance, impulsivity, parasuicidal ideation, and dissociative and paranoid ideation.

Furthermore, most of these earlier studies on the application of the schema-focused model to personality disorders included other psychological problems that co-occur with personality disorders, particularly agoraphobia and panic disorder (Ball, 2007; Ball et al., 2005; Gude & Hoffart, 2008; Hoffart & Sexton, 2002; Hoffart et al., 2002; Muris, 2006). For instance, Gude and Hoffart (2008) and Hoffart and Sexton (2002) examined the evidence for applying the schema-focused model to patients with panic disorder and agoraphobia co-occurring with cluster C personality traits (i.e., avoidant, dependent, and obsessive-compulsive personality disorders). Gude and Hoffart (2008) used an experimental group (patients treated with a schema-focused therapy program) and a control condition (patients treated with usual psychodynamic principles) in their study. The study results revealed a more significant improvement in interpersonal problems among participants in the experimental group than patients in the control group. This study also had large effect sizes in the experimental group compared to low-to-

medium effects in the treatment as usual group. Similarly, Hoffart and Sexton (2002) examined the effects of optimism, a healthy child schema mode, in the process of schema-focused therapy and observed that increased optimism predicted decreased maladaptive schema and psychological distress. They also noted that reduced maladaptive schemas and increased patient-experienced empathy from therapists, in turn, increased patients' optimism; and increased patients' optimism, in turn, increased insight, empathy, and therapists' optimism. However, Hoffart and Sexton (2002) used no control condition in this study. Consequently, one needs to be cautious in making inferences from the study results because the reduced maladaptive schemas and psychological problems might be due to other variables.

Recently, schema-focused therapy is still frequently applied to personality disorders (e.g., Bach & Farell, 2018; Bernstein et al., 2012; De Klerk et al., 2017; Dickhaut & Arntz, 2014; Hilden et al., 2021; Kunst et al., 2020; Reiss et al., 2014; Renner et al., 2013; Skewes et al., 2015; Videler et al., 2014; Videler et al., 2017; Tan, 2015; Tan et al., 2018; Van Maarschalkerweerd et al., 2021; Ten Napel-Schutz et al., 2017; Van Vrewijik et al., 2014). Most of these studies recruited patients with borderline personality disorder (Bach & Farell, 2018; Dickhaut & Arntz, 2014; Hilden et al., 2021; Kunst et al., 2020; Reiss et al., 2014; Renner et al., 2013; Skewes et al., 2015; Tan 2015; Tan et al., 2018; van Maarschalkerweerd et al., 2021; Ten Napel-Schutz et al., 2017; van Vrewijik et al., 2014) and individuals with cluster C personality disorders (Kunst et al., 2020; Skewes et al., 2015; Videler et al., 2017). Two of these studies conducted a case series study on the effectiveness of s schema-focused therapy in reducing personality

disorder symptoms (Dickhaut & Artz, 2014; Videler et al., 2017). Four of these studies were group schema therapy (Dickhaut & Artz, 2014; Hilden et al., 2021; Skewes et al., 2015; Videler et al., 2014). Two of the studies examined the association of personality disorders with EMSs and schema mode (Bach & Farell, 2018; Kunst et al., 2020). Four of the studies examined the perceptions of patients and/or therapists on schema therapy for borderline personality disorder (De Klerk et al., 2017; Ten Napel-Schutz et al., 2017; Tan et al., 2015; Tan et al., 2018).

Apart from Hilden et al. (2021), who observed that schema-group therapy was not more effective than treatment as usual group, other studies examining the effect of schema-focused on personality disorders is that they all reported a significant reduction in personality disorder symptoms. Additionally, most of the studies had large effect sizes (Dickhaut & Arntz, 2014; Videler et al., 2017; Renner et al., 2013; Skewes et al., 2015; Reiss et al., 2014; Van Vrewijik et al., 2014). For instance, Videler et al. (2017) extensively examined the effect of schema therapy on an older adult with personality disorders and reported a significant improvement in symptomatic distress and EMSs with large effect sizes. Dickhaut and Arntz (2014) also reported a significant reduction in dysfunctional schema mode with a large effect size (d = 1. 64) and improved healthy functional modes with a large effect size (d = 1.48). Skewes et al. (2015) reported significant reductions in EMSs and schema modes and improved adult mode with a large effect size (d = 2.20). Also, Van Vrewijik et al., 2014 reported a significant reduction in the severity of symptoms and schema modes among 53.2% of participants with moderate to high effect sizes. Reiss et al. (2014) conducted three independent uncontrolled pilot

studies with borderline personality disorder patients (n = 92) and observed significantly reduced symptoms of severe borderline disorders and global pathology severity with effect sizes ranging from medium (d = .43) to high (d = 2.84). Although limitations existed in these studies, they empirically support the effectiveness of schema therapy in improving personality disorders.

In contrast, the early stages of schema-focused therapy experienced scanty applications to a few other chronic problems: panic disorder and agoraphobia (Gude & Hoffart, 2008; Hedley et al., 2001; Hoffart & Sexton, 2002; Hoffart et al., 2002); PTSD (Cockram et al., 2010); eating disorder (George et al., 2004; Simpson et al., 2010); and substance used disorder (Ball, 2007; Ball et al., 2005). Additionally, Muris (2006) reported the association of maladaptive schemas with depression, disorders, disruptive behavior, eating disorders, and substance use. Suffice it to underline that most of these studies examined above mentioned psychological problems concurrently with personality disorders. The primary target during this period was personality disorders. However, these early studies yielded a significant reduction of psychological problems that were not personality disorders with medium to large effect sizes (e.g., Gude and Hoffart, 2008; Hedley et al., 2001; Hoffart & Sexton, 2002; Hoffart et al., 2002). Therefore, these studies offered hope for future research on the schema-focused model across various clinical conditions other than personality disorders.

Consequently, several empirical studies have emerged recently on adapting schema-focused therapy across a range of disorders, not of personality disorders. Precisely, several recent empirical studies have investigated the adaptations of schema-

focused therapy for panic disorder (e.g., Demir & Soygut, 2015; Kwak & Lee, 2015; Oguz et al., 2019; Peters et al., 2021; Sardarzadeh, 2017; Shibuya et al., 2018). Recent studies have also explored the application of the schema-focused model to PTSD (e.g., Bosch & Arntz, 2021; Boudouka et al., 2016; Boterhoven de Haan et al., 2019; Sardarzadeh, 2017; Peters et al., 2021). Studies have also emerged recently on the application of schema-focused therapy to depression (e.g., Kopf-Beck et al., 2020; Calvete et al., 2015; Gheisari, 2016; Hashemi & Darvishzadeh, 2016; Jalali et al., 2019; Malogiannis et al., 2014; Orue et al., 2014; Rashidi & Rasooli, 2015; Renner et al., 2016; Saritas-Atalar & Altan-Atalay, 2020; Wegener et al., 2013; Yigit et al., 2018). Many recent studies have equally examined the application of schema-focused therapy to social anxiety (e.g., Calvet et al., 2013; Calvete et al., 2014; Calvete et al.; 2015; Mairet, 2014; Orue et al., 2014; Parsons et al., 2017; Sardarzadeh, 2017); OCD (e.g., Kwak & Lee, 2015; Oguz et al., 2019; Peters et al., 2021; Sardarzadeh, 2017; Thiel et al., 2016). However, scanty studies have explored the association of schema-focused therapy with GAD (Peters et al., 2021; Yigit et al., 2018); acute stress (Sardarzadeh, 2017); eating disorder (Edwards, 2017; Simpson, 2020); and psychosis (Taylor & Harper, 2017).

Schemas Associated with Panic Disorder

Firstly, some EMSs have been implicated in maintaining panic disorder. These EMSs include vulnerability to harm and illness, emotional deprivation, abandonment/instability, incompetence/dependence, self-sacrifice/overresponsibility, unrelenting standards, grandiosity/self-centeredness, and subjugation (Demir & Soygut, 2015; Kasalova et al., 2020; Kwak & Lee, 2015; Petrowski et al., 2019; Sardarzadeh,

2017; Yan et al., 2018). For instance, using schema-focused therapy for a client with a panic attack with severe agoraphobia, Demir and Soygut (2015) found that the EMSs of dependency/incompetence schema, vulnerability harm, and abandonment schema were the core culprits of the client's mental health problems. The dependency and vulnerability to harm schemas developed due to impaired autonomy resulting from the overprotective attitudes of grandparents (Demir & Soygut, 2015). The schema of dependence is the belief that one cannot handle one's daily responsibilities (e.g., taking care of oneself, making good decisions, solving new problems) competently without considerable help from others. The vulnerability to harm schema involves the exaggerated fear that disaster is about to happen at any time and that one cannot protect oneself. Thoughts related to this schema include the unrealistic fear that something evil will happen to oneself, such as having a heart attack, going crazy, crashing, and fainting. Demir and Soygut (2015) also reported that the abandonment/instability schema developed after the client separated from her parents for a long-time schema. The abandonment schema is the disruptive perception that individuals are unreliable, unpredictable, or erratically present and cannot continue to provide emotional support, connection, strength, or practical protection but will eventually leave or reject one.

In another study, Kwak and Lee (2015) examined how EMSs were associated with participants with panic disorder (n = 46), OCD (n = 51), and normal controls (n = 70). The study findings revealed that participants with panic disorder exhibited higher activations of the schemas of vulnerability to harm and overresponsibility/self-sacrifice (i. e., focusing excessively on fulfilling others' needs at the cost of one's needs because

one is acutely sensitive to the other's pain and does not want to feel guilty) than participants with OCD and normal controls. Additionally, Sardarzadeh (2017) reported more EMS associated with panic disorder after examining the ability of EMSs to predict (maladaptive) emotional schemas in individuals (n = 109) with panic disorder with or without agoraphobia, specific phobia disorder, OCD, PTSD, GAD, or acute stress. Among other things, the author found that the EMSs of self-sacrifice, emotional deprivation, abandonment/instability, and dependence/incompetence predicted emotional schemas in participants with panic disorder. The study results also revealed that the EMSs of grandiosity (i.e., the belief that one should have whatever one wants regardless of its cost without showing any empathy toward others) and unrelenting standards (i.e., striving relentlessly to meet high standards or expectations of oneself or others at the expense of happiness, relaxation, spontaneity, playfulness, health, and accomplishment) predicted emotional schemas in participants with panic disorder.

Similarly, Petrowski (2019) found that panic disorder patients (n = 103) with positive attachment schemas to their mothers and partners experienced better therapeutic outcomes. Thus, the study implies that attachment schemas, including mistrust/abuse, abandonment/instability, emotional deprivation, social isolation/alienation, and defectiveness/shame, are associated with panic disorder. Also, Yan et al. (2018) explored the factor structure of the Young Schema Questionnaire-short form (YSQ-SF) with Chinese adolescents (n = 983) to underscore the maladaptive schemas associated with anxiety problems. Among other things, the study findings indicated that panic symptoms could be explained by the EMS of abandonment, vulnerability to harm, and subjugation

schema. The EMSs of abandonment and vulnerability to harm also predicted separation anxiety and GAD.

Secondly, the schema modes associated with these EMSs are also implicated in panic attacks and panic disorder (Demir & Soygut, 2015; Oguz et al., 2019). These associated schema modes include: the lonely/neglected child triggered by the emotional deprivation schema; the terrified child triggered by the vulnerability to harm schema; and the helpless surrender triggered by the negativity and pessimism schema (Arntz et al., 2021; Demir & Soygut, 2015; Edwards, 2022). Other schema modes include: dependent child triggered by the dependence/incompetence schema; the abandoned child and the rejected child triggered by the abandonment/instability schema; over diligent child triggered by the unrelenting standards schema; and the self-sacrificer/rescuer triggered by the overresponsibility/self-sacrifice schema (Arntz et al., 2021; Edwards, 2022). Other important schema modes associated with panic disorder are the guilt-inducing parent mode triggered by self-sacrifice, compliant surrender triggered by the dependence schema, and avoidance coping modes. For instance, Demir and Soygut (2015) reported that the lonely child, frightened child (i.e., terrified child), weak and powerless child (helpless surrender), obedient or compliant surrender, and detached protector were schema modes associated with their client's diagnosis with panic disorder with severe agoraphobia.

Thirdly, maladaptive emotional schemas (e. g., blaming others, dangerousness, rumination, duration, guilt, the need for control, numbness, rationality, validation by others, uncontrollability, and simplistic views of emotions) triggered by EMS are also

associated with panic attacks and panic disorders (Leahy, 2019; Oguz et al., 2019; Sardarzadeh, 2017). An emotional schema is the combination of one's primary learning history and inherent mood leading one to specific beliefs about one's emotions and others' emotions (Edwards & Wupperman, 2019; Sardarzadeh et al., 2017). Therefore, the emotional schema model is a type of schema mode. It is imperative to underscore that each maladaptive emotional schema is represented in a category of schema modes. For instance, guilt is a parent schema mode; rumination is a repetitive, unproductive coping mode; uncontrollability is a surrender schema mode known as helpless surrender; the need for control is the same as the overcontroller coping style; etc. Uniquely, the emotional schema model centers on how individuals perceive, interpret, evaluate, and respond to their emotions and others' emotions (Edwards & Wupperman, 2019). Thus, the model emphasizes people's interpretation of their emotions and others' emotions and the need to validate the emotions, make sense of the emotions, normalize the emotions, expand the meaning or modify beliefs about the emotion, and encourage acceptance of mixed feelings.

In one study, Oguz et al. (2019) examined the similarities and differences between a healthy control group and the clinical groups of OCD and panic disorder in relation to three schemas: metacognitive beliefs, maladaptive emotional schemas, and adaptive emotional schemas or cognitive flexibility. Cognitive flexibility or adaptive emotional schemas include acceptance, expression, higher values, consensus, and control (Oguz et al., 2019; Edwards & Wupperman, 2019). The study results revealed that clinical groups scored higher than the control group on the metacognitive beliefs of uncontrollability,

dangerousness, and the need to control thoughts and the maladaptive emotional schemas of dangerousness, rumination, and guilt. In contrast, the clinical groups scored significantly lower than the control group on adaptive emotional schemas or cognitive flexibility. Sardarzadeh's (2017) study also demonstrated that some emotional schemas triggered by EMS are implicated in panic attacks and panic disorders.

The Schema-Focused Model with Black Americans

Several studies exist regarding using the schema-focused model for Black Americans (e.g., Abrams et al., 2018; Allen et al., 2019; Borrell et al., 2013; Gerrard et al., 2013; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Hayman et al., 2015; Liao et al., 2020; Mahbubani, 2022; Sibrava et al., 2013; Sims et al., 2019; Watson-Singleton, 2017; Watson & Hunter, 2016). However, none of these studies examined clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder. Some of these studies have identified the specific EMSs, including emotion deprivation, mistrust/abuse, abandonment/instability, dependence, self-sacrifice, emotional inhibition, and unrelenting standards, behind the strong Black women schema (e. g., Abrams et al., 2018; Allen et al. 2019; Liao et al., 2020; Watson-Singleton, 2017; Watson & Hunter, 2016). The strong Black women schema has five basic schematic characteristics: the image of strength, self-reliance, caretaking and selflessness, emotional suppression, and the intense motivation to succeed. In a study with African American women across the United States (n = 158) between 18 to 59 years old, Watson-Singleton (2017) found that perceived emotional deprivation, together with increased psychological distress, is a significant predictor of the strong Black women schemas. The emotional deprivation

schema is a rejection schema that involves the expectation that one's needs for normal emotional support, including nurturance (e.g., affection, attention, warmth, or companionship), protection (e.g., strength, direction, or guidance), and empathy (e. g., understanding, listening, self-disclosure, mutual sharing of feelings) will not be fulfilled by the other (Boudoukha et al., 2016; Young & Lindemann, 1992). The schema of emotional deprivation is usually associated with activating the neglected/lonely child schema modes and the avoidance-coping mode of isolation, withdrawal, avoiding close relationships, self-reliance, self-silence, and being strong (Arntz et al., 2021; Edwards, 2022). These schema modes are usually activated in strong Black women to successfully navigated through hardships (Watson & Hunter, 2016).

Allen et al. (2019) reported that racial discrimination (another rejection schema) significantly interacts with four of the strong Black women schema subscales. These four subscales are the image of strength, emotional suppression, caretaking and selflessness, and intense motivation to succeed. However, the study results showed that strength and emotional suppression were protective of racial discrimination's health risk. In contrast, intense motivation to succeed and caretaking/selflessness exacerbated the health risk associated with experiencing racial discrimination. The subscale of intense motivation to succeed had the strongest interacting effects. Similarly, Abrams et al. (2018) investigated the strong Black women schematic characteristics responsible for depression using African American women (n = 194) ranging from 18 to 82 years old and including college students (n = 98) and community members (n = 96). The study findings indicated

that the schema of emotional inhibition and self-silencing had a significant mediating effect between the perceived obligation to manifest strength and depressive symptoms.

Additionally, using African American women (*n* = 222), Liao et al. (2020) examined the mediating effects of maladaptive perfectionism, self-compassion, collective coping, and spiritual coping between the strong Black women schema and mental health outcomes, including anxiety, depression, and loneliness. The authors observed that maladaptive perfectionism, self-compassion, and collective coping had significant mediating effects, whereas spiritual coping had no significant mediating role. Specifically, maladaptive perfectionism mediated between the strong Black women schema and anxiety and depression but not loneliness. Maladaptive perfectionism is an aspect of the unrelenting standards schema, which involves striving relentlessly to meet high standards or expectations of oneself or others at the expense of happiness, pleasure, relaxation, spontaneity, playfulness, health, satisfying relationships, and accomplishment (Boudoukha et al., 2016; Young & Lindemann, 1992). Secondly, Strong Black women tend to have low self-compassion, prioritize others' needs, postpone self-care, and suppress their emotions in the face of difficulties (Liao et al., 2020). Low self-compassion describes the self-sacrifice schema. Thirdly, collective coping mediated between strong Black women schema and loneliness, indicating that strong Black women use collective support to connect with others during stressful moments.

From a different perspective, more studies have reported that rejection schemas and other EMSs are positively associated with unhealthy behaviors (e.g., panic disorder, substance use, eating disorders, depression, hostility, and anger) among Black Americans

(Gibbons et al., 2021; Hayman et al., 2015; Mahbubani, 2022; Sims et al., 2016; Sims et al., 2019). For instance, Hayman et al. (2015) examined the differential impact of rejection schemas on African American women's eating behavior. The authors found that both out-group exclusion (i.e., by Caucasians) and in-group exclusion (i.e., by their fellow African American women) had negative effects on the African American women's eating behavior. The study findings further revealed that the exclusion of African American women by other African American women caused more emotional distress than the exclusion of African American Women by Caucasian women. In a similar study, Mahbubani (2022) included other ethnic groups, with African Americans constituting the largest number of participants. Precisely, Mahbubani (2022) examined the association of rejection schemas and ethnic identity with eating behavior among participants recruited from local hospitals (n = 137), including African Americans (n = 60), Latinos (n = 30), American Indian/Alaskan Native (n = 3), Asian/Pacific Islander (n = 7), Whites (n = 23), and others (n = 12). The author found a significant positive association between social rejection schemas and unhealthy eating behavior and a significant negative association between these two variables. Mahbubani (2022) underscored that these mixed findings suggested that different types of social stress impacted eating behavior through different mechanisms. Therefore, future research to further explore these differential effects is needed. Additionally, no effect of ethnic identity on eating behavior was found.

In another related study, Gibbons et al. (2021) suggested differential healthy behavior reactions to perceived racial discrimination and rejection between African American men and women. Gibbons et al. (2021) conducted a longitudinal study to

examine the association of perceived racial discrimination with exercise and healthy eating among African Americans from the Family and Community Health Study sample and the moderating role of optimism in perceived racial discrimination. The study results showed that female primary caregivers and their daughters who are highly optimistic responded to perceived racial discrimination experiences with more healthy behavior than male participants. This observation indicates that African American women activated a higher schema mode of optimism than African American men in reacting to perceived racial discrimination. Similarly, in their study to examine the association of optimism (a healthy schema mode) with healthy behavior among African American men and women, Sims et al. (2019) also found that young African American adult women, together with those who had higher socioeconomic status reported high schema mode of optimism. Additionally, substance use has been found as a type of coping mode to negative affect produced by the rejection schemas (e.g., mistrust, perceived racial discrimination, stereotypes, and microaggression) among African Americans (Borrell et al., 2013; Gerrard et al., 2018; Sims et al., 2016). For instance, Gerrard et al. (2018) reported that the combination of avoidant coping and poor social networks was associated with problematic alcohol consumption. Borrell et al. (2013) observed that African Americans with moderate or high levels of rejection schemas used more substances than those with fewer rejection schemas.

Hassija et al. (2018) also included other ethnic groups in examining the use of a schema-focused model with Black Americans. Precisely, Hassija et al. (2018) elucidated the association of EMSs with recollections of dysfunctional parenting and intimate

partner violence with women college participants (*n* = 305), including African American women (*n* = 21). The study findings revealed that the subjugation schema significantly predicted intimate partner violence and mediated the relationship between recollections of dysfunctional parenting and intimate partner violence. However, the subjugation schema, together with the self-sacrifice schema, accounted for 13.9% of the intimate partner violence variability. The study results also revealed that the EMSs of insufficient self-control and mistrust/abuse significantly predicted intimate partner violence perpetration. These two EMSs mediated the relationship between recollections of dysfunctional parenting and intimate partner violence perpetration (Hassija et al., 2018). However, the EMSs of insufficient self-control and mistrust/abuse, together with the EMSs of entitlement, abandonment, and social isolation, accounted for 11.3% of the variability in intimate partner violence perpetration.

Additionally, Lindsey (2014) examined the association of separation-individuation and the EMS of approval seeking with trait anxiety among undergraduate psychology students (*n* = 334) to determine whether approval seeking and separation-individuation could predict trait anxiety. From the perspective of ethnic groups, participants included: African Americans (*n* = 129); European American (*n* = 185); Hispanics (*n* = 5); Native American (*n* = 5); Asian Americans (*n* = 2); and other (*n* = 8). The author found a significant positive correlation between approval-seeking schema and anxiety and separation-individuation and anxiety for African American and European American college students. However, the study results further revealed that approval-seeking schema and separation-individuation did not significantly predict anxiety for

African Americans. In contrast, the two variables significantly predicted anxiety for European Americans. This author called for future research to investigate differences between African Americans and European Americans in trait anxiety.

Clinicians' Experiences of Using Schema-Focused Therapy

Studies have also highlighted clinicians' experiences of using schema-focused therapy for chronic psychological problems (Beterhoven de Haan & Lee, 2014; Bosch & Arntz, 2021; De Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2020; Tan, 2015; Ten Napel-Schutz et al., 2017). However, none of these studies has explored therapists' experiences of using schema-focused therapy with panic disorder in Black Americans. For instance, Ten Napel-Schutz et al. (2017) conducted focus groups with newly trained therapists (n = 16) in schema therapy for randomized controlled trials in personality disorder treatment and explored their perceptions of training, protocol, and peer supervision. The researchers found that therapists considered experiential learning approaches decisive during the training because schema-focused therapy strongly relies on experiential approaches for therapeutic change. Consequently, therapists listed a role-play as an example of experiential methods essential in learning and evaluating skills and emphasized that role plays were helpful in their training. Other experiential learning methods include techniques to pay attention to resistance (e.g., empathic confrontation and imagery) and procedures to provide feedback to learn required skills and attitudes (peer supervision). Additionally, the researchers observed that therapists emphasized the need for schema therapy supervision to pay more attention to therapists' schema and

mode activation during therapy. Attending to this concern would help schema-focused therapists overcome negative countertransference during therapy.

Following the observation of Ten Napel-Schutz et al. (2017) regarding paying more attention to therapists' schema and mode activation, Pilkington et al. (2022) conducted a qualitative study on the perceptions of schema therapists on the activation of their EMSs in therapeutic relationships and how they manage their countertransference. Therapists noted specific EMSs and modes that usually activate during therapy: abandonment, unrelenting standards, defectiveness/shame schemas, emotional deprivation, enmeshment, self-sacrifice, subjugation, approval seeking, avoidant protector, over-controller mode, compliant surrendered, demanding critic, punitive, angry child mode, and vulnerable child (Pilkington et al., 2022). They also identified specific countertransference associated with such activations of EMSs and modes. For instance, several therapists observed that when abandonment, unrelenting standards, or defectiveness/shame schemas during therapy were triggered (e.g., by clients canceling their therapy sessions), therapists felt rejected, incompetent, and inadequate. When defectiveness schema was activated (e.g., by clients feeling worse), they felt anxious. The study indicated several other negative impacts of schema and mode activations on therapists' countertransference during therapy, including perfectionism, detaching or avoiding, becoming argumentative or aggressive, over-functioning, burnout, and neglecting to set healthy limits or boundaries. However, the researchers underlined various strategies for managing schema activations and countertransference during therapy. These strategies include self-reflection, personal growth and healing, caring for

one's vulnerability and reconnecting with healthy adult mode, engaging in supervision and training, personal therapy, self-care, and using own schema to understand and help clients' schemas.

Furthermore, De Klerk et al. (2017) examined the perspectives of patients (*n* = 15) and schema therapists (*n* = 8) on schema therapy for personality disorders. They found that, similar to patients, therapists perceived some aspects of the schema therapy procedure as beneficial (e.g., Imagery rescripting techniques, schema mode model, and the therapeutic relationship in schema therapy). Precisely, therapists emphasized the importance of therapeutic relationships for therapeutic change. This aspect supports previous and current studies on a therapeutic relationship as a means for therapeutic change (Boterhoven de Haan & Lee, 2014; Tan, 2015; Wampold, 2015). Consequently, studies have indicated that therapists need to take the stance of reparenting or validating patients' subjective experiences for an effective therapeutic relationship (e.g., Gulum & Soygut, 2022; Kopf-Beck et al., 2020; Tan, 2015). Additionally, De Klerk et al. (2017) observed that therapists, as well as patients, considered the schema mode model to be a valuable framework for understanding the client's problem. This aspect supports the current tendency in schema-focused therapy to conceptualize chronic psychological problems using the schema-mode model (De Klerk et al., 2017).

However, therapists perceived some other aspects of schema-focused therapy as unhelpful. For instance, some therapists noted that 50 treatment sessions were insufficient for significant improvement. Also, therapists perceived therapeutic relationships as hard and taxing, although vital for therapeutic change. Therefore, De Klerk et al. (2017)

recommended supporting therapists through supervision, peer discussion, and experienced-aimed training. Another unhelpful aspect of schema therapy that therapists observed is unfamiliarity with schema therapy as a new therapeutic framework. This observation means that more schema-focused therapeutic experience and training enhance schema-focused therapy outcomes. The third unhelpful aspect of schema-focused therapy is clients' inability to focus on the personality problems, for instance, because of too much agitation in their lives or too much avoidance. Schema-focused therapy for a psychological problem would be unsuccessful without explicitly formulating the conditions for treatment focusing on the problem (De Klerk et al., 2017).

In a related study, Bosch and Arntz (2021) explored the perspectives of patients (*n* = 10) and therapists (*n* = 9) on the treatment with the schema-focused technique of imagery rescripting for PTSD due to childhood trauma. Similar to previous studies, patients and therapists observed that positive therapeutic relationships benefited therapeutic change (e.g., Boterhoven de Haan & Lee, 2014; Tan, 2015; Wampold, 2015). The authors also gathered that therapists underlined areas of emphasis during the imagery rescripting that lead to symptom reduction. During rescripting traumatic events, symptom reductions occurred when the therapist cared for the vulnerable child of the patient, ensured the vulnerable child's safety and privacy, confronted the perpetrator (e.g., an abusive parent), and broke through the avoidance of the patient by talking about it. For instance, therapists considered breaking through the avoidance of clients essential in helping clients express all feelings experienced during and after traumatic events (Bosch & Arntz, 2021). Therapists also noted that patients who recognize their emotions and

thoughts about traumatic events usually become more aware of their feelings and express them in rescripting and daily life. Another important aspect of imagery rescripting is encouraging patients to keep taking their therapy as required. Encouraging patients helps them overcome their fears and breakthrough avoidance. Therapists also believed that the patient's motivation (e.g., the willingness to speak about the most important issues throughout treatment and showing up despite feeling sick) and imagery ability helped rescripting technique become more effective (Bosch & Arntz, 2021). The therapists also perceived a new rescripting of the traumatic events as a means of creating an integrated self-image and new meaning of traumatic events during treatment.

Additionally, Pugh et al. (2020) conducted an email survey to examine the experiences of expert therapists (n = 40), including schema-focused therapists (n = 9), to identify factors supporting and preventing the use of chair work via teletherapy and the adaptations these methods require in an online environment. Therapists predominantly had a positive experience of tele-chairwork, maintaining that the technique is as effective as in-person delivery. However, therapists identified practical obstructions associated with tele-chairwork: technological faults, restricted space, limited access to chairs, and digital barriers. For instance, digital barriers in tele-chairwork challenged experts' ability to regulate and track clients, deprived them of vital communications, and reduced emotional activation, interpersonal connection, and client engagement with tasks. Therapists recommended warm-up exercises, close monitoring of clients' bodily expression, and amplifying clients' emotions with process comments (reflection,

repetition, and doubling encouragement) to adjust the practical impediments due to the online environment.

Summary and Conclusion

In this literature review, I focused on the conceptual framework of the study and the review of previous research on the key related concepts and variables. The conceptual framework centered on EMSs, schema modes, schema coping styles, and schema techniques as four essential concepts providing guidelines for the exploration of the clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder and the review of previous studies on the key related variables and concepts. Previous studies reviewed based on the key related concepts and variables highlighted that panic disorder is a major health public problem among Black Americans and that Black Africans are faced with several risk factors for panic disorder (Benner et al., 2018; Brown, 2019; Carter et al., 2021; Chou et al., 2012; English et al., 2020; Erving et al., 2019; Jones et al., 2020; Jones & Neblett, 2017; Kijakazi, 2019; Kisely et al., 2017; Lanier et al., 2017; Lavner et al. 2021; Manduca, 2018; Nguyen et al., 2020; Thomas et al., 2022 Oh et al., 2021). Further review of the literature indicated that schemas, including EMSs and schema modes, are associated with panic disorder. Consequently, schema-focused therapy has been applied to panic disorder and other chronic health problems resisting Beck's CBT and other focused interventions (Demir & Soygut, 2015; Kianipoor et al., 2020; Kwak & Lee, 2015; Oguz et al., 2019; Petrowski et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018). The application of schema-focused therapy to

panic disorder and other chronic mental health problems is more frequent in recent times than in the past (Peeters et al., 2021; Taylor et al., 2017).

Previous studies reviewed also showed that studies had been conducted with Black Americans using the schema-focused model and on clinicians' experiences of using schema-focused therapy (Abrams et al., 2018; Allen et al., 2019; Beterhoven de Haan & Lee, 2014; Bosch & Arntz, 2021; De Klerk et al., 2017; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Liao et al., 2020; Mahbubani, 2022; Pilkington et al., 2022; Pugh et al., 2020; Sims et al., 2019; Tan, 2015; Ten Napel-Schutz et al., 2017; Watson-Singleton, 2017). However, none of these studies focused on clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder. Therefore, the current study fills this gap in the literature. Based upon the findings of previous studies, the design for this study will be used to uncover clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. The next chapter presents an overview of the study's methodology.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. Precisely, the study purpose involved underscoring clinicians' experiences of using schema-focused therapy with Black Americans and the meaning clinicians ascribe to them. Consequently, the purpose of the study involved obtaining an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy for Black Americans with panic disorder. In this chapter, I detail the research methods and strategies that I used to collect relevant information from clinicians practicing schema-focused therapy who were recruited to participate in this study. The first section of this chapter is the research design and rationale for the current study. The next section is my role as the researcher, including conducting interviews, making appropriate field observations, analyzing, and interpreting data, presenting the findings, monitoring, and reducing biases affecting the study outcomes, and following proper ethical principles during the research.

Following the second section is the specific methodology, including participant selection logic that describes the criteria for selecting study participants and the strategy to identify that they meet the required criteria, instrumentation providing the detail about the data collection instrument and sources, and procedures for recruitment, participation, data collection, and the data analysis plan. Also included in this chapter are procedures for a pilot study, including participation and data collection. Following this section are trustworthiness issues, focusing on transferability, credibility, dependability, and

confirmability of the study results. The section after trustworthiness issues centers on potential ethical problems associated with this study. It includes ethical concerns associated with the Institutional Review Board (IRB) approval for participant recruitment and data collection, such as participant informed consent to participate in the study, participant privacy and confidentiality, data confidentiality, and data storage. The chapter ends with a summary of the main research methods and strategies that I used in this study.

Research Design and Rationale

The research question that I used to guide this study was: What are clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder? The central concepts of this study were schema-focused therapy, panic disorder, and Black Americans. Schema-focused therapy is a treatment approach that integrates aspects of cognitive-behavioral therapy, interpersonal therapy, experiential therapy, transactional analysis, object relations theory, mentalized-based therapy, dialectical behavior therapy, and positive psychology to address chronic psychological problems (Back et al., 2018; Taylor & Arntz, 2016). The therapy model focuses on maladaptive schemas impacting people's perceptions of themselves, others, the world, and interpersonal relationships. Panic disorder is a chronic anxiety problem consisting of recurrent panic attacks in the absence of real danger. Symptoms of a panic attack include a sudden surge of intense fear or intense discomfort, loss of control, and physical symptoms, such as fast heartbeat, sweating, shivering, chest pain, and feelings of choking and dizziness (Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al., 2021). Other panic attack symptoms include

nausea or abdominal distress, derealization, depersonalization, chills or hot flushes, fear of dying, numbness or tingling sensation, lighted head, and faint (Cackovic et al., 2021; De Jonge et al., 2016; Maisto et al., 2021). Black Americans are a racial group in the United States that includes a heritage of the Caribbean or West Indian (e.g., Haitian or Jamaican), African (e.g., Biafra, Ghana, and Kenya), African Americans, and other Black non-American descents (Gina et al., 2016).

I used a generic qualitative approach for this study to uncover clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder and the meaning clinicians attribute to these experiences. Generic research is an epistemologically social constructivist and theoretically interpretive study focusing on how people interpret their experiences and the meaning they attribute to their experiences (Kahlke, 2014; Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). It is epistemologically constructivist because the information is received through the subjective person who experiences the phenomenon, and the attempt to approach individuals' interpretations of experiences is always mediated by the researcher's interpretations (Kahlke, 2014).

I chose the generic qualitative design for this study because my focus was on clinicians reporting their experiences of using schema-focused therapy with Black Americans with panic disorder and the interpretation and meaning clinicians ascribe to these experiences (Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). This means that I did not focus on the shared living experiences of Black Americans with panic disorder. Therefore, the phenomenological methodology was not the appropriate

research design for this study (Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). Participants were selected from multiple locations in the United States rather than in a bounded unit or a particular cultural group. I did not use a case study, involving interviewing participants in a bounded unit, or ethnography, which involves participants from a cultural group (Burkholder et al., 2016).

Role of the Researcher

In this generic qualitative study, I was the primary instrument of data collection through interviews, observations, documents, and data analysis (see Burkholder et al., 2016; Ravitch & Carl, 2016). I used a nonprobability sampling strategy to choose participants carefully. Participants were limited to 14 male and female clinicians in the United States of America practicing schema-focused therapy. I conducted a videotaped semistructured interview with each respondent regarding their experiences of using schema-focused therapy in Black Americans with panic disorder. For the credibility of the research, I followed systematic steps to collect data through videotaped interviews, including making enough preparation for the interview and stating the purpose of the interview that aligns with the purpose of the study (see Luizzo, 2019). I developed clear, concise, nonconfrontational, and open-ended interview questions that were consistent with the research question and did not limit participants' freedom to respond (see Luizzo, 2019). Also, I kept the interview conversational and not interrogative and conducted the interview in a distraction-free environment. Another important step for enhancing the credibility of the interviews is observing the study participants' behavior, checking nonverbal expressions of feelings before, during, and after the interview, and taking

fieldnotes of what I observed. I used careful observations to balance power relationships with participants and the urge to seek the correct answers from them during the interviews. Another method that I used to navigate power dynamics was building rapport with participants (see Durkin et al., 2020). I also used careful observations to understand words and phrases associated with the observational cues from participants.

After collecting the data, I transcribed the interview and wrote down a note based on the field notes and the interview transcript. I analyzed the data collected using thematic data analysis, a flexible analytical method to derive the central themes from the data. The data analysis began with open or first-level coding after immersing myself in the length and breadth of the data content and proceeding to categorization (axial or second-level coding) to theme development (selective or third-level coding). In theme development, third-level coding categories or subthemes from axial coding were integrated into coherent, larger overarching themes (see Williams & Moser, 2019)..

Another important role I played as a researcher was interpreting the data findings. I constructed meaning from the data analyzed by connecting various themes and subthemes and creating a coherent, logical, and convincing storyline of the data to portray the validity of developed themes. The storyline was related to the literature around which themes' content revolves to show how the current study advances the understanding of techniques, strategies, and practices of effective schema-focused therapy in Black Americans with panic disorder.

One of the ethical concerns that I had during the interview was the possibility of the interview staying visible to other employees and managers in the interviewee's

organization (see Drabble et al., 2016). To overcome this problem, I discussed this possibility with my interviewees and proposed ways to keep the interview private and confidential. Again, because of my active role in the interview (e. g., encouraging conversation, reacting to what interviewees say, and asking detailed questions), my attitudes might have influenced the questions I asked participants and how I reacted to their answers. To avoid this interviewer bias, I was aware of how my emotions, attitudes, and reactions (e. g., smiles, frowns, silence) might encourage approval or disapproval to a question that an interviewee should have responded to differently (see Rubin & Rubin, 2012).

Methodology

Participant Selection Logic

Participants in this study were selected from the population of schema-focused therapists who provide individual or group therapy using schema-focused therapy in the United States of America. Participants needed to be licensed schema-focused therapists (i.e., a schema-focused therapists licensed under the laws of their states and who practice clinical psychology) across the United States and had conducted sessions with Black Americans with panic disorder in the last 5 years to be eligible for participation in this study. Precisely, participants needed to meet the following criteria: (a) they needed to be over the age of 18; (b) licensed schema-focused therapists, counselors, and psychologists who provide individual or group therapy in the United States; (c) they needed to be currently conducting sessions and must have completed at least 30 sessions most recently with Black Americans with panic disorder or have conducted sessions with them in the

past 5 years; (d) Black Americans involved in the therapy must have been diagnosed with panic disorder according to the Diagnostics and Statistical Manual of Mental Disorder (DSM-5 or DSM-5-TR) criteria; and (e) Black Americans diagnosed with panic disorder include Black racial and biracial groups in the United States, namely, African Americans, Caribbean Blacks, Africans, and other Black non-American descent. In contrast, the following do not meet the criteria for selection: (a) licensed psychologists, psychotherapists, and counselors who did not practice schema-focused therapy; (b) licenced psychologists, counselors, and therapists who practiced schema-focused therapy but have not had experience with Black Americans with panic disorder; (c) licensed schema-focused therapists, counselors, and psychologists who have not had experience with Black Americans with panic disorder in the past five years; (c) licensed psychiatrists and social workers who practiced schema-focused therapy even if they have had experience with Black Americans with panic disorder in the past 5 years.

Participants were limited to 14 male and female licensed schema-focused clinicians. In generic qualitative studies, the recommended sample size is usually eight to15 participants if the data collection procedure is individual interviews because data saturation (a situation in which additional data generate no new information during the collection process) usually occurs around this number of participants (Kostere & Kostere, 2022). Additionally, the sample size for this research was limited to 14 participants to ensure that enough data is collected to answer the research question. However, I selected extra participants for additional interviews in case I did not achieve saturation with the

initial sample size (see Kostere & Kostere, 2022). Because of this flexibility, the problem of reaching data saturation was solved.

Additionally, a nonprobabilistic and purposeful sampling strategy were used for this study to choose carefully fertile exemplars of schema-focused clinicians who have experienced working with Black Americans with panic disorder (see Kostere & Kostere, 2022; Queirós & Almeida, 2017). The purposive sampling strategy involved key informants, key knowledgeables, and reputational sampling (see Ravitch & Carl, 2016). This means that participants who had experience in schema-focused therapy with Black Americans with panic disorder and were willing to describe their experience needed to be selected. Similarly, the sampling was nonprobablisitic because a careful selection of these clinicians was essential to ensure fertile exemplars of the experience for the study. Therefore, the selection was not random or left to chance. However, the clinicians selected were from different sections of the state to prevent bias.

Participants for this study (i.e., clinicians who have had experience with Black Americans with panic disorder in the past 5 years) were recruited through flyers containing the objective of the study on the Walden Participant Pool, Counsgrads Liserv, "Research and Me," International Society of Schema Therapy (ISST) Listserv, Reddit, and Snowball. I also emailed therapists, counselors, and psychologists on Psychology Today. Participants interested in the study were directed to contact me through email or telephone to discuss the interview session and study details. However, participants were asked questions to determine if they meet the participation selection criteria (e.g., have you read the criteria for the study participation?). I followed the guidelines of the Walden

Institutional Review Board (IRB) for the recruitment. Participants received $10 thank you gift cards. Also, I continued recruiting until I had 14 participants and saturation was met.

Instrumentation

The primary instrument for collecting data from participants in this study was researcher-developed semistructured, open-ended interviews via audio-taped conversations, specifically Zoom conference meetings. A total of 11 concise, clear, semistructured, and open-ended interview questions and three follow-up questions were used in the study (see Appendix A). Interview Question 1 was an inquiry regarding participants' schema therapy experiences. Interview Question 2 centered on the schema-focused therapy techniques most frequently used with Black Americans with panic disorder. Interview Question 2 had a follow-up question that explores the schema-focused therapy least frequently used with Black Americans with panic disorder. Interview Question 3 explored aspects of the therapy most helpful to Black Americans with panic disorder. Interview Question 3 had a follow-up question centering on the aspects of the therapy least helpful to Black Americans with panic disorder Interview. Interview Question 4 explored the specific benefits Black American clients with panic disorder gained while using schema-focused therapy. Interview Question 5 asked participants the extent clients' needs were met. Interview Question 6 dealt with the EMSs addressed most in schema-focused therapy for Black Americans with panic disorder.

Also, Interview Question 7 explored the schema modes addressed most in schema-focused therapy for Black Americans with panic disorder. Interview Question 8 explored aspects of the therapy Black Americans with panic disorder perceive as

emotionally challenging. Interview Question 8 had a follow-up question, which asks participants to share aspects of the therapy they find emotionally challenging. Interview Question 9 asked participants to share how the activation of their EMSs and other schemas affect the therapist's schema-focused therapy. Interview Question 10 centered on the strategies clinicians applied to manage their EMS activation during therapeutic relationships. Interview Question 11 centered on the clinician's recommendation for effective schema-focused strategies for Black Americans with panic disorder.

Furthermore, the interview questions were consistent with the research question and covered relevant areas the research question was exploring (see Luizzo, 2019). In this regard, the two most important dimensions of content validity (i.e., item relevance and content coverage) guided the development of the interview questions and ensured they accurately reflected the full breadth of the research question (see AERA et al., 2014). I developed the interview questions based on the literature insights, the conceptual framework, and a pilot study in which a few clinicians of schema-focused therapy reviewed each interview question and determined the content validity of the interview questions and whether they were easily understood. Additionally, recorded interviews constituted the primary data collection source. Specifically, I used the Zoom conference meeting for this purpose. Fieldnotes were also useful for collecting data, noting and remembering the participant's behavior during the interview, activities and events that occurred during the interview, and interpretating these events. Fieldnotes included record-keeping notes (e.g., date, time, place), descriptive information, the meaning of observed behavior, activities, and events, and reflexive notes on how these meanings

ascribed to these events informed me as the researcher. However, synchronous audio interviews have some limitations, including reduced social cues (e.g., the interviewee's body language) and the possibility of internet connection problems, which posit difficulties in communicating easily or hearing what the participant is saying. In any case, I ensured that data collection was strictly confidential and anonymous. Therefore, the data were saved on a separate hard drive with a password.

Pilot Study

I conducted a pilot study for this research with three clinicians. These clinicians are my friends and colleagues but with experience in using schema-focused therapy with Black Americans with panic disorder. I also discussed the interview session and details of the study with them by telephone and sent them the interview questions before the actual day of the interview via email. I used the pilot study to review interview questions and determine their content validity to know whether they were easily understood without making respondents defensive. I also used the feasibility study to check whether the interview questions would be completed within an appropriate time frame and identify any flaws in the study procedures. To avoid bias, respondents for the pilot study were similar to those in the primary study; they are schema-focused therapists in the United States and have conducted sessions with Black Americans with panic disorder in the last 5 years. I collected data through individual interviews via zoom conference meetings, maintain participants' confidentiality and privacy, and saved the data collected on a separate hard drive with adequate password.

Procedures for Recruitment, Participation, and Data Collection

Having established the criteria for selecting participants (e.g., clinicians in the United States who have had experience with Black America with panic disorder), I sent out emails containing participant selection criteria and the objective of the study to schema-focused therapists across the United States. Specifically, I used the online therapist directory to secure the emails of qualified participants. I also used, schema therapy society listserv, couselorslistserv and Walden student/alumni pool via the participant pool webpage to recruit participants. Additionally, I posted recruitment flyers (from Walden Writing Center) on social media, including Research and Me, Linkedln, Google, and Reddit for participant recruitment. Using online recruitment procedures allowed me to reach a more heterogeneous sample with participants from a wide range of geographical regions, improving the generalizability of the study findings. Participants interested in the study were directed to contact me through email or telephone to discuss the interview session and details of the study. I also asked clinicians who had accepted to participate in the study to help me recruit two schema-focused therapists who wanted to participate.

Additionally, I emailed the selected participants an informed consent form (from Walden IRB) to participate in the research. The consent forms contained the study's purpose, duration, benefits, confidentiality, and the right to decline participation in the study or discontinue participation. The consent was written with simplified easy-to-understand language. I provided participants with enough opportunities to ask questions and clarify doubts. To this effect, I endeavored to answer all questions and clarify all

doubts on the subject satisfactorily. I set up the interview time with participants who signed and returned the study consent. Not returning the consent after a friendly reminder was interpreted as a decline to participate in the study.

Regarding data collection, I received approval from Walden IRB before beginning any data collection activities, and the entire data collection process followed the IRB's ethical guidelines. I collected data through interviews with 14 participants via Zoom conference meetings. Firstly, before the interview date, the participants were given the opportunity to see the interview questions. Therefore, participants received the interview questions through email before the interview date. Before beginning the interview proper on the interview date, I defined my role to the participant as a student researcher and informed the interviewee of the interview's purpose, and the importance of the study to me (see Rubin & Rubin, 2012). I verified the participant's name and job roles to be sure I was interviewing the right person and assured the participant that any identifying information would be kept strictly confidential by using an assigned alpha-numeric, such as P1, P2, etc. Similarly, I ensured that the setting for the interview guaranteed the participant's confidentiality. I also informed each participant how the interview would proceed and how long it would last (i.e., 60-90 minutes). Additionally, I informed participants that the interview would be recorded for transcription purposes, but the information would be kept confidential. I also did not hesitate to let participants know that they were free to stop the interview at any point (see Rubin & Rubin, 2012). Interview questions were concise, clear, and open-ended, allowing for open communication and flexible and dynamic interviewing (see Kostere & Kostere, 2022).

Interview questions proceeded from the easiest to the most difficult one. I thanked and appreciated participants with a $10 gift card at the end of the interview. After collecting the data, I used the Amberscript to transcribe the first nine interviews and the Rev.com service to transcribe the remaining five interviews because it was less costly. Precisely, I uploaded the recorded audio to the transcription tools and converted them into texts.

Data Analysis Plan

I analysed the data collected through the lens of the research question and not interview questions (see Kostere & Kostere, 2022). Additionally, I used only data that answered the research question for the analysis. Furthermore, I manually performed thematic data analysis (a flexible analytical method to derive the central themes from the data) on the data collected. Precisely, the thematic data analysis was in six phases. The first phase was familiarizing with the data documented in different transcripts and generating initial codes from them. In this phase, I gained an overall understanding of the data received through careful reading and rereading of interview transcripts, highlighted meaningful sentences, phrases, or paragraphs, and used the research question to determine their usefulness to the study (see Kostere & Kostere, 2022). As already indicated, I created and labeled a separate file for all the highlighted data that were unrelated to the research question or dd not provide enough support for answering the research question, even if they were interesting data. However, I reviewed them later to see if they had eventually become useful for the research question. Secondly, I performed open coding or first-level coding after immersing myself in the length and breadth of the data content. This process involved listing important ideas related to the research

question, recurrent concepts, patterns of meaning, and key issues of interest in the data and coding them with words, phrases, and sentences. I also highlighted patterns of potential interest that are unusual, noteworthy, or contradictory from the study's perspective (see Vaismoradi et al., 2016).

The second phase was axial coding or the second level coding. In this stage, I organized the common patterns that emerge from initial open codes into categories or subthemes (see Williams & Moser, 2019). The third phase was selective coding or the third level coding. In this stage, I integrated categories or subthemes from axial coding into coherent, larger overarching themes. It is also imperative to note that some first-level codes went on to form main themes (Braun & Clarke, 2006). The fourth phase was reviewing themes. Here, I examined whether I had a satisfactory thematic map in which themes captured the contours of the coded data. In this light, I reexamined all the coded data extracts for each theme to double-check their coherency with one another and with their themes. Incoherent patterns among coded data extracts for each theme indicated that the theme was problematic or that some of the data extracts did not fit. I reworked affected themes created new themes for the data extracts that did not cohere with others. Secondly, I reread the entire data to double-check for any data omission in the earlier coding stages and code them within themes.

The fifth phase was defining and refining themes. In this phase, I wrote a detailed analysis for each theme, underscoring the essence of what each theme was about (i.e., the story that each theme told) and the aspect of each participant's data each theme captured (see Kostere & Kostere, 2022; Vaismoradi et al., 2016). This phase indicated how well

themes fit into the whole data in relation to the research question (see Vaismoradi et al., 2016). The sixth face was constructing meaning. In this phase, I synthesized various themes and subthemes and consequently interpreted the meaning and implications in relation to the research question by creating a coherent, logical, non-repetitive, and convincing story of the data (see Kostere & Kostere, 2022). The meaning was created in ways to portray the validity of developed themes. This storyline was related to the literature around which themes' content revolves to show how the current study advances the understanding of techniques, strategies, and practices of effective schema-focused therapy in Black Americans with panic disorder.

Issues of Trustworthiness

In qualitative research, trustworthiness involves establishing confidence among readers in the study findings (Stahl & King, 2020). Researchers can establish trustworthiness or confidence in the study findings when they establish the integrity of the data, the findings accurately reflect the phenomenon under study or the process of the study rather than the researcher's bias or limitations of the study design, and the study results can be communicated and applied to other settings and contexts. Therefore, the criteria to evaluate the trustworthiness of qualitative research include credibility, transferability, dependability, and confirmability (Lincoln & Guba,1985; Stahl & King, 2020).

Credibility

The credibility criterion of trustworthiness means that the research findings and interpretations accurately reflect plausible information participants provided (Bloomberg

& Volpe, 2019; Stahl & King, 2020). Thus, this criterion establishes confidence in the truth of the study findings and interpretations (Bloomberg & Volpe, 2019). Credibility is a qualitative counterpart to the criterion of internal validity in quantitative research (Stahl & King, 2020). A crucial step that I followed to maintain the credibility of the current study was to ensure that I do not deviate from the phenomenon under study. To this effect, I used a pilot study to review interview questions and determine their content validity and comprehension.

Another important step that I followed to maintain the credibility of this study was using a wide range of participants for data collection. Using a wide selection of study participants is a form of triangulation in which participants' opinions and experiences are validated against others so that a rich picture of the phenomenon under discussion emerges in line with the participants' contribution (Lincoln & Guba, 1985; Shenton, 2004). Because I used a wide range of study participants, I achieved data saturation, further establishing the credibility of study. Thirdly, carefully observing the study participants' behavior, checking nonverbal expressions of feelings before, during, and after the interview, and taking fieldnotes of what I observed enhanced the credibility of the data collection process and the study findings in the end. Fourthly, I used member checking to maintain the credibility of the current study. After transcribing the interview, participants proofread the interview content to check for omissions or distortions of ideas presented during the interview (Bloomberg & Volpe, 2019). Additionally, I used data analysis methods that have been used successfully in previous studies in this research (see Shenton (2004).

Transferability

The criterion of transferability is the extent to which the patterns, interpretations, and conclusions from one study can be applied to other settings, contexts, situations, and populations (Burkholder et al., 2016). The conditions in one setting must be similar enough to those in other settings for qualitative study findings to meet the criterion of transferability or applicability to another in two different settings must be similar enough for findings to be applicable or transferable (Lincoln & Guba, 1985). The criterion of transferability is analogous to external validity and generalizability in quantitative research. A primary strategy I underlined to use to establish the transferability criterion in the current study was maintaining thick descriptions. Based on this strategy, I provided a clear and detailed account of the data collection procedures, the study participants, and the context surrounding data collection (e.g., where the interview takes place, the best time the interview will be conducted to prevent participants' feeling exhausted, and other aspects of data collection that will help provide a good understanding of the data collection setting). Additionally, I clearly described the criteria for including and excluding participants for the current study. Such clear and detailed descriptions enhanced correct judgment regarding what applied or did not apply from the current study to other settings (see Burkholder et al., 2016; Stahl & King, 2020).

Dependability

Dependability is the trust in the trustworthiness of a qualitative study (Stahl & King, 2020). Building trust in a study also includes the study procedures being reliable and another study of the data arriving at similar findings using the same procedures.

Therefore, the dependability criterion accounts for the factors of instability and change within the naturalistic fields of the study (Lincoln & Guba, 1985). This criterion corresponds to reliability in quantitative research (Burkholder et al., 2016). One strategy that I employed to ensure the dependability of the current study was an audit trail. I provided clear documentary evidence of the entire data collection process, including recording the interview responses, transcribing the interviews, and documenting data gathering using overlapping methods. Similarly, I provided a transparent description of the data analysis and data interpretation (e.g., I described and explained the rationale for merging codes, and provide the meaning of the themes emerging from data analysis). With an audit trail I was able to protect fieldnotes and transcripts used in this study in case researchers might wish to duplicate this study in the future. I was also able to maintain participants' authenticity and establish that study findings were based on participants' responses rather than on the researcher's preconceptions (see Lincoln & Guba, 1985; Korstjens & Moser, 2018). Another strategy that I used to establish dependability is peer scrutiny or debriefing. In this strategy, I constantly consulted with my research moderators, including the chairperson and other research committee members, throughout the research process. My research moderators double-checked every step of the study, including my transcripts, data analysis, coding, study results, and interpretations, and provided feedback (see Stahl & King, 2020).

Confirmability

The confirmability criterion of trustworthiness is the level of objectivity involved in the study (Stahl & King, 2020). Precisely, the confirmability criterion of

trustworthiness ensures that the researcher's biases do not shape the data findings and interpretations. Rather, it ensures that data findings are based on participants' responses. Therefore, the criterion of confirmability is the qualitative counterpart of objectivity in quantitative research. To reduce potential sources of the researcher's biases and ensure this study satisfied the confirmability criterion, I used an audit trail to account to maintain an in-depth description of the data collected, data analysis, and data interpretation (e.g., I presented a line-by-line data coding and identified, with interview excerpts, clear patterns, and themes relevant to the research question). Additionally, I eliminated the researcher's bias by using an interview question guide to ensure consistency with different participants and avoiding emotional and behavioral reactions that might have influenced interviewees' responses. I maintained the internal coherence of the data findings by using a wide range of study participants, seeking clarifications during the interview, and asking participants to proofread the interview transcript to check for omissions or distortions of the collected data. I further achieved the study confirmability by presenting the study limitations.

Ethical Procedures

I received approval from Walden IRB before beginning participant recruitment and data collection activities. The entire research process followed IRB ethical guidelines on participant recruitment and data collection, including respecting participants' voluntary consent to participate by signing a consent form containing the purpose of the study, the study duration, the study benefits, confidentiality, and the right to refuse or discontinue participation; protecting their privacy and confidentiality; and respecting

their right to decline or discontinue participation at any time. Consistent with IRB ethical standards, one important ethical concern associated with participant recruitment and data collection was how to manage my reactions when a participant discontinues participation during an interview. To overcome this problem, I became self-aware of how my attitudes, emotions, and reactions might infringe on participants' right to decline or discontinue participation at any time. Similarly, I replied to all participants who declined to participate in the current study with a letter, accepting their decision and respecting their right to decline to participate.

Another ethical concern associated with data collection was the possibility of the interview staying visible to other employees and managers in the interviewee's organization (Drabble et al., 2016). Therefore, it was imperative to discuss this possibility with my interviewees and proposed ways to keep the interview private and confidential. Also, the need to protect participants' privacy and confidentiality and keep collected data strictly confidential and anonymous was another ethical concern consistent with IRB standards. To overcome this ethical problem, the data collected and transcriptions for the current study were saved on a separate hard drive with an adequate password and locked in storage. However, I will destroy them after the recommended seven years. Additionally, to maintain the full confidentiality of participants and provide extra protection for their identification, I assigned each of their names a number. Finally, another essential ethical consideration was the possibility of my emotions, attitudes, and reactions influencing interviewees' responses (e.g., smiles might be a sign of approval to a question that an interviewee should have responded to negatively). Consequently, self-

awareness of how my emotions and reactions during data collection helped me overcome this problem.

Summary

The focus of this chapter was on the research design and rationale, the researcher's role, methodological procedures for participant recruitment and data collection to explore the research question, trustworthiness issues and ethical considerations for the research process. In this light, the chapter first addressed the central concepts of the current study, namely, panic disorder and schema-focused therapy, a therapy model that centers on maladaptive schemas impacting people's perception of themselves, others, the world, and interpersonal relationships. The chapter also showed that generic qualitative research design, an epistemologically social constructivist and theoretically interpretive study approach, was most suitable to address the current study because the study focused on clinicians reporting their experiences of using schema-focused therapy in Black Americans with panic disorder and the interpretation and meaning clinicians ascribe to their experiences (see Kennedy, 2016; Kostere & Kostere, 2022; Merriam & Tisdell, 2016). The chapter further addressed my role as the researcher. This role includes conducting interviews, making appropriate field observations, analyzing and interpreting data, presenting the findings, monitoring and reducing biases affecting the study outcomes, and following proper ethical principles during the research.

Additionally, this chapter provided detailed information on the research methodology: the criteria for selecting study participants and the strategy to identify that

they meet the required criteria, the detailed account of the data collection instrument and sources; the procedures for a pilot study, the procedures for recruitment and participant selection, data collection, and the data analysis plan. Next, the chapter addressed issues of trustworthiness, including strategies to establish credibility, transferability, dependability, and confirmability of the current study. Strategies used to establish credibility for the study included: using a pilot study to review interview questions and determine their content validity; carefully observing the study participants' behavior; taking fieldnotes of what is observed; asking participants to proofread the interview content; and stopping data collection only when saturation is achieved (see Bloomberg & Volpe, 2019; Kostere & Kostere, 2022). Thick descriptions of participation selection logic, data collection procedures, the study participants, and the context surrounding data collection were the strategies used to provide transferability criterion in the study. An audit trail and peer debriefing or scrutiny were the strategies used to provide the dependability criterion. Being aware of how my emotions and reaction impacted participants during interviews and an audit trail helped establish the study's confirmability criterion. Finally, ethical considerations for the study involved issues of the Institutional Review Board (IRB) approval for participant recruitment and data collection, including the participant's informed consent to participate in the study, the participant's privacy and confidentiality, data confidentiality, and data storage. In the next chapter, I will provide a detailed account of the study results.

Chapter 4: Results

Introduction

Black Americans have a history of experiencing racism, oppression, subjugation, and discrimination. These factors are associated with increased risks of developing panic disorder (Benner et al., 2018; Brown, 2019; Kijakazi, 2019; Lavner et al., 2021; Oh et al., 2021). Studies have shown that panic disorder and other chronic psychological problems resist Beck's short cognitive therapy and other interventions that overlook the roots of psychological problems (Bach et al., 2018; Dadamo et al., 2016; De Klerk et al., 2017; Peeters et al., 2021; Rameckers et al., 2021). In contrast, studies have indicated that schema-focused therapy has been adopted more conveniently over the most recent years for their effective treatment of chronic psychological disorders (e.g., Kianipoor et al., 2020; Petrowski et al., 2019; Sardarzadeh, 2017; Shibuya et al., 2018; Tariq et al., 2021). The purpose of this qualitative study was to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. I explored clinicians' experiences of using schema-focused therapy with Black Americans and the meaning clinicians ascribed to these experiences. The study involved obtaining an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy for Black Americans with panic disorder. This study had one research question: What are clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder?

This chapter includes eight sections following this introduction. The section after the introduction is the description of the pilot study and its impact on the main study. The

next section includes a description of the setting, including the personal conditions influencing participants or their experience at the time of study that may influence the interpretation of the study results. After the section on the research setting, the chapter includes information about the demographics of the study participants and their characteristics relevant to the study. The next section is on data collection details, including the location, frequency, duration, and data collection recording. The chapter also includes sections on data analysis, evidence of trustworthiness, and the study results, respectively. In the data analysis section, the processes used to move from codes to categories and themes will be described. The section on the evidence of trustworthiness involves the description of the implementation and adjustment to the strategies of credibility, transferability, dependability, and conformability. The section on the study results includes the research findings and how I used them to answer the research question. The final section summarizes answers to the research questions and provides a transition to Chapter 5.

Pilot Study

I conducted a pilot study for this research with three clinicians. These clinicians are my friends and colleagues, but they had experience in using schema-focused therapy with Black Americans with panic disorder. I discussed the interview session and details of the study with the respondents and sent them the interview questions guide before the actual day of the interview via email. I conducted the interviews via audio Zoom conference meetings. During the interview, I observed all the ethical principles and standards required for data collection. I also maintained their confidentiality and privacy

and saved the data collected on a separate hard drive with an adequate password. Participants were asked all the interview questions, and I recorded fieldnotes during the data collection.

From the pilot study, I underlined the exact time frame for completing the interviewing questions. Using the pilot study, I identified some typographical mistakes in the study questions. Additionally, through the pilot study, I understood how to proceed with the interview without making respondents defensive. By conducting the pilot study, I understood each interview question's difficulty level and proceed from the easiest question to the most difficult one during the actual data collection. Additionally, using the pilot study, I was able to evaluate the content validity of each interview question in relation to schema-focused therapy and Black Americans with panic disorder.

Research Setting

All the interviews took place over an audio Zoom conference in safe and confidential environments, allowing for open and honest responses. Fourteen licensed schema-focused clinicians who have met Black Americans with panic disorder for 30 sessions in the past five years participated in these audio Zoom interviews. After the data collection, each interviewee went through the transcript corresponding to their contribution to confirm that the transcript represented their responses. In addition to the professional condition of being a licensed clinician and having worked with Black Americans with panic disorder, some other areas influenced the study participants or the results of the study. They include the number of years participants have experienced as

schema-focused therapists, education type (e.g., clinical psychologists, counselors, and psychologists), and therapy type practiced (e.g., individual therapy or group therapy).

Demographics

All participants were licensed schema-focused therapists, counselors, or psychologists working in the United States of America who have met Black Americans with panic disorder for about 30 sessions in the past 5 years. Originally, it was not part of this study to collect demographics. However, some participants identified their states. Two participants indicated living in Florida, and others indicated living in Illinois, Pennsylvania, South Florida, and New York. Many participants also indicated the number of years that have practiced schema-focused therapy, their therapy type (e.g., individual or group), and their education type (e.g., clinical psychology and counseling).

Data Collection

As already indicated, data for this study were collected from 14 respondents through audio Zoom interviews. The Institutional Review Board approved data collection for the study on February 8, 2023. Walden University's approval number for the study is 02-08-23-0659828. After this approval, I started recruiting participants through the Walden Participant Pool, "Research and Me," International Society of Schema Therapy (ISST) Listserv, Counsgrads Liserv, Reddit, and Snowball. I also emailed therapists, counselors, and psychologists on Psychology Today. From the Walden Participant Pool, I had 11 participants who volunteered in the study. However, only two of them met the study criteria. From the "Research and Me," 32 participants indicated their interest in the study. However, only five met the study criteria. Out of these five, only one completed

the interview. The remaining four dropped out after receiving the consent form or the interview question guide. From the ISST, five participants indicated an interest in the study, and four completed the interview. From Reddit, two participants indicated interest in the study, and one completed the interview. The remaining six participants who completed the interview came through snowballing.

I designed an interview question guide containing 11 concise, clear, semistructured, and open-ended interview questions and three follow-up questions to maintain consistency with different participants and plan different levels of questions with each of participants. Like the pilot study, I emailed participants the interview questions guide before the interview day and conducted the interviews via audio Zoom conference meetings. All the participants were asked all the interview questions, and the interviews lasted approximately 50 to 75 minutes. During the interview, I observed all the ethical principles and standards required for data collection, including maintaining participants' confidentiality and privacy, which continues after the interview. The data collected were recorded through Zoom recordings and saved on a separate hard drive with a protected password. I also recorded fieldnotes during the data collection.

After collecting data, I used the Amberscript to transcribe the first nine interviews and the Rev.com service to transcribe the remaining five interviews because it was less costly. Also, each interviewee went through the transcript corresponding to their contribution to confirm that the transcript represented their responses. One change in the data collection from the plan presented in the previous chapter was conducting the feasibility study with three clinicians rather than four. The pilot study provided essential

knowledge regarding the exact time frame for completing the interviewing questions and other important facts on conducting the main study effectively, including understanding each interview question's level of difficulty and proceeding from the easiest question to the most difficult during the actual data collection rather than proceeding in the order noted in the previous chapter. During the data collection process, one unusual circumstance was a participant trying to participate in the study the second time using a different name and email. This observation was specific to the Walden Participant Pool.

Data Analysis

Through the lens of the research question, the collected data were analysed manually following the inductive process of open or first-level coding, axial or second-level coding, and then selective or third-level coding (see Kostere & Kostere, 2022; Williams & Moser, 2019). In open coding, for each interview question, I identified important units of meaning and ideas related to the research question, including key issues of interest, ideas, concepts, and patterns of meaning and coded them descriptively with words, phrases, or sentences. According to Saldaña (2016), a descriptive code summarizes the key topic of the excerpt in a word or phrase. These codes are identifications of the topic and not abbreviations of the content. Additionally, I reviewed all the highlighted data, with their codes, that did not provide sufficient support for answering the research question for any usefulness for the research question. Patterns of potential interests that were unusual, contradictory, or noteworthy from the study's perspective were also noted.

In the axial or second-level coding, I determined the interconnections among these codes for each interview question and organized the common patterns that emerged from them into categories or subthemes (Kostere & Kostere, 2022; Williams & Moser, 2019). Therefore, these categories or subthemes formed during the axial coding are words or phrases describing a group of codes after the first-level coding is complete (Kostere & Kostere, 2022). In the selective coding, I synthesized categories or subthemes from the axial coding into cohesive, coherent, and larger overarching themes (see Braun & Clarke, 2006; Burkholder et al., 2016; Kostere & Kostere, 2022; Williams & Moser, 2019). Also, I developed some over-arching themes from the second-level or axial coding.

It is imperative to note that I further reviewed all the themes and double-checked their coherency with one another to be sure a satisfactory thematic map in which themes captured the contours of the data had been obtained. Additionally, I reread the entire data to double-check for data omission in the earlier coding stages and coded the missing ones within themes. Furthermore, I defined and refined themes to underscore the essence of what each theme was about (or the story that each theme told) and how well each fit into the whole data in relation to the research question (see Kostere & Kostere, 2022; Williams & Moser, 2019). Consequently, I wrote a detailed analysis for each theme. I synthesized various themes and subthemes and interpreted the meaning and implications in relation to the research question by creating a coherent, logical, non-repetitive, and convincing story of the data (see Kostere & Kostere, 2022). The meaning was created in ways to portray the validity of developed themes. This storyline was related to the literature around which themes' content revolves to show how the current study advances

the understanding of techniques, strategies, and practices of effective schema-focused therapy in Black Americans with panic disorder.

Issues of Trustworthiness

Credibility

As indicated in the previous chapter, the credibility criterion of trustworthiness in the research findings is an internal validity criterion involving the research findings and interpretations accurately representing the information participants provided, and this establishes confidence in the truth of the study findings and interpretation (Bloomberg & Volpe, 2019; Stahl & King, 2020). An important step that I followed to maintain the credibility of this study was using a wide range of participants for data collection. Using a wide selection of study participants is a form of triangulation in which participants' opinions and experiences are validated against others so that a rich picture of the phenomenon under discussion emerges in line with the participants' contribution (Lincoln & Guba, 1985; Shenton, 2004). Because I used a wide range of study participants, I achieved data saturation, further establishing the credibility of study. I also used the interview questions guide to maintain consistency with different participants and to ensure that I stayed within the phenomenon under study. I carefully observed the study participants' behavior during the interview and took fieldnotes throughout the research process. I also used member checking to maintain the credibility of the study. After transcribing the interview, participants proofread the interview content to check for omissions or distortions of ideas presented during the interview. Additionally, I used data analysis methods that have been used successfully in previous studies. According to

Shenton (2004), following the specific procedures that have been employed successfully in previous comparable studies promotes the credibility of a study.

Transferability

The transferability criterion involves the extent to which the patterns, interpretations, and conclusions from one study can be applied to other settings, contexts, situations, and populations. In this study, the first important method I used to establish the transferability criterion was clearly describing the criteria for including and excluding participants. These boundaries provide essential insight for researchers and readers to make transferability judgments regarding the applicability of the study to other similar situations. I also maintained thick descriptions, which involved providing a clear and detailed account of the data collection procedures, study participants, the number and length of data collection procedures, and the context surrounding data collection. Researchers and readers can use such descriptions to correctly judge what applies or does not apply to their situation (Burkholder et al., 2016; Stahl & King, 2020).

Dependability

The dependability of a qualitative study means building trust in the study by ensuring that the study procedures are reliable. This criterion ensures that the study results are consistent with the study procedures, including the raw data, process notes, and data reduction (Golafshani, 2003; Stahl & King, 2020). One strategy that I used to ensure the dependability of this study was documenting the entire data collection process, including recording the interview responses, taking fieldnotes during the interview, and transcribing the interviews. I also provided an in-depth data analysis and data

interpretation. This audit trail provided the conviction that the study findings were based on participants' responses rather than on my preconceptions (see Lincoln & Guba, 1985). Another method utilized to establish the dependability criterion for this study was consulting with my research moderators constantly, including the chairperson and other research committee members, throughout the research process. In this strategy, my research moderators double-checked every step of the study, including my transcripts, data analysis, coding, study results, and interpretations, and provided feedback.

Confirmability

The confirmability criterion of qualitative research measures the effect of the researcher's bias and the internal coherence of data findings and interpretations (Lincoln & Guba, 1985). In this study, I eliminated the researcher's bias by using an interview question guide to ensure consistency with different participants and avoiding emotional and behavioral reactions that might have influenced interviewees' responses. I maintained the internal coherence of the data findings by utilizing a wide range of study participants, seeking clarifications during the interview, and asking participants to proofread the interview transcript to check for omissions or distortions of the collected data. I further achieved the study confirmability by utilizing line-by-line data coding and identifying, with interview excerpts, clear patterns, and themes relevant to the research question. Also, I achieved the study confirmability by presenting the study limitations.

Results

Guided by 11 interview questions, the research question explored clinicians' experiences of using schema-focused therapy with Black Americans. Precisely, the

research question was: What are clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder? Five base themes and 13 subthemes emerged from the data analysis in addressing the research question. The base themes include the effectiveness of schema-focused therapy with Black Americans with panic disorder, early maladaptive schemas for Black Americans with panic disorder, and schema modes for Black Americans with panic disorder. Other base themes are schema-focused therapy and strategies for Black Americans with panic disorder and the challenges of using schema therapy for Black Americans with panic disorder.

Table 1

Emergent Themes

Themes	Subthemes
1. The effectiveness of schema-focused therapy for Black Americans with panic disorder	1.1. Schema-focused therapy improves clients' adaptive skills
2. Early maladaptive schemas associated with Black Americans with panic disorder	2.1. Relational schemas. 2.2. Self-concept schemas.
3. Schema modes associated with Black Americans with panic disorder	3.1. Unhealthy child modes 3.2. Parent or inner critic modes 3.3. Coping modes 3.4. Healthy modes
4. Schema-focused therapy aspects and strategies for Black Americans with panic disorder	4.1. Data collection and schema identification strategies 4.2. Schema change strategies 4.3. Multicultural Strategies. 4.4. Clinician's self-improvement
5. Challenges of schema therapy for Black Americans with panic disorder	5.1. Effects of clinicians' schema activation and emotional challenges on the therapy. 5.2. Managing Clinicians' schema activation and other emotional challenges during and after therapy sessions

Theme 1: The Effectiveness of Schema-Focused Therapy for Black Americans with Panic Disorder

All participants (*n* =14) perceived schema-focused therapy to be effective with Black Americans with panic disorder. Participant 2 shared that a high percentage of this population recovered, although not a 100% recovery. Similarly, P3 stated: “I have been using the schema therapy for a while for my clients, especially Blacks, and most of the time, it worked. I wouldn't say that it's 100% effective. But. I would say it's really effective.” According to P4, “I have been helping Black Americans and Africans who are in America suffering from panic disorder. And what I can say is that schema therapy, for me, is a good therapy, and it's a very effective therapy.” For P5, “basing my argument on my experiences, I can say so far so good regarding using schema-focused therapy for Black Americans with panic disorder. Probably, I will say that everything has been awesome.” In the experience of P6 and P9, schema therapy is quite effective.

Participant 11 reported that schema-focused therapy is “amazing” both in her personal experience when she suffered from anxiety and panic disorder as an undergraduate and in her professional experience. For instance, she noted: “Professionally, I don’t think there is any therapy better than schema therapy.” Participant 7 reported that schema-focused therapy is helpful for Black Americans with panic disorder and recommends schema therapy for Black Americans with other mental disorders. Also, P10 echoed a similar experience, noting: “As a therapist, my experience with schema-focused therapy is about its effectiveness in treatment because it goes into those underlying patterns of the schema.” Similarly, P13 shared that schema-focused

therapy with Black Americans with panic disorder was very rewarding and effective. The remaining three participants (P1, P12, and P14) reported that the therapy effectively helped Black Americans with panic disorder deal with their mental health problems.

Reporting the extent to which Black American clients' needs were met, all the participants reported a percentage that supported the effectiveness of schema-focused therapy on this population. Seven participants (P1, P3, P7, P12, P11, P13, and P14) placed the effectiveness between 75% and 95%. For instance, P1 placed the extent schema-focused therapy met the needs of his Black Americans with panic disorder between 80% and 90%; P3 and P7 placed the efficacy level at 80%; P12 placed the effectiveness between 75% and 85%; P11 and P13 placed the effectiveness level at 90%; and P14 placed the effectiveness level at 95%. Furthermore, four participants (P4, P5, P6, and P10) placed the extent schema-focused met the needs of Black Americans with panic disorder at 70%. For instance, P4 stated: "I can say the problem is solved to a maximum of 70% because we cannot fully solve the problem. But at the end of the therapy, you can find that the situation has become better to the extent of maybe 70%." In addition to placing the therapy effectiveness level at 70%, P10 reported that the therapy provided them with "deep level change and long-lasting remedy, and they are able to maintain progress and manage future challenges." Also, two participants (P8 and P9) placed the effectiveness at 60%, and one participant (P2) reported that 50% of mental health problems of Black American clients with panic disorder were solved.

Using the reduction of panic symptoms as another way of expressing the effectiveness of schema-focused therapy with Black Americans with panic disorder,

seven participants (P2, P4, P5, P7, P10, P12, P14) explicitly reported how schema focused-therapy served their Black American clients. For instance, P14 noted that the therapy weakens their maladaptive coping modes, heals their early maladaptive modes, and breaks their schema-driven life patterns. While maintaining the healing effect of schema-focused therapy on Black Americans with panic disorder, P2, P4, P5, P7, and P12 highlighted that the reduction of their panic symptoms was not 100%. For instance, P2 stated: “They get healed even though they don't get the hundred 100% healing. Similarly, P4 reported: “Though we cannot completely vanish or deal with the problem, to some extent, I can say we can reduce the intensity of the panic disorders.” Participant 5 reported that the therapy reduces the panic symptoms of Black Americans with panic disorder to an extent and places the effectiveness level at 70%. Similarly, P12 shared that schema-focused therapy reduces the frequency of Black Americans’ panic symptoms but to some extent. Also, P7 shared that schema-focused therapy really worked with Black American people with panic disorder, even though not 100%, noting thus:

> Anytime any Black American people have tried it or rather anytime we have tried to help (my team and I), we have received more than 90% positive feedback from the families and even from patients themselves saying that the schema therapy or the session was helpful. They improved their emotional and behavioral functions, and their life improved by the therapy. So, I think it's effective.

Subtheme 1.1: Schema-Focused Therapy Improves Clients’ Adaptive Skills

Clarifying the usefulness of schema-focused therapy for Black Americans with panic disorder, participants reported how the therapy improved adaptive skills to manage

panic disorder among this population and enhanced their self-worth. For instance, P10 reported self-acceptance, self-esteem, self-worth, and improved interpersonal relationships with his Black American clients using schema-focused therapy. P1 stated that schema-focused therapy provided his Black clients with "the mechanism to cope with their irrational thoughts and emotions they are feeling at that particular moment" and to know what to do "when these episodes ever occur again in the future." Commenting on the maladaptive schema of mistrust, P1 observed that schema-focused therapy is an "effective way to deal with this maladaptive schema, and it really helped his Black clients understand how they were supposed to deal with mistrust and reduce panic disorder. Similarly, P4 noted that "they are going to know a better way to deal with the problem." In the same vein, P5 noted that they acquired healthy skills to cope with their panic disorder and help others who are passing through the same problem. In his words, "they'll be able to help others. If you know basic skills to cope with your problem, you also tell someone. If you share some ideas with someone, he or she is going to further share the ideas with others."

When explaining specific areas schema therapy was beneficial to her Black American clients with panic disorder, P9 reported that "one is replacing the unhealthy coping mode with beneficial coping modes." For P12, the therapy helped her clients "manage their triggers and reduce the frequency of panicking." Also, P13 and P14 reported that the therapy helped their Black American clients develop a healthy adult mode, a healthier way of responding to schema activations. For example, P13 reported:

> I would say that the healthy adult mode is strengthened and that when they feel vulnerable and anxious, maybe because a schema is getting activated or some type of trigger is happening in the environment, they have a healthier way of looking at it and better coping mechanisms that are not going to make the situation worse or reinforce their schemas. I mean, this particular client really grew in his ability to catch himself and see how he had chosen people that reinforced his schemas and how the modes that came out when he got triggered actually made things worse. And how he learned to fight those and replaced them with better, healthier behavior.

Additionally, P13 noted an important aspect driving the efficacy of schema-focused therapy. In her words, the therapy "involves different types of therapeutic interventions, which is like learning to play all instruments in the orchestra." The complex nature of the therapy, continued P13, matches the complexity of human nature. Thus, she noted: "Human beings are complicated, and this model, more than any other model, seems to capture all the complexity and its transdiagnostic. So, conceptualizing somebody's personality can be done no matter the diagnosis using this model."

Other adaptive skills schema-focused therapy provided Black Americans with panic disorder include reparenting their inner child as a good parent by identifying their unmet needs (P6 and P9), reframing negative thoughts (P6), and interacting effectively with others (P8 and P12). For instance, P6 reported that there was also an aspect of reparenting to help them learn to speak to themselves and react positively to triggers because a lot of this disorder comes from childhood experiences. Regarding effective

interactions, P8 indicated that schema-focused therapy provided this population with the skills “to create more meaningful relationships and friendships. Similarly, P12 noted that “at the end of the therapy, they usually have adapted, they'll have gained the aspect of relating with people, good relationship with people.”

Schema-focused therapy also provided Black Americans with panic disorder with insight into their problems (P3, P5, P8, and P11) and improved their self-esteem (P10). In this light, P5 reported that this population acquired knowledge regarding the root cause of the problem, leading to a solution, and learned to educate and help others with panic disorder. Also, P8 maintained that “they're able to understand their traits and both the negative consequences and the positive consequences and that is when it comes to socializing.” Participant 13 also reported that schema-focused therapy provided true insight into her Black American client: “The more he went through schema therapy, the more he understood why he had such strong reactions to certain situations. I think having insight and healing some of those schemas through imagery helped him be less reactive and hypervigilance.” Also, using one of her clients as an example, P11 stated:

> I think there was a real sense of insight into how much parenting, which she seemingly thought was a good childhood or decent parenting, did not meet her needs. I think the insight into her childhood and the belief she had adopted from her parents, for example, if she wasn't self-sacrificing, she was a selfish, bad person, were the culprits for a lot of what she was dealing with when she contacted me.”

Theme 2: Early Maladaptive Schemas Associated with Black Americans with Panic Disorder

The early maladaptive schemas (EMSs) therapists addressed when working with Black Americans with panic disorder formed the second major theme of the data collected for this study. Participants reported several EMS from four schema domains: disconnection/rejection (P1, P2, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14), other-directed (P9, P10, P11, P13, and P14), hypervigilance (P5, P6, P7, P8, P11, and P13) and impaired autonomy (P1, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14). However, two subthemes cluster around this major theme: relational early schemas and self-schemas/self-concept schemas.

Subtheme 2.1: Early Relational Maladaptive Schemas

Relational schemas are beliefs and expectations about the self and others which guide subsequent behavior. All EMSs belonging to the disconnection/rejection domain and a few EMSs in the other-directed schema domain were the relational schemas associated with panic disorder among Black Americans. Regarding disconnection and rejection schemas, apart from P3, other participants (n = 13) reported abuse/mistrust as a common EMS associated with their Black American clients with panic disorder. Participants 1 and 2 noted the role of mistrust schema in Black Americans with panic disorder. In the same vein, P6, P7, P8, P12, and P14 reported how abuse schemas were related to mistrust and anxiety; P9 indicated that the abuse schema was associated with panic disorder among Black Americans; and P4, P5, P7, P8, P11, and P12 additionally

highlighted the drivers of the abuse schemas among this population. For instance, P7 reported the situation thus:

> Most Blacks with panic disorder complained about their family, domestic violence, brutality, and harassment at institutions when they were in school, and maybe some violent guys were bullying them. So, it's a kind of bullying, abuse from parents and encountering some kind of fatal tragedies like accidents. Those were the main maladaptive schemas of abuse that the patients mentioned.

Similarly, the most common drivers of abuse schemas other participants shared include: bullying during childhood (P4); raping, gun threats, and seeing someone being shot (P5); sexual abuse and betrayal by trusted friends or partners (P8); emotionally abusive husbands or parents (P11); family violence, raping, and childhood punishment (P12). All these abuse schemas made Black American with panic disorder apprehensive. According to P12, clients who received punishment during childhood usually became apprehensive because they feared getting punished. Also, the abuse schemas led them to mistrust and anxiety (P6, P7, and P8). For instance, P7 shared: “Because you don't even trust your partner who is violent, you think that your partner may become violent anytime because you experienced that kind of life when you were growing up.” In the same vein, P14 observed: “Yes, I think this is characterized by the belief that others are untrustworthy, and this can hurt the patient.”

Eight participants (P1, P2, P4, P6, P8, P11, P13, P14) reported that shame/defective schema was also an important EMS addressed among Black Americans with panic disorder. As P11 and P13 already indicated, having a sense of unworthiness,

including defectiveness and shame is connected to several other EMSs in the disconnection/rejection domain associated with panic disorder in Black Americans. Reporting how defectiveness and shame related to panic disorder among Black Americans, P14 stated: “Clients believe that they’re full of flaws and they feel that something is very wrong with them. So, they will be looking forward to criticism, rejection, and humiliation. So, they will have low self-esteem.” These dispositions were central to their panic disorder.

In the same vein, P1 mentioned that defectiveness or shame made Black American clients constantly anxious that they would be criticized and laughed at by their peers. Such a fragile sense of self is associated with their panic disorder. For example, in the academic setting, “because they do not have the right answer, they are most probably ashamed that most students around them are going to burst into laughter, and this can create panic attacks.” Similarly, P2 noted that defectiveness and shame developed during childhood caused Black American clients to have low self-esteem, leading to interpersonal anxieties of all sorts. Responding to the schema of shame and panic disorder among Black Americans, P6 reported, "I think a big one is definitely the schema of shame because, in the Black community, there has been a bit of stigma around mental health for a long time, although it's improving. So, there's a lot of shame." Participants 1 and 8 pointed out that shame among Black American clients mostly developed from body shapes, intellectual ability, and life at home.

Seven participants (P1, P2, P10, P11, P12, P13, and P14) reported that abandonment schema was an important EMS associated with panic disorder among Black

Americans. For instance, P1 shared: “Most of them really had the problem of abandonment when they were young. Their parents never cared anything. So, this is one of the EMSs my Black clients with panic disorder struggle with.” According to P1, “the effect of the rejection in the childhood may include the fear of intimacy, distrust, even anxiety and depression, and people-pleasing behaviors.” Also, P10 reported that “abandonment is a major one where the clients might feel like they've been left alone or they're losing support. They feel quite insecure, and that triggers panic symptoms because they have some kind of fear in relation to abandonment.” Participant 11 described a Black client whose abandonment schema that triggered panic attacks fed on her fragile sense of self within relationships. In this description, P11 noted the connection among several maladaptive schemas within the disconnection/rejection domain:

> Let's start with the defectiveness and shame that there was such a sense of unworthiness of not being worthy of being treated in a way that was kind and respectful. She also felt she was overweight as a kid, and still as an adult, and she was teased in school. And so, all of that led to a very fragile sense of self. And so there was a constant sense, most especially with romantic relationships, that she wasn't good enough. And so, she was constantly anxious that she was going to get left and dumped. So now we've got a link to abandonment because she wasn't good enough.

Supporting this observation that schemas within the disconnection/rejection domain go together, P13 highlighted that her Black client with panic disorder “also has abandonment, social isolation, shame, and defectiveness because they often all go

together." Also, five participants (P2, P8, P10, P13, and P14) reported that the social isolation/alienation schema was essentially associated with panic disorder among Black Americans. Like the schema of abandonment, P13 and P14 noted that the schema of defectiveness/shame was behind the social isolation, which eventually triggered panic symptoms among their Black clients as they struggled to connect with others.

Six participants (P1, P2, P9, P11, P13, and P14) reported that emotional deprivation schema was also a major culprit in the panic disorder among Back Americans. For instance, narrating how emotional deprivation led to panic disorder, P11 shared the following about a client: "This client's history was that she had an older sister, and her mother really favored the older sister. And so, the older sister got all the attention, and she didn't get any attention." Consequently, continued P11:

> She had such low expectations of people being kind to her and caring for her, especially in romantic relationships. And she would sort of accept the crumbs, I guess I would say. And so there was anxiety about not having people be kind to her, care about her, or listen to her in romantic relationships. And when she did get it, there was always a sense that it was going to be fleeting.

Similarly, P14 observed that in the case of emotional deprivation, "clients feel that they are not worthy of love, attention, or care, leading to a lot of anxiety." According to P14, "people with this schema learn to withdraw, isolate, and avoid close relationships. They feel difficult to ask for assistance when facing any type of issue. And anytime you tell them no, they will dismiss your help or positive feedback." For P9, emotional deprivation led to emotional repression or self-sacrifice in Black Americans with panic disorder.

Regarding the domain of other-directed schemas, four participants (P9, P11, P13, and P14) observed that their Black American clients used schemas from this domain maladaptively to cope with other schema activations (especially emotional deprivation), leading them to panic disorder. Schemas from this domain implicated for this purpose include emotional repression or inhibition, self-sacrifice/over-responsibility or overcompensation, approval seeking, and subjugation. For example, P9 observed that her Black American clients used emotional repression or inhibition and self-sacrifice to cope with emotional deprivation. In her words "childhood emotional deprivation led Black American clients to "respond either by learning repress their emotions or learning to work so hard to get that attention." Also, P14 reported that "they find it difficult to ask for assistance when facing any type of issue" because of their emotional deprivation. Participant 13 reported that her Black American client had "self-sacrifice and approval seeking as a way to try to get people to meet his needs, pay attention to him, care about him, or treat him better. He often tried to rescue people or impress people." Similarly, P11 explained that, like other clients, Black American clients with childhood emotional deprivation learned to care so much, meet others' needs, and not pay attention to their needs to attract attention, care, and support from others. Thus, she reported:

> Self-sacrifice/overresponsibility schema is a way of almost coping with these things. If I give more, if I am really kind, if I'm meeting everybody's needs, If I'm not paying attention to my needs, then maybe people will actually pay attention to me. Maybe I can get them to care about me by giving so much, or maybe they won't leave me if I'm so giving.

Participants 10 and 11 also shared that subjugation was a vital EMS among Black Americans with panic disorder. For example, P10 reported that “Black Americans have always felt inferior in some way because of discrimination. So, you have to help them explore and process these schemas and address racial experiences.” Participant 11 reported how her Black American client with panic disorder was always taking the heat at her place of work, despite her level of education, because she felt she might be let off if she created a healthy working boundary. According to P11, the client “felt like she needed to do more or work harder than her Caucasian colleagues because she felt like she was more likely to take the heat or possibly be let go off because she was a Black American.” This attitude, continued P11, was not based on “the failure schema because she is bright, but just like this is the way the system is, it's unfair, it's unjust.”

Subtheme 2.2: Self-Concept Schemas

These are beliefs and expectations about the self, which guide subsequent behavior. Under this subtheme, two schema domains were reported as associated with panic disorder among Black Americans: impaired autonomy/achievement and hypervigilance. Within the domain of impaired autonomy, vulnerability to harm/illness schema (P4, P5, P6, P7, P9, P10, P12, P13, and P14), failure schemas (P1, P4, and P8), and incompetent/dependent schemas (P4 and P8). Within the domain of hypervigilance, negativity and pessimism schema (P5, P6, P7, and P13) and unrelenting standards (P8 and P11) were reported.

It is imperative to indicate that vulnerability to harm (i.e., the exaggerated fear that disaster is about to happen at any time and that one cannot protect oneself) and

negativity/pessimism schema (i.e., difficulties focusing on the positive and optimistic aspects of life while focusing pervasively on the negative aspects of life, such as death, loss, sickness, pain, disappointment, potential mistakes, potential harm, guilt, and hostility) are associated with related pervasive thoughts and feelings that something bad is going to happen (Young & Lindemann, 1992). Consequently, participants might have conflated both schemas in their responses. For instance, P4, P6, P7, P10, P12, and P13 noted that childhood or earlier catastrophes (e.g., accidents, abuse, rape, violent parents, dead of a loved one) were the drivers of the vulnerability to harm schema.

Clearly, P5 observed that experiencing natural calamities that have harmed people, road accidents, and violence or abuse from parents disposed his Black American clients to a heightened sense of vulnerability to danger and to anticipate always that something harmful was about to happen. This heightened sense of vulnerability, continued P5, was "very fundamental in triggering panic attacks." Similarly, P12 reported that, "after experiencing a tragic situation, such as abuse, rape, or witnessing the death of a loved one during childhood, and it got into their head, any time they encountered similar situations, it triggered panic attacks and other forms of anxiety." When P13 was asked whether she had observed her Black American clients with panic disorder exhibited vulnerability to harm/illness schema, she responded: "Yeah. I think that is another one that I should have included as one of his schemas. I kind of lumped that in with mistrust and abuse." P14 observed that they were vulnerable to harm because they lacked a defense mechanism. Thus, "if anything is negatively thrown to them, they don't have the power to defend it. They become vulnerable to harm and pain and eventually anxious."

Regarding the schema of negativity and pessimism, P5 noted that harsh parental punishments for mistakes and verbal abuse were the cause of this schema in his Black American clients. Similar current actions trigger panic attacks because they were severely punished and criticized when they were kids. Similarly, P7 stated that "about 10% or 5% of his Black American clients with panic disorder" indicated a heightened vulnerability to danger. When P6 was asked whether he had observed hypervigilance with his Black clients with panic disorder, he responded affirmatively but noted that the schema "fell slightly under the vulnerability to harm." Also, P13 reported that hypervigilance was an important schema associated with her clients from this population. In this light she stated: "I think with emotional flashbacks, he learned why certain things had such power."

Participants also indicated that failure schema (P1, P4, and P8), and incompetent/dependent schema (P4 and P8) were associated with panic disorder among Black Americans. Participants 4 and 8 further relayed that incompetent/dependent schema and unrelenting standards were the drivers of failure schemas. For instance, P4 shared that his Black client developed the belief that he was a failure because he could not defend himself as a child. In his words, "Because the child was bullied when he was young, he developed the schema that he cannot defend himself from certain problems, including fighting back." Also, P8 reported that "most of them have set for themselves unrealistic standards of what they want to attain. And so, this causes a bounce back."

Theme 3: Schema Modes Associated with Black Americans with Panic Disorder

During the interview, participants reported their experiences with schema modes associated with panic disorder in Black Americans. Participants reported unhealthy child

modes (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14), coping mode (P5, P6, P8, P9, P10, P13, and P14), and parent/inner critic mode (P5, P6, P8, P9, P13, and P14). Thus, these schema modes clustered around four subthemes: unhealthy child modes, parent modes, coping modes, and healthy modes.

Subtheme 3.1: Unhealthy Child Modes

Participants reported several unhealthy child modes associated with panic disorder in Black Americans. In the category of vulnerable child modes, P3, P9, P11, P13, and P14 reported that vulnerable child modes were commonly associated with Black Americans with panic disorder. For instance, P11 reported that the modes associated with her Black clients with panic disorder were "largely the vulnerable child modes." For P13, "I think for him the modes were largely the vulnerable child modes." In listing the schema modes she addressed when treating her Black clients, P14 added "Then there are the vulnerable child modes." Participants also noted specific modes within the category of vulnerable child modes. For example, P1, P2, P7, P9, P10, and P12 shared that an important mode in which their Black American clients with panic disorder responded to their EMS activation was an anxious mode. For instance, P1 observed that they experienced "anxiety where the heartbeat is high, and some of them usually sweat." For P9, the anxious mode in which "their mind is always running" was a common mode.

Participants 3, 4, 7, and 10 highlighted addressing the lonely/neglected and abandoned child modes in this population as a way of reacting to their EMS activation. According to P10, feeling neglected was an important vulnerable child mode Black American client with panic disorder shared with him. The family dynamics driving this

mode, continued P10, were neglect, emotional deprivation, abandonment, social isolation, or invalidation in the early stages of life. In the experience of P4, “some feel they are so lonely; they are abandoned, and this results in fear, anxiety, and panicking.” For P7, “feeling left out by the people that you love or cared for” was an important mode her Black clients with panic disorder struggled with. Similarly, P1, P5, and P6 reported the rejected child mode. For example, when P1 was asked if he observed rejected child mode among his Black American clients with panic disorder, he responded: “That really plays out when we're having sessions. Most of them with rejected child mode experience a lot of mixed emotions” The rejected child mode, continued P1, was associated with “fear of intimacy, distrust, anxiety, depression, and people-pleasing behaviors.”

Other important vulnerable child modes reported include the helpless child (P7), the terrified child (P1, P4, P11, and P14), the abused child (P3 and P6), humiliated child (P6), mistrustful child (P1 and P7), and the confused child (P1). For example, P7 reported that “most of them felt helpless in response to vulnerability to harm.” Regarding the terrified and mistrustful child, P1 observed that some of his Black American clients with panic disorder struggled with “the fear of intimacy and distrust.” Also, P4 noted that they were always afraid of one thing or the other.” For P14, “they had a lot of fear, and this made them sad.” In a detailed report, P11 noted her client’s terrified child mode:

> She was terrified of lizards and birds. And she said that lizards were creepy looking, they were ugly, they were fast. It was a full-blown phobia, which was really difficult because in her area they're everywhere. And she had had that phobia for a very long time.

Within the category of angry/unsocialized child mode, participants shared the following experiences with their Black American clients with panic disorder in responding to their EMS activation: angry child (P1, P3, P7, P8, P10, P12, P14), aggressive child (P2, P5, P8, P10, P11, P13), enraged child (P8 and P14), complaining child (P5), and frustrated child (P7). Most of these modes were adopted to respond to their EMS activation, including vulnerability to harm schema, emotional deprivation, defectiveness and shame, and social isolation. For instance, P2 reported that "they became aggressive toward the source of their anxiety." Similarly, P8 noted that they could become enraged at the source of the anxiety. Participant 13 reported that her client utilized aggression to overcompensate for vulnerability to harm (e.g., domestic violence). In her words, "the other overcompensating, though for vulnerability to harm, I would say were punitiveness and aggression." For P14, living with panic disorder "makes them angry and full of rage."

Subtheme 3.2: Parent or Inner Critic Modes

This subtheme highlighted the internalization of punitive, anxiety-inducing (or demanding), and guilt-inducing messages or voices from parents or other authorities that Black Americans with panic disorder struggled with. Precisely, P5, P6, P8, P9, and P13 reported punitive parent mode. For instance, P9 reported that some of her Back American clients were "overly critical of themselves, which may come from their childhood experience." Because "they were highly criticized, they have learned to be overly critical of themselves." Also, P5 reported that they blamed and condemned themselves for their

panic disorder Similarly, P6 reported that some were very harsh on themselves and could even resort to self-harm. Precisely, P6 stated:

> How they were talked to when they were growing up is the same way that they have also learned to talk to themselves. So even when they start feeling those feelings, rather than giving themselves compassion, they tend to be very harsh on themselves, which worsens their condition and the symptoms.

Other parent modes Black American clients with panic disorder utilized to respond to their EMS activation were demanding and anxiety-inducing, guilty-inducing, and pessimistic attitudes (P5 and P14). According to P14, having internalized the demanding voice to be perfect, they tried to avoid questions or complaints. “So, this is the mode of the need to control negative events to look perfect.” Because of this inner demand to be perfect, they blamed themselves for their panic triggers and became anxious and ashamed of such triggers. Similarly, P5 reported that “they feel they are hated.”

Subtheme 3.3: Coping Modes

Another subtheme under schema mode associated with Black Americans with panic disorder was coping mode. Participants’ observations were categorized under surrender/rigid mode, flight/avoidance mode, and fight/overcompensation schema. Under surrender/rigid mode, coping modes associated with Black Americans with panic disorder included helpless surrender (P5, P7, P10, P13, P14), compliance surrender (P11), and self-sacrifice/rescuer surrender (P13). For instance, P5 reported “the lack of courage or confidence” to deal with their EMS activations. Noting her observation about

her client, P13 reported that “in some ways, he surrendered to emotional deprivation. I'm never really going to get my needs met.” In P11’s observation, “there was a major compliance surrender mode. And I think that the compliance surrender is obviously trying to prevent bad things from happening.”

Under flight/avoidance mode, P6, P7, P8, P9, P10, P11, P13, and P14 reported that their clients self-soothed with food or substance use, such as alcohol, marijuana, and tobacco smoking to become distracted from their unpleasant feelings. For example, P6 reported: One of the maladaptive ways they used to cope is using substances. So, drugs, alcohol, especially before learning other techniques.” For P8, they use drugs to escape reality, especially alcohol. You have also marijuana, which is so popular. In P10’s observation, “they tend to drug and a lot of drinking. I've been having a lot of drinking clients here who just drink every day. I think drug is one way they cope with panic anxiety.” According to P14, “Some might end up using drugs to escape reality.” Also, P13 reported that her client self-soothed with drug, but became insightful in the end:

> He also had a detached self-soother mode. Now he got into it, initially when I met him, I think there was more possible smoking going on, but in the end, someone had introduced him to microdosing of psilocybin mushrooms, like real tiny doses of it for anxiety. And when he really needed to soothe himself, he tried those. And what he found is they actually made him more insightful. So, it didn't actually allow him to go into complete detachment. It actually helped him to be more insightful about why he was anxious rather than drinking a bottle of vodka. It was more like, oh, now I can understand better using the schema framework and

> putting things together. He would be kind of self-reflective and feel more centered and grounded. So, I would say that was still trying to be a detached, self-soothing mode, but it ended up turning into more of a healthy adult mode.

Two of these participants (P6 and P9) added that their clients had reported self-soothing with self-harm. In this regard, P6 stated: And also, some are prone to physically harming themselves." For P9, "As I mentioned, there's also self-harm, especially for people with panic disorder. Additionally, P11 noted that her client self-soothed with food and was seriously overweight. In her words:

> She self-soothed and still probably does. She self-soothes with food. She is seriously overweight. When she was growing up, her grandparents had a corner store, a grocery store. And so, she would always go there and get sweets and things like that. And because she was bullied in school, I think that might have also played a factor into her using food to self-soothe.

Other coping styles reported under flight/avoidance include avoidant protector (P5, P8, P9, P10, P11, and P14) and detached protector (P10). For instance, reporting how their Black American clients avoided situations (people, places, activities, topics, or discussions) that might trigger their panic anxiety, P5, P8, and P10 shared that some of them secluded themselves from the public. According to P9, "In my experience, they might avoid some activities that are not really scary, but their tendency is always to avoid feelings or being in a panicked state." Similarly, P14 reported that "they don't go to the place where they'll be triggered." Making a similar observation, P11 shared that her client avoided dating because of her overweight: "I think that a big part of that was

because she was really overweight and had been bullied and teased for being overweight as a child that she just avoided dating because she didn't want to feel ashamed." From another perspective, P10 shared that his Black American clients with panic disorder used "defense mechanisms to prevent paying attention to the panic triggers and avoided their own needs and emotions so that they would not feel anxious."

Under the fight or overcompensation mode, P13 reported perfectionism and punitiveness in her Black Americans client. In addition to being a self-sacrifice/rescuer, P13 noted that the client utilized perfectionism, being a rescuer or a fixer, or self-sacrifice mode to overcompensate for shame or defectiveness, social isolation, and emotional deprivation. Thus, she endorsed: "I think he overcompensated for shame and defectiveness and social isolation by being a perfectionist, a rescuer, a fixer, an entertainer. And the same with emotional deprivation. He really went out of his way to be perfect and successful." Also, P13 indicated that the client utilized punitiveness, in addition to aggression, to overcompensate for vulnerability to harm.

Subtheme 3.4: Healthy Modes

Two categories of coping mode were reported under this subtheme: healthy adult mode (P11, P13, P14) and healthy child mode (P3, P6, and P13). All the participants who shared their experiences of their Black American clients with healthy adult and child modes noted this experience when discussing their clients' improvement. For instance, P3, P13, and P14 noted strengthening their clients' healthy adult modes and addressing their contented child modes (e.g., optimism, happy mode, resilience, self-confidence) to eliminate the unhealthy modes and reduce panic disorder.

Also, P6 reported "teaching them how to reparent themselves, in the sense of how to talk to themselves, and how to think of themselves." Explaining how she helped her client develop healthy adult mode from the vulnerable child, P11 shared:

> We found a picture of her when she was younger that she really could identify with and felt compassion toward, and we made it the screensaver on her phone so it could remind her of that little person inside of her who needed the adult her to protect her. So, there was the vulnerable child and, obviously, the healthy adult we were developing together.

Theme 4: Schema-Focused Therapy Aspects and Strategies for Black Americans with Panic Disorder

Participants highlighted many schema-focused techniques, strategies, and aspects in relation to their usefulness or frequently used with Black Americans with panic disorder. For instance, several participants reported using guided imagery frequently when working with Black Americans with panic and endorsed that it was helpful. Four participants (P9, P10, P11, and P13) emphasized the usefulness of schema psychoeducation, and nine participants (P4, P6, P7, P8, P9, P10, P11, P13, and P14) reported the essential role of limited parenting in general. In any case, four subthemes were built around this base theme: data collection and schema identification strategies, schema change strategies, multicultural strategies, and clinicians' self-improvement.

Subtheme 4.1: Data Collection and Schema Identification Strategies

Within this subtheme, 12 participants (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11, P12, and P13) reported using guided imagery most frequently with their Black American

clients with panic disorder. For instance, P6 reported using guided imagery to help Black American clients with panic disorder imagine themselves at a particular age and connect to the root cause of their panic disorder. Similarly, P7 shared using the imagery work to help them "picture or imagine how life was when they were growing up to connect them to occasions that might have contributed to their current panicking." Participant 8 shared using guided imagery, among other schema-identical strategies, frequently when working with Black Americans with panic. Participant 9 related using "a lot of imagery and child dialogues to really immerse them into those emotions and into how they felt the first time they experienced some of these things that might have informed these false schemas." Participant 12 highlighted:

> One technique that I usually use is imagery work because schema therapy is a therapy that references things that happened when someone was growing. And so, I try to tell them to imagine and see some flashbacks of what happened when they were growing up. What do they believe caused the panic disorder?"

Ten participants (P1, P2, P3, P6, P7, P8, P9, P11, P12, P13) emphasized that the imagery work was most helpful to Black Americans with panic disorder because it was a powerful tool for imagery rescripting of situations triggering their panics and anxieties. For example, P6 expressed: "I find the imagery very helpful because you're able to actually describe the feelings they were feeling in that state that have caused these narratives that are in their head, making their panic attacks continue to occur frequently." Reporting the usefulness of guided imagery for Black Americans with panic disorder, P8 shared having them "imagine a certain incidence that they remember about their

childhood, maybe remembering something that happened to them when they were five years old. So, you tell them to focus on that image and try to rescript that image." Also, P9 reported asking Black American clients with panic disorder to remember a time when a traumatic event happened in their childhood. So, they were "asked to picture the room, how they were feeling, what happened, and now training their mind to visualize that situation in a positive light so that they can break that cycle." Participant 11 was emphatic on the usefulness of the imagery work and noted clearly:

> But really, the piece of schema therapy that I think is the most helpful is the imagery work where you're really helping your client to take their current triggers and anxieties and beginning to connect them to where they originated from and not from the prefrontal cortex and an irrational place, but from the other part of the brain where emotion is stored. And getting them in touch with that connection of why they feel what they feel and where it came from. It's incredibly powerful.

Like guided imagery, all participants, except P7, indicated that the techniques to collect clients' data to identify their maladaptive schemas were mostly helpful. However, participants emphasized differentially the usefulness of these techniques and their frequency. For instance, P3 stressed that clinicians should first make the right diagnosis for the client and recommended: "Let's just not assume that the client has panic disorder only. Let's go an extra mile to find out if there are other conditions?" Participants 9, 10, 11, and 13 emphasized the usefulness of schema psychoeducation and noted using them frequently. Participant 10 reported frequently using with Black Americans with panic disorder "schema psychoeducation, where you tell them about the concepts of their

problems that helped them understand and learn how it impacted their lives." Participant 13 stated: "I think psychoeducation is important upfront so they can buy into it and are willing to take the inventories or schema questionnaires because they're a kind of long." Similarly, P11 reported using psychoeducation frequently earlier to help them "cognitively understand their maladaptive lenses just from a conversational, explaining pros and cons, the sort of rational piece of it."

Also, P1, P3, P11, and P13 reported the usefulness of conceptualizing client's problems to be sure their needs were met. For example, P11 reported: "When you are meeting the client's need, you have to be very clear that you are not meeting the need inappropriately for the wrong schema. So, the conceptualization is very important." Participant 9 also indicated the usefulness of using "need inventories to explore the basic unmet needs of her Black American clients." Participants 8 and 12 noted the inevitability of using behavioral pattern analysis, including mode exploration, to identify maladaptive schemas when treating Black Americans with panic disorder and to help them develop adaptive coping strategies. For example, P8 stated:

> The most desirable strategy to use is behavioral pattern analysis whereby I identify one by one, the maladaptive behaviors that reinforce these kinds of schemas and hinder their well-being. So, by exploring the consequences of these behaviors, I will be able to allow these clients to develop adaptive coping strategies and behaviors. What I have come to learn about African Americans is that it's better when you take them step by step and making them understand the importance of every step and learning from their behaviors one by one.

Additionally, P13 acknowledged that using mode sequences and understanding the client's social context were helpful for her Black American client. Regarding the usefulness of mode sequencing, P13 reported:

> An aspect specific to schema therapy applied to family work is mode sequences, involving helping them understand how they bring out certain modes and the dysfunctional patterns that evolve when one person gets triggered and schema gets activated and the person goes into a mode and then that brings out a mode of the other person because their schemas are activated, and how to catch it early and be able to talk. So, that is an intervention that's schema based for couples and families. So, I thought that was helpful.

However, P1, P4, P5, P7, P13, and P14 related the difficulty of using these specific data collections and schema identification techniques frequently, despite their usefulness. Their concerns include omitting important information about clients, the length of the data collection tools, and the pain clients endured during the guided imagery. For instance, P4 reported: "Schema therapy emphasizes much the relationship. But when I give you some questionnaires to fill, you'll be doing it on your own and then you'll get bored, and I'm not going to capture a lot of information about you." Participant 14 noted that some data collection techniques take a long time. In her words, "I think mostly it takes a lot of time to complete, for instance schema questionnaire, and sometimes clients find it difficult to endorse things that are against them, leading to inaccurate information about them." Similarly, P7 observed: Some of them do not give the full information because maybe what happened when they were kids was something

to do with family issues or shame, and they fear to share the stories." Reporting her concerns about schema questionnaires, P13 shared:

> Questionnaires that assess schemas and modes are long, and they're a lot of words. And because in some states, we have a very bad school district and a lot of people who even have high school diplomas or even college degrees have limits in their literacy and comprehension, those questionnaires could be a lot for some people to read and comprehend if they have had poor education due to just being in a bad school district.

Although two participants (P4 and P5) reported that guided imagery was useful, they noted that one big problem with the technique was that it reminded their clients of their problems and opened their pains. For example, P4 stated that guided imagery helped his Black clients with panic disorder explore adverse childhood events, better understand how their maladaptive schemas might have developed, and identify appropriate schema-focused therapy techniques for the problem. In his words,

> This is where you allow them to explore adverse childhood events and better understand how their maladaptive schemas might have developed. And when you do that, you're going to know the root, where the problem started. And that will also help you in knowing that they are suffering from this kind of schema or that schema. And when you have that information, you will be able to derive a very better approach to the problem.

However, P4 added that guided imagery inevitably creates a painful experience because "you're digging into their past wounds." Similarly, P5 reported:

> Guided imagery is something good because you will have a good means of treating or helping the client overcome their problems because you know the root cause of the problem. But now, on the other side, there's something you're triggering, which is painful as you are digging into the client's wound.

Consequently, P14 recommended that imagery work should be used only when clients are fully informed and ready because "it works better after you've gone on with clients for a while and their minds are calmer."

Subtheme 4.2: Schema Change Strategies

Participants reported frequently using several schema techniques with Black Americans with panic disorder and highlighted the usefulness of these strategies. This subtheme was organized into four categories: relational, experiential, and cognitive restructuring strategies.

Relational Strategies. Two participants (P3 and P13) noted the importance of ensuring a supportive environment for clients as a relational strategy. Participant 3 reported the importance of "making sure that the people around Black American clients were very supportive." Similarly, P13 reported that knowing the client's social context was very helpful for her Black American client:

> It's helpful to have sessions with the family because you get to see what the client is dealing with in other people, and you also get to hear from other people who know what they're like in real life. So, I saw this client's wife several times with him in sessions. I saw his son with him several times in sessions, and that was really helpful. Some therapies would not encourage that, but I found that to really

> help me understand his social context, make him feel like I understand who he was dealing with, and make some interventions. So, that was an aspect of schema therapy that I thought was helpful.

All participants (n = 14) shared using the relational strategy of limited reparenting in one form or the other frequently because of its usefulness. More than half of the participants (P4, P6, P7, P8, P9, P10, P11, P13, and P14) reported the essential role of limited parenting in general, taking the strategy to be very helpful and unavoidable in schema-focused therapy. For instance, P11 noted: “We're a limited reparenting model,” which involves “clinicians “really trying to understand what the unmet need is and to respond, not like a therapist would, but a parent would, but obviously in a limited capacity.” So, “there's a real sense of warmth and empathy and care that comes with the therapy that I think in of itself is healing very different from other therapies that try to be a little bit more distanced or neutral.” Once clinicians are meeting the client's needs appropriately using conceptualization, there's real healing in limited parenting because the client feels that sense of curiosity and care from their therapist in a way that goes beyond just a neutral approach of other therapies.

Similarly, P14 stressed the usefulness of limited parenting in “ensuring that her Black American clients’ emotional needs were met in a healthy way considering all the elements around it, their coping styles, and their modes.” Participant 4 reported that “schema therapy emphasizes much on the relationship,” insisting that it was a very important strategy with his Black American clients with panic disorder. Participant 8 shared that limited reparenting, involving relationships between therapists and clients, is

very helpful with schema therapy and any mental health therapy. He emphasized that it "helped your clients feel comfortable with you because people with maladaptive schemas could have developed certain behaviors from a very traumatic experience, and they find it difficult to open up to you."

For P5, the relationship-oriented aspect of the therapy helped him build a secure attachment with clients and be in their situation or in their shoes to know how they are feeling. Thus, he reported: "The aspect that allows me and the client to be connected is very helpful." Similarly, P9 noted that the limited reparenting helped her Black American clients "get a secure attachment style, which led to their growth and healing." Also, P13 reported: "I think limited reparenting, having a good connection with the therapist is critical, particularly in this one because you're basically modeling healthy adult and that even though I was of a different race and gender, I think because of that we really connected." Also, P10 related that one aspect of schema-focused therapy that was helpful for Black Americans with panic disorder was "limited reparenting where you provide empathetic responses to the clients and modeling healthy interactions." P10 maintained that it helps "clients develop a more compassionate and nurturing inner voice." It also "helped therapists to think rationally with clients and come up with a solution." Similarly, P7 noted that the connection strategy of schema-focused therapy is the most helpful aspect because it helped him "be in a position to know that this person feels this way and he needs this kind of assistance." However, P13 advised schema-focused therapists to "always take care of themselves so they really be modeling what a good parent would model when working with clients because of the limited reparenting aspect."

Aside from mentioning the importance of limited parenting in general, every participant emphasized the importance of using one or more aspects of limited reparenting, such as empathic listening, non-judgmental, validating clients' views, empathic confrontation, and providing safe havens with Black Americans with panic disorder. For instance, eight participants reported the usefulness of empathy. In this light, P11 stated that "empathy is the key ingredient. And so, I think that is so important, especially understanding why Black Americans are going to be more likely to encounter panic disorder, especially in the world we live today." Also, P3, P4, P5, and P12 noted that empathizing with their Back American clients and ensuring they do not feel guilty were very helpful. Additionally, P6 and P14 noted the importance of being patient, putting yourself in the client's shoes, and understanding their feelings, especially when they are unwilling to open up. In the same vein, P7 related that understanding clients' perspective makes them connect with you and helps you appropriately assist them. In this light, P10 noted: "not validating clients' subjective perspectives was not helpful." However, P12 warned clinicians should not over-empathize with clients so they can touch on the client's real problems. In his words, "attitudes, such as empathy is helpful in therapy, but therapists should not allow it to affect therapy negatively, such as jumping essential steps and omitting clients' information."

Highlighting the usefulness of other aspects of limited reparenting, P1, P6, P9, and P14 reported the usefulness of empathic confrontation. For example, P9 stated: "We also use the confrontation, but we use it in an empathetic way so that you can also challenge some of the negative behaviors or the maladaptive modes they've been using to

cope.” However, P13 advised clinicians to use empathic confrontation sparingly and carefully to avoid becoming too confrontative, especially if clients are anxious and clinicians are trying to build trust. Reporting empathic confrontation in relation to her Black American client, P13 noted:

> I think empathic confrontation, if it's done well and not too often, can be helpful. But if it's not done well or it's done too much, I think the client can feel like they're not understood, or they're being criticized, and in this case, I think this client had a lot of the rejection sensitivity schemas, like emotional deprivation, mistrust, abuse, social isolation, abandonment. So, I think he is particularly sensitive to feeling criticized or misunderstood. So, I had to be very careful, and at times, it may have left him feeling judged, criticized, or misunderstood even though I was trying not to do that.

Other aspects of limited reparenting respondents reported were remembering what clients shared during therapy (P14) and creating safe havens for them (P1, P2, P3, P6, P12, and P13). For example, P14 shared that “it's good when your clients know that what they told you is not forgotten.” Participant 3 said it was helpful to ensure this population was in a safe environment where they would not feel judged. Similarly, P8 emphasized the need to “create a safe space for clients to express their emotions related to racial experiences and work towards building resilience and coping strategies specific to their racial identity.” Participant 13 reported that being sensitive to the Black Americans’ sense of shame and the stigmatized mental health helps create a sense of comfort with them and noted: “I think it is stigmatized still going to a therapist in the black

community. So, being sensitive to that and asking what it's like to be in therapy is helpful. Are they hiding it from people? Are people supportive?" Participant 1 recommended virtual therapy for Black American clients who do not like sharing their emotions face to face as a good alternative to maintaining safe havens during therapy. Also, P6 reported:

> What is essential here is that these people are very deeply traumatized. So, there's a lot of self-blame or shame, especially for the Black community. So, there should be a lot of empathy involved and making them feel that they're in a safe space.

For P1, P2, and P12, normalizing clients and building rapport, trust, and hope were invaluable ways of creating safe havens in his therapeutic relationships with Black Americans with panic disorder. For example, P2 recommended that letting Black Americans with panic disorder "know they are loved, and every feeling is accepted creates a safe space for them." Participant 1 reported: "I disclose my experience with panic disorder to normalize their feelings and experience, build their hope and trust, and inspire them to open up." Similarly, P12 shared:

> You have to tell them that I had someone like you having the same problem; he went through this therapy, and he got healed. So, when you create that interaction and rapport at the start of the therapy, then trust me, the client will cooperate, and you are going to go on well with the client with no distractions and hesitations, and the whole thing will run well.

Participant 13 reported another aspect of limited parenting over her Black American clients with panic disorder, involving giving them audio or video recordings of the therapy session and audio flashcards so the therapist's voice would remind them of

the healthy adult ways of thinking. Precisely, she noted: “And I also sent him recordings of our sessions so he would have them, and he said he listened to them, and it helped him remember what we talked about and remember these new ways of looking at things.” Similarly, P11 reported clinicians’ availability to client during sessions (in person) and in between sessions (via text messages) as a helpful aspect of limited parenting over her Black American clients with panic disorder. Thus, P11 stated:

> Another one that sort of sets us apart from other therapists is that we make ourselves more available to our clients than other therapists do. And so in between sessions, if something comes up or one of my clients is struggling, they're free to text me. I mean, I'm not going to spend hours, but I will certainly spend time outside of the session connecting with them. And that also helps to strengthen the bond and the sense of care I think that the therapist has. So, I think that's another unusual piece of schema therapy.

Experiential Techniques. Participants reported using several experiential techniques for Black Americans with panic disorder. As in the case of guided imagery, almost all respondents noted that imagery rescripting was helpful with their Black American clients and that they used it frequently. It is imperative to underline that most participants discussed guided imagery and imagery rescripting together because both complement each other as one process in which clients revise painful memories by recreating (imagery rescripting) the image of past events usually reached through guided imagery. Some simply used the expression imagery work for both techniques. In any case, some respondents noted transitioning from guided imagery to imagery rescripting,

whereas others simply called it imagery rescripting. For example, P1 simply said: “Imagery rescripting is a helpful technique for my clients.” Participant 9 also stated using “a lot of imagery and child dialogues to really immerse them into those emotions and into how they felt the first time they experienced some of these things that might have informed these false schemas.” However, P9 indicated the transition to imagery rescripting when she reported “using the technique to train their minds to visualize situations positively and to break their maladaptive cycle after asking them to remember a traumatic event in their childhood.” Similarly, P8 shared that in using image rescripting with Black Americans with panic disorder:

> You have them try to create an image of each stage of their lives. So, when it comes to childhood, you have to tell them to rewrite their story and then reimagine and rescript that kind of imagery. When they rescript that image, then you already have a material to use.

Participants (P3, P4, P6, P9, P13 and P14) also reported that schema dialogues, including role reversal, mode dialogues, and chairwork) were frequently used and very helpful for this population. For instance, P6 noted that she used schema dialogues “to help them connect with their emotions and understand their negative thoughts.” For P14, schema dialogues helped them express their feelings, wants, and things affecting them, speak to their maladaptive schemas by playing the role of healthy schema modes, and control their anxiety. Participant 9 reported using schema dialogues and imagery work frequently but underlined that “what's not very effective is going straight into, the chairwork where you ask them very deep questions that may come in later.”

Participant 13 reported using mode dialogues frequently but not chairwork because she conducted sessions mostly on Zoom due to the pandemic, and so it was hard to do chairwork. Consequently, they "did mode dialogues, without changing chairs like is often taught to do in schema therapy because of the setup in his apartment and it just seemed too complicated." Also, P13 relayed that even if it was in-person, some people have trouble with chairwork, noting: "I've noticed some people do have problem with it." In this case, she used only mode dialogues to be sure they were comfortable. When asked whether the tendency of chairwork to provoke emotional pains was why she did not use it frequently, P13 said that it was never the reason because using mode dialogue alone also provoked clients' emotional pain. She emphasized that the mode dialogue was helpful to his Black American clients. Thus, she reported:

> Once they get into it, once they understand that they're supposed to be speaking from this one part of themselves, I find that once they let themselves do that, then they do okay. Getting them to understand in the beginning that you're just talking from this one part of you may be a little weird for some people. Some people have a little trouble understanding modes. But once they get it, then I think they seem to be able to do it and benefit from it.

However, P8 reported using role-playing less frequently because "playing a role to be someone else who has a particular behavior and see things from the person's perspective was difficult for some of his Black American clients." In any case, P8 demonstrated how he used chairwork: "I put an empty chair in front of them and tell them that's your girlfriend. Can you talk to her? Sometimes, I'll listen. Sometimes, I'll go out

and come back and ask them, what did you tell your girlfriend?" Participant 11 reported not using chairwork frequently and shared: "We did more imagery work, and we did less chairwork." She also noted that this depends on the client's needs: "Well, I wouldn't say with everybody, but this client, I think it depends on the client. I mean, I love all the different tools that schema therapy offers. So, it really depends." Similarly, P5 related not using schema dialogue frequently, noting: "From my experience, Black Americans with panic disorder usually have the problem of feeling ashamed because of their problems. This makes schema dialogue difficult and not very helpful with them." Also, P2 reported not using role-playing with clients frequently but did not offer reasons for this.

Cognitive-Behavior Interventions. All participants reported using one cognitive behavior intervention or the other with their Black American clients with panic disorder. As noted in the study conceptual framework, schema-focused therapy involves several cognitive-behavior interventions, including schema diary, flashcards, relaxation training, homework, schema triggering and mode analysis logbook, rewarding adaptive behavior, psychoeducation, rehearsal of adaptive behavior, restructuring thinking patterns, and breaking maladaptive behavior patterns. Firstly, six participants (P1, P2, P3, P4, P5, P9, endorsed incorporating cognitive behavior interventions in general in their schema-focused therapy with Black Americans with panic disorder. Participants 1, 2, 3, and 9 reported that these interventions helped this population to break their maladaptive behavior patterns and recommended them to clinicians. For instance, P1 stated that the cognitive behavior interventions "alter the unwanted behavior by challenging their negative attitude patterns." Participant 9 reported: "I use cognitive behavior techniques.

They focus more on why the clients act the way they do and finding a way to break those patterns and transform them into different outcomes." In contrast, P4 and P5 expressed some concerns that most cognitive behavior interventions involve homework, journaling, and diary, leading to clients' disinterestedness most times. For instance, P5 noted that cognitive behavior interventions "involve things that you are going to leave clients to do for themselves. So, I don't think they may be helpful to clients because they will not do most things on their own."

Specifically, more than half of the respondents (P3, P5, P7, P11, P13, and P14) shared using schema flashcards frequently with this population and underlined that it was most helpful in reinforcing their healthy responses to schema triggers during recurring schema triggering situations. For instance, P7 noted the usefulness of completing schema flashcards with his Black American clients to track their current feelings, modes, things that trigger them to panic, and negative thoughts about these triggers and to underline healthy responses to specific schema triggers (e.g., healthy cognitive thinking and behavior). Participant 7 added: "I have been using that technique quite well, and that's why I will categorize or maybe, put it amongst the techniques that are most frequently used." Similarly, P14 also noted the usefulness of using schema flashcards to "guide them to organize the everyday experiences of their schema modes and identify the schema modes and when the modes are triggered, what triggers them, what they are doing to cope effectively with the triggers." Because they carried them about and read them during schema triggers, continued P14, they had tangible rational responses that readily defeated irrational and unhealthy responses.

Participants 11 and 13 relayed the usefulness of using frequently audio flashcards. In this light, P13 reported that it was helpful to use “audio flashcards and video recording of the therapist’s voice that remind them of some of the healthy adult ways of thinking.” Similarly, P11 observed:

> I love schema flashcards mostly now because of the advent of the cell phone and the fact that everybody carries one on them. I do audio flashcards for my clients, and I find that to be incredibly helpful for them. When they're triggered, get into the amygdala, and can't find a way out, they've got something they can listen to, and that really helps them to regroup, connect where this is coming from, and then proceed in a way that's not going to perpetuate the schema or the problem.

Participant 5 reported using schema flashcards frequently because it “helped in monitoring patients’ current feeling and their schema triggers, the things they may be experiencing, and as a result, come up with positive ways to meet their needs in the present.” However, P5 had concerns that clients did not usually comply with instructions on schema flashcards. Three participants (P4, P9, and P12) perceived that schema flashcards were effective, despite using it less frequently with their Black American clients. For example, P4 stated that “it is most helpful, despite that, it is least frequently used” because it helps “to derive information on the sources of clients’ triggers and how they respond to them.” Participant 12 simply indicated not using flashcards frequently but noted having a counselor friend who used it frequently. Similarly, P9 reported: “It's more of a personal experience, but I'm still aware of other therapists who use it.” Also, P9 stated that it depends on each client’s needs:

> It also depends on each client because some people maybe more open to talk about the past and immerse themselves with guided imagery, while others may be more of giving them tasks to take home and do so. You can't say that one method is not effective, it just depends on the client.

Buttressing this point, P8 also stated: “I really don't know if there is one strategy that is least useful because when it comes to therapy, different therapists use different methods which they think is suitable to clients.” Similarly, P11 reported: I think it depends on the client. I mean, I love all the different tools that schema therapy offers. And so, it really depends.” Additionally, P6 reported:

> I don't really know if I could specifically say a specific technique is least helpful. Maybe it may vary from client to client because some clients may be a bit avoidance and. Yeah, but I don't think I would necessarily say that there's a technique that's not helpful. Similarly,

Regarding schema diaries, P4, P5, P9, P12, and P13 shared that they frequently used this strategy with Black American clients with panic disorder. It is necessary to indicate that schema diary and schema flashcard are similar. The significant difference between the two techniques is that clients, after getting advanced in schema-focused terms, complete a schema diary when a schema is triggered to prevent them from dysfunctional behavior (Arntz & Jacob, 2013). Participant 13 reported that she gave her Black American clients “a schema diary card, as homework, to fill out when they get activated during the week, and that helped prevent them from dysfunctional behavior or after they've done something they regret.” Schema diary, continued P13, helped them

“process what happened and talk about it, put it in schema terms, what schemas were activated, what modes did I go into, what could I have done, what would've been a healthy adult.” Similarly, P12 reported using a schema diary frequently with this population because it helped them record the pattern of their behaviors. For instance, when panic occurs, “the client will record the time, cause, or the circumstances of that trigger the panic. The client will also record what he does to control the panic.” Additionally, the strategy helped clients evaluate their thought process and challenge their negative thoughts. Also, P5 reported allowing his Black American clients to fill some diaries about their behaviors, the schema activation, its frequency, and healthy ways of coping with the triggers.

Participant 9 observed that schema diaries and similar strategies (e.g., flashcards, journaling, and other homework), “helped her Black American clients with panic disorder be aware of their emotions and behavior and respond in healthy ways.” Reporting the usefulness of another homework, P9 reported using letter writing to help her Black American clients address the person that caused them the negative emotions, for example, their parents. She underscored that writing “a letter as if they are addressing that person and telling them how they feel their needs are unmet, how they made them feel in childhood and what they wished they could get from their them” was helpful.

However, some participants underscored some difficulties and concerns, leading them to avoid schema flashcards, schema diaries, homework, and journaling. For instance, P8 observed that Blacks generally do not feel comfortable when others know they are seeing a therapist. “So, when you give them homework assignments, they are not

gonna feel comfortable discussing their mental health issues with their loved ones, including children, parents, relatives, and friends." Hence, P8 advised that using cell phones for schema flashcards, diaries, journaling, and other homework will improve this situation. For P8, "Cell phones provide some privacy because people can use their phones without somebody else accessing them."

Similarly, P4, P5, P7, and P10 complained that Black American clients did not always complete their assignments because diaries were given as homework. In this light, P4 observed that this was perhaps "because they were doing it alone and became disinterested." Participant 5 added that because they were completing the diary alone, "you're not going to capture a lot of information from them." Similarly, P7 reported that "when clients are doing things on their own, they are not going to do it the way it's supposed to be done. They are going to leave out a lot of information really needed for schema therapy." Participant 10 denied using schema diaries, journaling, and other self-help techniques because they involve "a lot of work with clients alone." Consequently, P7 and P12 insisted that when clients follow instructions, these strategies will be effective and improve their mental health.

Other essential cognitive behavior interventions participants (P1, P2, P4, P6, P8, P12, and P14) reported using with Black Americans with panic disorder were cognitive restructuring, reattribution, and reframing. As already seen, these techniques are essential parts of schema flashcards and diaries. However, clinicians can still use them all alone. Participants 1, 2, 8, and 10 acknowledged using cognitive restructuring strategies frequently for this population by helping them generate a list of alternative explanations

to disprove unhealthy and dysfunctional evidence supporting maladaptive schemas. In their observation, restructuring thinking patterns was helpful for this population and reduced relapse rates. Also, P3, P6, and P14 recounted using the reattribution technique, which is essentially replacing some negative thoughts with more positive ones, and they also recommended it for clinicians working with this population.

Six participants (P1, P2, P4, P9, P10, and P14) reported using relaxation techniques frequently with Black Americans with panic disorder and that the techniques were helpful. For example, P1, P2, P10, and P14 shared using deep breathing with this population. Consequently, P1 recommended that "clients having a panic episode need to sit down, relax, and take deep breaths. You can say it verbally to yourself: breathe in one, two, three, and so on to calm your nerves." In addition to deep breathing, P14 reported using other forms of relaxation techniques, including yoga, listening to music, reading books, and drawing, to help this population relax and overcome or control their panic triggers. Participant 4 emphasized "taking a walk and talking to a friend as a means of relaxation." Also, P1 reported that muscle relaxation was another essential technique he used with this population. He described, "They can do physical exercise, maybe stretching. That helps because it relaxes their muscles and make them feel rejuvenated."

Some participants (P2, P8, P9, and P10) shared frequently using maladaptive behavior pattern breaking with Black Americans with panic disorder. For instance, P10 recounted assigning activities that challenge them to counteract their maladaptive schemas (e.g., telling a client who is locked up to socialize). Using an instance of introverted panic disorder clients, P10 noted: "You can tell them to talk to strangers once

a week. That would be really a challenge. And when they have done it, it's a goal that has been achieved, and that's a lot of progress." According to P10, such an assignment helps them practice new behavior that counteracts the maladaptive schema. However, P10 advised: "It must be gradual. Let them start as small as they are comfortable with." Therefore, clinicians need to set small goals at a time. Participant 9 indicated "using scripting, journaling, and rewarding adaptive behavior to help Black American clients with panic disorder challenge their maladaptive schemas." Two participants (P3 and P8) reported different ways schema therapy would benefit this population. Participant 3 noted that "when clients enter therapy convincingly, they benefit a lot, unlike clients who enter therapy without proper conviction," while P8 highlighted the importance of "educating clients about the circumstances leading EMS activations."

However, P14 expressed some concerns that some clinicians are so fast with clients when using behavioral pattern breaking, leading clients to be unsatisfied in the process. Thus, P14 advised clinicians to be sure that clients have accepted the decision to change before using this technique and to be gradual when using it because changing maladaptive behavior can take some time. In her words, "It has to be the decision of the client to change. And you need clients to gradually come up with the skills you are teaching them." Participant P6 reported using the rehearsal of adaptive behavior least frequently "because it feels almost like masking what is happening as opposed to actually uncovering it and figuring out proper solutions and proper framing." Finally, P11 reported not using cost-benefit technique (e.g., what is the benefit or cost of this schema)

frequently because “the strategy should come out in more organic ways than a cost-benefit list in the therapy.”

Subtheme 4.3: Multicultural Strategies

Six participants (P8, P10, P11, P12, P13, and P14) underlined the importance of culturally responsive schema-focused therapy for Black Americans with panic disorder. For instance, P8 reported that “acknowledging and validating the impact of racial trauma on individuals' schemas and panic disorder” was helpful for this population and recommended clinicians treating Black clients to always address racial trauma. Participant 12 also recommended that clinicians learn and understand their clients' personalities and cultural backgrounds to treat them effectively. Similarly, P11 shared, “It's so important to really try to understand, especially as a White person, your Black American client's world of having to deal with systemic racism. So, I guess within that is a tremendous amount of empathy, really wanting to walk in the shoes of your client. And I would say more so with the Black American. Further, P11 stated:

> I think that is so important, especially understanding why Black Americans are going to be more likely to encounter panic disorder, especially in the world we live in today. Whether it's seeing blue and red lights in your rear-view mirror. I mean, these are legitimate reasons to have panic attacks.

Additionally, P13 shared that going into therapy could be weird and hard for people of color, so getting a sense of their Black American clients’ preferences and needs in therapy is essential. For instance, “Are they going to be comfortable? What are their preferences for race and gender in a therapist?” Participant13 noted that “it would be best

if Black American clients can be with somebody of the gender and race and maybe even age if they prefer because it may make it harder for some to relate to somebody from another race or another gender." Therefore, P13 advised clinicians to "have cultural humility about being open to learning about the client's experience that may be very different from the therapists in their family, in their neighborhood, and in their everyday life." Similarly, P14 advised clinicians to always be open to ideas, suggestions, and clients' cultural values. According to P14, "open-mindedness will work because you're willing to welcome new ideas. You're willing to change, and you're willing to accept other people's cultural values." Also, P10 advised clinicians to be self-aware of their bias and how their cultural values might impede the therapeutic process when treating Black Americans with panic disorder.

Subtheme 4.4: Clinicians' Self-Improvement

Four respondents (P7, P10, P13, and P14) reported that the clinician's continuous knowledge update in schema-focused therapy was helpful for effective therapy treatment. For example, P10 shared: "I try to stay up to date. I interact with different people in this field, and it's really helpful." Similarly, P14 recommended clinicians to read empirical research on schema-focused therapy regularly to "find out what other therapists are doing, what has been working for them, and what hasn't been working." Participant 13 encouraged schema-focused therapists to join the schema therapy community. In this community, there are online sessions where therapists present almost weekly challenging problems they have with clients. Also, "there's teaching, sometimes there're interviews with experts, and all of that builds your sense of confidence and ability to stay in your

healthy adult when dealing with challenging clients." Recommending an important avenue for schema therapy knowledge update, P7 recommended an online course in the therapy for schema-focused clinicians:

> So, I would recommend other peers to get some information about schema therapy, maybe have an online course and try to use it with their patients, because we are all here to help people and change people's lives. So, we should use the very best method like schema therapy to help them.

Half of the participants (P5, P8, P9, P10, P11, P13, P14) reported the importance of self-care as schema-focused therapists with Black Americans with panic disorder. One important self-care that almost all these respondents noted was seeking personal therapy, counseling, guidance, and consultation. Participant 10 indicated that clinicians generally need assistance occasionally and should acknowledge it. In P10's words, "They need to seek guidance when they need it because one cannot know everything. They need help too." Furthermore, P10 noted: "I do personal therapy sometimes with very qualified and nonjudgmental therapists just to explore my own EMS." Participant 9 echoed the same thing when she said, "It is important for therapists to seek therapy if they feel their EMSs are being activated." Similarly, P8 endorsed "seeking consultation and collaboration with other healthcare professionals, such as psychiatrists or primary care physicians, to gather additional insights and perspectives on managing emergencies." Participant 14 related, "I can also seek support from colleagues, friends, supervisors, and anyone I believe can offer help." Participant 13 reported that consulting peers in supervision helped her conduct sessions efficiently and highly recommended it to other schema-focused

therapists. In P13's words: "The other thing, and it may not be a thing in the session, but I highly recommend it to therapists because it helps me in sessions, is supervision." Other essential self-care the respondents reported include taking time off for a break and interacting with friends and lovers, going to the gym, meditation, exercising, focusing on good habits every day, and eating healthy diets.

Theme 5: Challenges of Schema Therapy for Black Americans with Panic Disorder

Schema-focused therapy is not without challenges. In this light, participants indicated several challenges they encountered while treating Black Americans with panic disorder. Categories organized around this base theme include: the lengthy nature of schema-focused therapy, clinicians' commitment and close engagement with clients, and the complex nature of the therapy. Other categories include clients' emotional challenges, clinicians' emotional challenges, and cultural issues.

The Lengthy Nature of Schema-Focused Therapy. In describing their experiences of schema-focused therapy with Black Americans with panic disorder, many participants (P7, P8, P9, P12, and P13) acknowledged that the therapy is lengthy and time-consuming. For instance, P9 noted that the therapy is lengthy although effective. Thus, she stated: "It takes some time to really start to see progress compared to other modalities, but it's effective in the long run." Similarly, P7 and P12 shared that schema-focused therapy is lengthy and time-consuming, and this is challenging for both clients and clinicians. For example, P12 reported: "I think it demands client's commitment, time, and compliance to work. It requires some dedication and some close engagement. And the whole thing is somehow complicated unlike other therapies. Some clients usually find it hard to comply

with everything.” For P11 and P13, the therapy is lengthy, leading to high costs. For instance, P13 relayed that "schema therapy is expensive to people of lower income due to systematic racism." In her words: "A lot of schema therapists do not take insurance just because insurance doesn't pay much. And I've noticed a lot of schema therapists that I've met in the United States, and some don't take insurance." So, it is hard for poor people to utilize this therapy in the United States. Additionally, P13 reported that schema-focused therapy questionnaires are long and difficult with limited literacy, including people with high school diplomas. Hence, she to noted:

> A lot of people who even have high school diplomas or even college degrees have limits in their literacy and comprehension. I could see where those questionnaires could be a lot for some people to read and comprehend if they have had poor education due to just being in a bad school district.

Clinicians’ Commitment to Clients. Some participants also reported clinicians’ commitment and engagement with clients as a challenging aspect of schema-focused therapy. For example, P7, P9, P10, and P13 emphasized that the therapy involves commitment, dedication, and engagement with clients. In this regard, P7 indicated that “it's time consuming.” Similarly, P13 acknowledged that “it takes time, it takes work and commitment.” In P10’s words: “It's a long-term treatment that involves a lot of regular sessions. There are a lot of transformative behaviors in the clients. So, you have to be very observant, and you have to use a lot of expertise in this.” However, these participants reported that such commitment, dedication, and engagement also contributed

to the efficacy of the therapy. For example, P9 reported: “It takes some time to really start to see progress compared to other techniques, but it's effective in the long run.”

The Complex Nature of Schema-Focused Therapy. Three participants (P3, P12, and P13) also related that schema-focused therapy is challenging because of its complex nature. For example, P13 shared that the therapy is complicated, and therapists must learn all the parts of the therapy to use it effectively. Thus, she relayed that schema-focused therapy involves “different types of therapeutic interventions, which is like learning to play all instruments in the orchestra. But overall, it is rewarding and positive.” Therefore, “it does require a lot of training and a lot of different skills and the therapist to be in a healthy adult mode.” Similarly, P12 reported the complex nature of the therapy when he emphasized that schema therapy is complicated and hard. Because of its complex nature, continued P12, the therapy also demands clients’ commitment, time, and compliance. Hence, P12 maintained that when “clients, who really want help, decide to comply with our instructions, then the whole therapy procedure will be very simple.”

Clients’ Emotional Challenges. Almost all participants (n = 13) reported some emotional challenges among Black Americans with panic disorder during schema-focused therapy. The first emotional challenge respondents observed was trust issues. For instance, P1, P8, P12, and P14 shared that some of their Black American clients had the problem of trusting the therapy process or therapists. According to P1, some had “the problem of trusting the therapy process, leading to withholding information during therapy.” Similarly, P8 relayed that it was challenging for them to confide in the therapists. He said, "When you ask them some personal questions, and they look at you

for about two minutes and decline to answer that question, it is because they mistrust the therapy." Participant 14 noted this trust challenge increased when the therapy did not seem to improve their panic disorder. Commenting on such mistrust, P12 reported that "schema-focused therapy is a new therapy, and clinicians are learning to use it most efficiently, and some do not yet have full trust in it."

The second emotional challenge for clients that participants reported was shame and stigmatization. In this light, P1, P2, P4, P7, P10, and P12 observed the emotional challenge of shame and stigmatization among their Black American clients and noted that it was also associated with withholding information in therapy. In this regard, P12 reported that most of his Black American clients “usually find it hard or maybe they feel ashamed when they were telling their stories.” Similarly, P7 observed that some of his Black clients had difficulty disclosing their problems because of shame. Thus, P7 stated:

> It's hard for some of them to give out their full information because some might be very shameful and others disgusting. So, they usually tend to hide some information. From the way he or she is giving out or narrating her story, you can detect that some information is left out.

Using himself as an example, P1 reported, “I struggled with the issue of shame because of panic disorder. So, when a patient comes to me and they’re really struggling with panic disorder and shame, it truly disturbs me. Additionally, P1 reported that this population saw “disclosing their problems as a sign of weakness.” According to P2, this population had difficulty disclosing some cases (e.g., rape and other sexual abuses

experienced during childhood) because of shame and stigma and had no problem disclosing other problems (e.g., gun violence and road accidents).

Supporting this point, P4 reported that some of his Black American clients had difficulty disclosing their emotional problems they considered shameful and stigmatizing.

Also, P10 observed that shame was because they wrongly thought therapy to be judgmental. In P10's words: "I'd say that they consider opening up very difficult. They have a challenge doing that because they kind of think that people are judgmental."

Hence, P1 recommended virtual therapy for clients overwhelmed with shame and stigma:

> Another thing I will recommend for the Black Americans who really don't like sharing face to face is the use of the Zoom where you are not using the camera. This does not necessarily mean that you cannot express your emotions. So, you can just talk about it verbally to the therapist. You can just talk about it directly to me. I don't have to judge you because most of them feel like when you see them, you will judge them based on their appearance. So, they feel like when you see them, you will say, oh you're feeling ashamed, and you look like this.

The third emotional challenge for clients observed by participants was the tendency of the therapy to reenkindle clients' past emotional pains. Five Participants (P5, P6, P10, P12, and P14) observed that emotional pain was an essential challenge confronting their Black American clients when they wanted to disclose their emotional problems. For instance, P5 stated: "Schema therapy is emotionally challenging because it takes clients back to the root of their pain." In this light, P5 underlined imagery work as a primary means of such emotional pain. Using role-play as an example, P6 stated that

“getting into a role-play situation and replaying in the moments what happened or gave rise to these panic attacks or other symptoms might be emotionally challenging. Although it's useful, it's also very challenging at times.” From the perspective of P10, taking his Black American clients to their past experiences was challenging to them because it usually brought up very painful memories. Thus, P10 shared: “Visiting their past experiences is also challenging, where you have to talk about their childhood and their life events and try to understand how these schemas developed. It could bring up very painful memories.” Similarly, P14 simply remarked that imagery work was emotionally challenging to her Black American clients with panic disorder. Reporting the same emotional pains, P12 shared:

> When they narrate their stories, they inevitably remember what they passed through, what caused them to develop that panic disorder, and they usually get emotional, very, very emotional. And they may even end up panicking. So, that's a challenge for Black Americans with panic disorder during schema therapy.

However, some participants (P6, P9, and P13) relayed that these emotional pains were therapeutic. For example, P9 emphasized that when clients are stuck to emotional pain during therapy, they would go through them even if they were difficult and received improvement. Thus, she relayed: “If they stick with it definitely, they are able to go through the emotions, even if they might be difficult.” Similarly, P6 reported that “schema therapy can be very intense for clients because it goes into troubling memories but very effective over time.” For P13, clients might feel emotionally overwhelmed when telling their stories or when going back through imagery scripting, but that was actually

part of the healing. Participant 13 maintained that “being able to cry for your little self to connect to your vulnerable child is part of healing. Reporting the transformative effect of her Black American client’s emotional pain during therapy, P13 stated:

> So yes, when he did imagery scripting, he would cry, but it felt like it was healing, and he finally got the nurturance, you know the needs, but there was a lot of physical and emotional abuse in his growing up years that was part of those rescripting sessions. So, listening to those and trying to work with them was hard.

Acceptance and long-term change were the fourth clients’ emotional challenges. In this light, P2 reported that breaking with the old behavior pattern was challenging for some of his Black American clients with panic disorder because “it's hard to change your behavior if maybe you're used to any behavior.” In turn, this challenge was challenging for him as a therapist because he needed to help his clients change. Similarly, P10 reported that accepting their problems and adopting long-term change were very hard for some of his Black American clients with panic disorder. Thus, he shared: “Accepting the situation as it is and the willingness to change, to adapt, to set new habits and retrieve themselves from these panic disorders are very hard for some of them.” Consequently, “they fall back into their old ways eventually.” In the same vein, P11 related that accepting and recognizing the source of the problem were hard for her Black American client with panic disorder. In P11’s words:

> I think what was really hard was recognizing that a lot of the schemas and dysfunction that she was experiencing in her life were related on many levels to

her mom. She didn't want to see her mom in the light that we were beginning to see her in, which was definitely far from being the perfect mother.

Clinicians' Emotional Challenges. All Participants (*n* = 14) reported clinicians' emotional challenges during schema-focused therapy with Black Americans with disorder. About three quarters of the participants (P1, P2, P3, P4, P9, P10, P11, P12, P13, and P14) admitted suffering vicariously when treating this population. For example, P1 narrated that listening to his clients' stories on panic disorder rekindled his childhood experience of panic disorder, shame, and associated disturbing thoughts. Thus, P1 stated: "Because I've experienced the whole scenario of panic disorder in my childhood, the thoughts they share with me really disturb me. I will say that's something that really challenges me in my work as a therapist." Similarly, P10 shared: "When a client is telling you about panic disorder and trying to narrate her own story, that may actually activate in you something you have passed through during your childhood, it might begin to activate certain pains in you." Also, P2, P3, P4, and P12 reported that listening to different clients and their stories sometimes had an emotional toll on them, especially when clients shared some health issues clinicians had experienced. Participants 3 and 12 added that they had to seek therapy at some point because of such traumas.

Participant 14 reported that “vicarious trauma has often happened to her, but it gives her strength to conduct effective therapy with her clients.” Participant 13 also endorsed experiencing a lot of vicarious traumas after listening to the physical violence and trauma her Black American clients had experienced and are still surrounded by, and

the trauma associated with it. Thus, reporting the source of her vicarious trauma with this population, P13 shared:

> There's a lot of guns in this town. I would just hear stories from this client of things that happened during the week, arguments with neighbors and with teachers at his children's schools and other parents at his children's schools and even his own family, the level of aggression and deprivation they were still dealing with on a regular basis while trying to recover from anxiety problems.

Participant 11 reported that she used to suffer vicariously while treating clients in the first ten years of her career as a therapist:

> I think in the beginning of my career, that happened a lot more. I started doing this work in 1998, so I guess now almost 20 or 25 years later, I don't have that happen anymore. I had that happen in the beginning. Probably the first 10 years, but not so much anymore.

From a different perspective, respondents (P2, P5, P6, and P13) reported feeling bad because of clients' current emotional problems. Participants 2, 5, 6, and 8 reported that they usually felt sad when Black American clients shared painful stories about the death of a loved one, sickness, abuse, mistreatment, or similar difficulties. In this regard, P2 shared: I usually feel for them when they talk about things like death, abuse, mistreat, and those kinds of things. I'm also a human being. Those aspects usually make me feel emotional." For P5, "Asking them about the cause of their problem is reminding them of their problem. I feel bad sometimes about this. However, I must do that because if I don't, then I'll not be in a position to help." Similarly, P6 shared seeing these clients so

vulnerable and passing through a lot made her feel bad: “I think mostly I would say trying to keep my emotions because some of these stories or some of these exercises can also be hard on you, especially seeing your clients so vulnerable.” Also, P13 reported that she usually wondered whether the therapy was enough for clients living in a hostile environment. Thus, she stated: "I also have the feeling like, is this therapy going to be enough to keep them alive and safe when there are several aggressive people in their environment? So, I found that to be very challenging."

Another emotional challenge participants (P8, P9, P11, P13, and P14) reported was rupture, including difficulty responding to the client's reaction and resistance with positive countertransference. Sharing this emotional difficulty, P9 reported: "Resistance from clients is the biggest challenge I would say I faced during therapy." According to P9, trying to calm down and not be reactive when clients get very angry while you are empathizing with them might be challenging at times. Similarly, P11 admitted the challenge of negative countertransference to clients' negative reactions. Giving an example of a male client who was extremely demanding with entitlement, P11 reported that these two maladaptive schemas together were highly triggering for her. She said, "If I came out to the waiting room literally three minutes late, and of course, that triggered his deprivation, and he would come into my office and get really mad at me. Yeah, I would definitely have countertransference." However, P11 noted that rupture and similar emotional challenges are where some of the deepest work and healing occurred, irrespective of its challenges. Thus, she stated: "When there is a rupture, which is

difficult, I think for most therapists that deal with it, especially when it relates to the therapist, that is where some of the deepest work happens, healing."

Participant 8 also relayed experiencing emotional challenges when his Black American clients did not respond positively to instructions during therapy or stop coming to therapy because the therapist indicated their real problems. Hence P8 stated: “Some of them will be in denial and others will feel like this an insult. They don’t want to accept that’s really themselves. So, I think that’s the most challenging emotionally with Black community.” Similarly, P7 noted that he felt a lot of challenges when Black American clients refused to open up during therapy because it required a lot of patience and work to convince such clients. Sometimes, continued P7, he judged clients harshly, thinking they discriminated against him. Participant 14 shared that she might be angry when her clients are not cooperating, responding to instructions (e.g., not completing their homework, such as schema diaries), or acting frustratedly and angrily. In P14’s words:

> Sometimes my clients do not know how to reciprocate. For instance, I've been teaching them, I have been given them techniques, but some are not responding to my instructions. Some do not complete homework on schema flashcards, schema diaries, or other important homework. So, this will make it difficult for me.

Participant 13 also reported that schema-focused therapy's complex nature made it overwhelming to try to do it well, especially when you have a client with a complicated history. In this light, she noted: "Because it's got so many pieces to it and you tend to take on clients that have complicated personalities and histories and personality disorders, the therapy is challenging to therapists." Therefore, P13 advised that not burning out is the

trick to counter this challenge. Similarly, P3 noted that when Black American clients had other mental conditions besides panic disorder, such complexity increased, making the situation more challenging for clinicians.

Personal and Cultural Issues. Participant 11 endorsed battling regularly with failure schema, and this affected her therapy. She says, "The major challenge that I have battled is the failure schema, the sense that I'm not smart enough and that I am pale compared to my peers." In continuation, P11 shared: "Because I never feel like I am good enough, it affects my work." Participant 10 reported that waiting and listening to the client's whole story was challenging. In his words:

> Sometimes I'm really tempted to just ask them straightforwardly what really happened. But I find it not helpful. So, I have to just be patient and wait for them to just go around until they bring me back to the whole story. It's challenging to be patient and wait for the whole story.

Participant 13 underscored some challenges due to culture, including culturally humility, learning about Black American clients' culture, and not making assumptions or having biases. Thus, she emphasized:

> The other thing is just being culturally humble, trying to learn about his culture and not make assumptions. And not having biases is like an added layer. And I think it helped him that I was humble and curious rather than thinking that I understood what it was like for him or that.

In this light, she advised clinicians to be culturally humble when treating clients with these words: “I think the therapist has to have cultural humility about being open to

learning about the client's experience that may be very, very different from the therapists in their family and in their neighborhood and in their everyday life."

Subtheme 5.1: Effects of Clinicians' Schema Activations and Emotional Challenges on the Therapy

Some participants reported that schema activations and emotional challenges improve the therapy. These respondents underlined the improvement of their skills due to these challenges. They also observed that the activations and emotional challenges improved their therapeutic relationships with clients (P1, P2, P11, 14). In contrast, other participants indicated the negative effects of these activations. These participants observed that such challenges reduce therapy effectiveness and make therapy longer.

Clinicians' Schema Activations and Other Emotional Challenges Improve the Therapy. More than three-quarters of the participants (P1, P2, P3, P4, P6, P8, P9, P10, P11, P13, and P14) reported that their schema activations and other emotional challenges had improved the therapy. For instance, P1, P10, P11, and P13 observed that these challenges helped them develop mechanisms to handle their emotional challenges and assist clients. From P1's observations, "When clients talked about issues that rekindled certain memories that I had, I wouldn't say that it really affects my schema therapy sessions. Rather, I have developed a mechanism to cope with the emotional challenges." Similarly, P11 and P13 acknowledged that schema-focused therapy provided them with the tools to alleviate their emotional challenges. In the words of P11, "My own schema therapy, which I continue to be in myself, also gives me the tools that I can pretty quickly

manage what's happening internally when I do get triggered." Also, P13 noted utilizing imagery rescripting when she had traumatic memories and scenes and stated:

> Clients' traumatic stories probably affect my mental health, but as far as I know, that's one of the things I like about schema therapy because it gives you something to do with it. You don't just feel helpless. The imagery scripting helps you do something with these traumatic memories and traumatic scenes.

Additionally, P13 admitted that specific schema activations, including unrelenting standards, self-sacrifice, and approval seeking, in some ways, helped her really try to do a good job for clients. For P10, the activation helped him "learn essential skills, get more from clients, and make a better response to them." These essential skills continued P10, also helped "when treating other clients and when the activation occurred next time.

In line with P10's observations, P2, P4, P9, and P14 reported that experiencing emotional challenges disposed them to know the exact solutions to overcome subsequent problems. For instance, P9 stated: "I think with emotional awareness, you're able to cope with similar situations, and it becomes a bit easier." Participant 4 noted that the challenge also helped him have personal feelings about clients' experiences and know how to help them. Similarly, P14 explained: "When you have heard disturbing stories repeatedly and probably heavier than those your client is telling you, they begin to have less effect on you because you have developed skills to handle them and gradually habituate to them." Thus, P14 relayed: "So, you have already handled several cases such that you can easily handle new ones without any negative effect compared to the earlier ones." Additionally, P6 reported that emotional challenges helped her appropriate the tools she taught clients,

including relaxation techniques in these words: “When those feelings come to head, sometimes you find yourself using the skills you teach clients, such as breathing techniques or other techniques. So, you find yourself also applying them.” On a scale between zero and ten, P8 rated the negative impact of emotional challenges on schema-focused therapy at a six. In his words, “Let me say on a scale of ten, a six because I won't say It's entirely negative. I'd be lying if say it's entirely negative or entirely positive.”

Participant 11 underlined that rapture was a difficult emotional experience. However, she reported that despite its difficulty, the rupture was where the richest, most profound work of healing happened in her therapeutic relationships with a Black American client with panic disorder. Hence, P11 stated: "for most therapists that deal with, especially when it relates to the therapist, rupture is where I think some of the deepest work happens, healing." Reporting a case with her Black American client, that usually got pissed off if she came two minutes late, P11 indicated:

> First of all, I'd have to center myself and recognize what was getting triggered in me. But then it was used as an opportunity to do some reality testing about what is really going on for you because being three minutes late is unacceptable. And so, I think when there's a rupture in the therapy room with a client, that's where the richest, most profound work happens.

Another positive aspect of schema activations and other emotions the participants reported was therapeutic relationship improvement. For instance, P2, P6, P7, and P10 observed that the activation helped them connect and empathize with clients. According to P2, experiencing emotional pain connected him to the feelings of his Black American

clients with panic disorder and put him in their shoes “to understand them, advise them, and to know exactly what they want.” Participant 6 also indicated: "My emotional challenges made me be in their shoes, understand their pains, and empathize with them." In the words of P10, "The EMS activation will bring about a deeper understanding of the client's difficulty during the schema-focused therapy. It brings a different understanding of the specific needs of clients."

Clinicians' Schema Activations and Other Emotional Challenges Reduce the Therapy Effectiveness. However, some participants (P5, P8, P9, P10, and P12) indicated the negative effects of their schema activation and emotional challenges during therapy. From the observations of P5, P12, and P14, these emotional challenges could be time-consuming. For example, P5 noted that taking a break to calm down made the session longer. Thus, he reported: during the schema activation, I will just take a break or take a deep breath, calm down, and then we will start again.” Also, he added: “But at that moment, it is affecting that therapy process because instead of continuing, I have to stop. So, it is affecting the therapy by elongating or making it longer than it should have been.” Similarly, P14 reported that "schema activation draws the therapy back a little because you still need more time to adjust again and begin to get the flow once again."

Participant 9 reported that she had to cancel sessions when overwhelmed emotionally. According to P10, sometimes, he became blunt when his schemas got triggered. Thus, he stated: "Sometimes I will be blunt a little bit; I don't go straightforward because maybe I was the problem, and I pushed them a bit too much." Personal triggers continued P10, "could interfere in the present, and you are not attuned

to the client's needs." According to P12, the emotional challenge delayed the therapy procedure.

Subtheme 5.2 Managing Clinicians' Schema Activations and Other Emotional Challenges During and After Therapy Sessions

In describing how they managed their emotional challenges, participants reported using different self-care measures, including relaxation techniques, physical activities, seeking therapy, schema-focused therapy tools, and self-awareness.

Relaxation Techniques. More than three-quarters of participants (n = 11) reported using relaxation techniques to manage emotional challenges during and after therapy. For instance, P1 noted listening to music, reading books, and practicing deep breathing and muscle relaxation as essential to coping with his emotional challenges. Thus, he stated, "When I feel like these emotions are coming up and they want to overwhelm me, I just take deep breaths and grab a book and start reading slowly or listen to my childhood favorite music." Similarly, P7, P9, P10, and P11 shared that breathing techniques and meditation were helpful in coping with their emotional challenges during and after therapy. For instance, P11 shared: "I definitely will use, make sure my breathing is not becoming shallow and I'll try to get my breathing under control." Participant 9 also related: "I'd say maybe breathing techniques in your own time:

Also, P12 reported reading articles and playing cards to calm himself down.

Participants 2, 4, 5, 10, 12, 13, and 14 noted taking a break from the therapy to relax when their emotional challenges became so intense. For example, P2 reported: "We can go for a 15-minute break. We can go and grab a glass of water, and then we come

back. By the time we return, we are fresh again and can continue the therapy." Similarly, P4 related: “I take a break, maybe take a walk.” Participant 5 relayed: I usually follow the normal routine of giving self-care, including giving myself some break or some space to interact with people. After some minutes, I will get back myself to continue with the therapy.” Reporting a similar skill, P12 stated: "Sometimes I have just to take a break from the therapy. Ten minutes break, and by the time I'm coming back, I'm really calm and ready to continue." For P10, “Sometimes I have to just take a break from the therapy. Two minutes break and by the time I'm coming back, I'm really calm and I'm ready to continue.” Participant14 also shared the same coping skill when she reported: “When I am becoming emotionally overwhelmed, taking a break in the session is essential. So, I just tell them, can we take some minutes, maybe go have a cup of coffee, go outside, then come back."

Although P13 admitted the importance of taking a break when clinicians are emotionally overwhelmed, she underlined a caveat that pausing a session should be done in ways that clients are not left to feel that therapists do not know what they are doing, or they are out of control. In her words:

> I would say that if you can't get yourself back, it's okay to say, give me a moment. What you're saying is I'm trying to process it. As long as it's not turned into leaving the client feeling like you don't know what you're doing or you're out of control. It has to be done on thinking of reassuring empathic confrontation, if you're going to confront them, it has to be with empathy. And if you're going to pause the session, it has to be helpful and it could be more helpful if you could

> take a moment and digest what they're saying. So, I think pausing sessions is therapeutic if it's done rightly.

Similarly, P6 advised therapists to take some time to release their emotional stress after therapy "because if clients see you vulnerable, that may also scare them."

Regarding relaxation techniques adopted after therapy, P2, P4, and P7 admitted relaxing with friends to relieve their emotional stress. For instance, P2 shared: "After the session, if I feel emotionally stressed out, I can go to my friends, relax, drink, and crack some jokes." For P4, “I have multiple choices. I might call someone connected to me, maybe my best friend, maybe we can talk, or I engage in something that I like doing.” Similarly, P7 reported cracking some jokes or having a friendly conversation to relax after the therapy session.

Engaging in Physical Activities. Five Participants (P2, P5, P10, and P12) endorsed engaging in physical activities to manage the emotional stress that ensued from therapeutic relationships. Participant 2 endorsed swimming and yoga: “I'll go for swimming; I'll go for some yoga classes. And it will take me a few hours to get back to myself. To cut the story short, I'll engage myself in some activities that I like.” Participants 5 reported engaging in any exercise that will distract his mind, including going to the gym. In his words, “I will do things that usually sweep me out or carry my mind away. These things include gymming or something that will distract me.” Similarly, P10 acknowledged going to the gym and other healthy activities: “I go to the gym. I try to just focus on these good habits every day, including meditation and exercise.” Participant 12 noted taking a walk, jogging, or other aerobic exercise.

Self-Awareness. Four participants (P11, P13, and P14) reported that self-awareness was an important means of coping with their emotional challenges during and after therapy. For instance, P14 reported that her primary coping skill during therapy was knowing what triggers her maladaptive schemas and modes and developing strategies to soothe them. In her words, “The first thing I do is that I have to know what triggers me so that I can start to develop strategies to manage.” Similarly, P11 reported that self-awareness of what triggers her schema and how to soothe them was very helpful in managing her emotional challenges during therapy. Although this trigger obviously happened quite quickly, continued P11:

> I think about what my little vulnerable child might be fearing or feeling. I try to shift from her into the adult me that can handle the situation, soothe the little child within me, and then quickly respond to what's happening in the therapy room.

Participant 13 also reported that one important technique they learned in training was "to notice when you start to be overwhelmed, flooded or triggered and to soothe it with good parent behavior (e.g., empathic confrontation) against using angry or vulnerable child." For instance, continued P13, the therapist might say, "I'm putting this my vulnerable child over here, and I'm going to do what a good parent would do and manage this from my healthy adult and not from my angry child or my vulnerable child modes." Participant 13 noted needing to say this to herself sometimes during therapy if the client is doing something that would trigger her, rather than using a maladaptive coping mode. Thus, she acknowledged:

> I found myself sometimes needing to say that to myself. Like I'm not going to urge to do something that I knew was not going to be helpful or professional or whatever, and I would be able to stop myself and say, wait a minute, vulnerable child, or that's angry child, put her over here and just be a good parent and try to use empathic confrontation if the client is doing something that would trigger anybody, but do it in a professional therapeutic way and not from a maladaptive coping mode.

These three participants P11, P13, and P14 gave their recommendations for clinicians struggling with schema activations. Participant 11 advised that clinicians know their schemas, what triggers, and how to soothe them. In her words: "I wish this was true for the model, but people getting trained in this, I think it should be mandatory to know your own schemas and to know what triggers your own schemas and know how to soothe them." Similarly, P14 advised clinicians to address their unresolved maladaptive schemas in therapy to be more aware of their triggers: "If you have unresolved EMS, it's important to work on addressing them in your own therapy so that you can be more aware of the triggers." Participant 13 advised that avoiding burning out is the trick to counter this challenge of being emotionally overwhelmed. Hence, she reported: "Because it's got so many pieces to it and you tend to take on clients that have complicated personalities and histories and personality disorders. So, I think I would say not burning out is the trick."

Seeking Therapy and Using Schema-Focused Therapy Tools. Four participants (P3, P9, P10, and P12) reported resorting to counseling or therapy at one point in time to alleviate their emotional stress. For example, P9 noted the importance of clinicians

“talking with kindness to themselves and not maybe becoming mean or emotional in front of the client.” Additionally, P9 underscored the importance of seeking therapy sometimes when her schemas were activated and advised other therapists to do the same. Similarly, P10 noted: "I do personal therapy myself sometimes with very qualified and nonjudgmental therapists just to explore my own maladaptive schemas." Also, P12 reported: "We're also humans. So, sometimes you may also need therapy because some of the stories you may hear from clients, especially stories of abuse, may be challenging to listen to."

As already seen, P11 and P13 reported using resources from schema-focused therapy to alleviate their emotional challenges during and after therapy. For example, P11 shared: my own schema therapy, which I continue to be in myself, I think also gives me the tools of when I do get triggered that I can pretty quickly manage what's happening internally.” Similarly, P13 acknowledged the importance of imagery rescripting when she had traumatic memories and scenes. In this light, P13 reported:

> Well, it probably affects my mental health, but as far, that's one of the things I like about schema therapy because it gives you something to do with it. You don't just feel helpless. The imagery scripting really helps you do something with these traumatic memories and traumatic scenes. So, I think it takes away the sense of helplessness, but while you're doing it, it can be very intense.

Summary

The research question addressed clinicians' experiences of using schema therapy clinician's experiences of using schema-focused therapy with Black Americans with

panic disorder. Firstly, all participants indicated that schema-focused therapy was effective with their Black American clients with panic disorder. However, there were some variations in the effectiveness level of the therapy. Half of the participants (P1, P3, P7, P12, P11, P13, and P14) placed the effectiveness level between 75% and 95%; four participants (P4, P5, P6, and P10) placed the effectiveness level at 70%; two participants (P8 and P9) placed the effectiveness at 60%; and one participant (P2) reported that 50% mental health problems of his Black American clients with panic disorder were solved. The basic criteria participants used in rating the effectiveness of schema-focused therapy with Black Americans with panic disorder were the extent to which the therapy improved healthy coping modes and other adaptive skills and reduced panic symptoms.

The study results also revealed clinicians' experiences of relational and self-concept EMS associated with panic disorder in Black Americans. Participants reported that four schema domains (disconnection/rejection, other-directed, hypervigilance, and impaired autonomy) were associated with panic disorder in Black Americans. For the disconnection/rejection domain, 13 participants (P1, P2, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14) noted abuse/mistrust as a common EMS associated with this population. Eight participants (P1, P2, P4, P6, P8, P11, P13, and P14) reported that shame/defective schema was also an important EMS addressed among this population. Seven participants (P1, P2, P10, P11, P12, P13, and P14) reported that abandonment schema was an important EMS associated with panic disorder among Black Americans. Also, five participants (P2, P8, P10, P13, and P14) reported that the social isolation/alienation schema was essentially associated with panic disorder among Black

Americans. Six participants (P1, P2, P9, P11, P13, and P14) reported that emotional deprivation was also a major culprit in the panic disorder among Back Americans.

Regarding the domain of other-directed schemas, two participants (P9 and P14) observed that emotional inhibition was an important EMS associated with panic disorder in Black American clients. Three participants (P9, P11, and P13) observed that their Black American clients adopted the schema of self-sacrifice/over-responsibility or overcompensation for coping with other maladaptive schemas, especially emotional deprivation. Also, P13 indicated that her Black American clients utilized the approval-seeking schema to get others' attention and meet their needs. Two participants (P10 and P11) underlined subjugation as an important EMS associated with this population.

Within the domain of impaired autonomy, nine participants (P4, P5, P6, P7, P9, P10, P12, P13, and P14) reported the vulnerability to harm/illness schema as commonly associated with panic disorder among this population. Other schemas in this domain associated with panic disorder in this population include failure schema (P1, P4, and P8) and reported failure schemas, and two participants observed incompetent/dependent schemas (P4 and P8). Within the domain of hypervigilance, five participants (P5, P6, P7, P12, and P13) reported negativity and pessimism schema, and two participants (P8 and P11) endorsed unrelenting standards (P8 and P11) as EMSs associated with panic disorder in Black Americans with panic disorder.

The study participants also reported clinicians' experiences with the schema modes associated with panic disorder in Black Americans. Participants reported addressing vulnerable child modes, angry/unsocialized child modes, parent modes,

coping modes, and healthy modes. Under vulnerable child mode, six participants (P1, P2, P7, P9, P10, and P12) shared that anxious mode was commonly associated with this population in response to EMS activations. Other vulnerable modes participants reported as related to this population in response to EMS activations include lonely/neglected child (P3, P4, P7, and P10), rejected child (P1, P5, and P6), terrified child (P1, P4, P11, and P14), abused child (P3 and P6), humiliated child (P6), mistrustful child (P1 and P7), confused child (P1), and helpless child (P7). Generally, P3, P9, P11, P13, and P14 simply highlighted the category of vulnerable child modes as commonly associated with this population.

Within the category of angry/unsocialized child mode, participants shared the following experiences with their Black American clients with panic disorder in reacting to their EMS activation: angry child (P1, P3, P7, P8, P10, P12, and P14), aggressive child (P2, P5, P8, P10, P11, and P13), enraged child (P8 and P14), complaining child (P5), and frustrated child (P7). Most of these modes were adopted as a means of responding to their EMS activation, including vulnerability to harm schema, emotional deprivation, defectiveness and shame, and social isolation. Within the category of parent modes, P5, P6, P8, P9, and P13 reported punitive parent mode; P14 reported demanding and anxiety-inducing; and P5 reported guilty inducing and pessimism in life.

In the category of coping mode, the participants observed that their Black American clients with panic maladaptive struggled with specific surrender/rigid modes: hopeless surrender (P5, P7, P10, P13, and P14), compliance surrender (P11), and self-sacrifice/rescuer surrender (P13). Participants also reported flight/avoidance modes as

associated with this population in responding to schema activations, including self-soothing with self-harm (P6 and P9), food (P11), and alcohol, marijuana, tobacco smoking, and other substances (P6, P7, P8, P9, P 10, P13, and P14); avoidant protector (P5, P8, P9, P10, P11, and P14); and detached protector (P10). Participant 13 also observed that her Black American client used fight or overcompensation modes, including perfectionism and punitiveness, to respond to schema activations. Additionally, some participants reported that their Black clients began utilizing healthy adult modes (e.g., P11, P13, and P14) or healthy child modes (P3, P6, and P13) as the therapy preceded.

The study results also revealed clinicians' experiences with schema-focused therapy techniques and strategies for treating Black Americans with panic disorder. These techniques clustered around data collection and schema identification strategies, schema change strategies, multicultural strategies, and clinicians' self-improvement. Twelve participants (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11, P12, and P13) reported using guided imagery (for schema identification) and imagery rescripting (for schema change) frequently for Black Americans with panic disorder. Ten of them (P1, P2, P3, P6, P7, P8, P9, P11, P12, and P13) emphasized that the imagery work was very helpful for this population. However, two of them (P4 and P5) showed some concerns that the strategy reminded their clients of their problems and opened their pains despite being effective.

Generally, 11 participants (P1, P2, P3, P4, P5, P6, P8, P9, P10, P11, 12, P13, and P14) indicated that techniques to collect clients' data to identify maladaptive schemas were mostly helpful. In addition to guided imagery, strategies highlighted include

psychoeducation (P9, P10, P11, and P13), conceptualizing client's problems (P1, P3, P11, and P13), behavioral pattern analysis (P8 and P12), and need inventories (P9). However, some participants (P4, P5, P7, P13, and P14) were concerned about the length of schema questionnaires, the ability of clients to comprehend them, and the tendency for clients to leave out a lot of information because of these difficulties.

Regarding schema change strategies, all participants reported using limited reparenting in one form or the other (e.g., empathy, nonjudgmental, validating clients' experience, empathic confrontation, normalizing, providing safe havens, and building trust and hope) frequently because of its usefulness. Additionally, P11 and P13 noted the usefulness of audio recordings/flashcards and clinicians' availability to clients in and between sessions via text messages. Participants also shared using specific experiential techniques frequently and acknowledged that they were helpful: imagery rescripting (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11, P12, and P13); and schema dialogues, including role reversal, mode dialogues, and chair work (P3, P4, P6, P9, P13, and P14). However, P8 reported using role-playing less frequently because it was difficult for some of his Black American clients.

Participants also reported using specific cognitive-behavior interventions frequently with Black Americans with panic disorder and admitted that they were very helpful: schema flashcards (P3, P4, P5, P7, P9, P11, P13, and P14); schema diaries and other homework (P4, P5, P9, P12, and P13); cognitive restructuring, reattribution, and reframing (P1, P2, P3, P4, P6, P8, P10, P12, and P14); relaxation techniques (P1, P2, P4, P9, and P14); and maladaptive behavior pattern breaking (P2, P8, P9, and P10); adaptive

behavior rehearsal (P6); and clients' schema education (P8). However, some participants underscored some difficulties and concerns with Schema flashcards (P8), schema diaries, and other homework (P4, P5, P7, P8, and P10) because their black clients hardly utilize or complete them at home. Additionally, six participants (P8, P10, P11, P12, P13, and P14) underlined the importance of culturally responsive schema-focused therapy for Black Americans with panic disorder. Also, four respondents (P7, P10, P13, and P14) reported that clinicians' continuous knowledge update in schema-focused therapy was helpful for effective therapy treatment. Half of the participants (P5, P8, P9, P10, P11, P13, and P14) also reported the importance of self-care as schema-focused therapists with Black Americans with panic disorder.

The study results also revealed clinicians' experiences of schema-focused therapy challenges when treating Black Americans with panic disorder. These challenges include the therapy being lengthy and expensive (P7, P8, P9, P12, and P13), complex (P3, P12, and P13), and involving clinicians' commitment and engagement with clients (P7, P12, and P13). Another challenge participants reported were clients' emotional challenges: trust issues with the therapy process (P1, P8, P12, and P14); shame and stigma (P1, P2, P4, P7, P10, and P12); acceptance and long-term change (P2, P10, and P11); and the tendency of the therapy to reenkindle clients' past emotional pains (P4 P5, P6, P10, P12, and P14). However, some participants (P6, P9, and P13) relayed that reenkindling emotional pains was an inevitable healing process.

All Participants reported clinicians' emotional challenges during schema-focused therapy with Black Americans with panic disorder. These challenges include: vicarious

trauma (P1, P2, P3, P4, P9, P10, P11, P12, P13, and P14); feeling bad because of clients' current emotional problems (P2, P5, P6, P8, and P13); rupture, including the difficulty of responding to client's reaction and resistance with positive countertransference (P7, P8, P9, P11, P13, and P14); and the complex nature of schema-focused therapy (P3, P13). Some participants also endorsed cultural (P13) and personal challenges (P10 and P11)

The study findings also revealed the effects of clinician's schema activations and other emotional challenges. Some participants noted that it had positive effects: improves therapeutic relationships with clients (P2, P6, P7, and P10) and facilitates clinicians' development of mechanisms to handle their emotional challenges and assist clients (P1, P2, P4, P9, P10, P11, and P13). In contrast, other participants indicated these activations reduce effectiveness and prolong therapy (P5, P9, P12, and P14). Finally, the study results underscored how clinicians manage schema activations and other emotional challenges when treating Black Americans with panic disorder. These strategies include relaxation techniques (P1, P2, P4, P5, P6, P9, P10, P11, P12, P13, P14), physical activities (P2, P4, P5, P10, P12), seeking therapy and using schema-focused therapy tools (P3, P9, P10, P12, and P13) and self-awareness (P11, P13, and P14). The next chapter centers on the interpretation of the findings, the limitations of the study, recommendations for further research, and implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. Research has revealed that panic disorder is a significant public health problem among Black Americans (Erving et al., 2019; Jones et al., 2020; Kisely et al., 2017; Nguyen et al., 2020; Thomas et al., 2022). Research also indicated that schemas, including EMSs and schema modes, are associated with panic disorder. Additionally, previous studies exist on the use of schema-focused therapy for Black Americans and on clinicians' experiences of using schema-focused therapy (e.g., Abrams et al., 2018; Bosch & Arntz, 2021; De Klerk et al., 2017; Gibbons et al., 2021; Hall, 2017; Hassija et al., 2018; Liao et al., 2020; Mahbubani, 2022; Pilkington et al., 2022; Pugh et al., 2020; Sims et al., 2019; Ten Napel-Schutz et al., 2017). However, none of these studies focused on clinicians' experiences of using schema-focused therapy with Black Americans with panic disorder. I used a generic qualitative approach to uncover clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder, and the meaning clinicians attribute to these experiences. I usd audiotaped semistructured interviews to collect data from 14 schema therapists. I manually performed an inductive thematic data analysis on the information received. Five themes and 13 subthemes emerged from coding and categorizing the research data, and the study results clustered around the themes and subthemes.

The study results revealed that the participants perceived that schema therapy was effective with Black Americans with panic disorder and improved their adaptive skills.

Secondly, the study findings showed that EMSs were associated with Black Americans with panic disorder. All EMSs from the rejection/disconnection domain were implicated. Other schemas associated with panic disorder in this population included: emotional inhibition, self-sacrifice/over-responsibility or overcompensation, approval seeking, and subjugation from the other-directed domain; vulnerability to harm/illness and failure schema from impaired autonomy domain; and negativity and pessimism, and unrelenting standards from hypervigilance domain.

Thirdly, the study results underlined schema modes Black Americans with panic disorder used to respond to their EMS activations. These included: anxious mode, lonely/neglected child, terrified child, abused child, and mistrustful child from the vulnerable child category; angry child, aggressive child, enraged child, complaining child, and frustrated child from the angry/unsocialized child category; and punitive parent mode, demanding/anxiety-inducing, guilty inducing, and pessimism from the parent mode category. The modes also included hopeless surrender, compliance surrender, self-sacrificer/rescuer, self-soothing, detached protector, avoidance protector, perfectionism, punitiveness, and overcompensation from the coping mode category. As the therapy progressed, healthy adult modes and healthy child modes were used more frequently. Fourthly, the study results also revealed schema-focused therapy techniques and strategies clinicians used in treating Black Americans with panic disorder. These techniques clustered around data collection and schema identification strategies, schema change strategies, multicultural strategies, and clinicians' self-improvement.

Fifthly, the study results highlighted several challenges clinicians and clients encountered during schema-focused therapy with Black Americans with panic disorder. These challenges include the therapy's lengthy and complex nature, the therapy involving clinicians' commitment and engagement with clients, cultural challenges, clients' trust issues with the therapy process, shame, stigma, the challenge of acceptance and long-term change, and the tendency of the therapy to reenkindle clients' past emotional pains. The study findings underlined two positive effects of clinicians' schema activations and other emotional challenges: improving therapeutic relationships with clients and facilitating clinicians' development of mechanisms to handle their emotional challenges and assist clients. In contrast, the study findings also revealed two negative effects of such challenges: therapy effectiveness reduction and therapy elongation.

In this chapter, I provide the concluding details of the study, beginning with the current introductory section. The next section is the interpretation of the findings. Following this section is the limitation of the study. Also included in this chapter are recommendations for further research and implications for social change. Finally, I present the conclusion of the study.

Interpretation of the Findings

As already indicated, I manually performed an inductive thematic data analysis on the information received. Five themes and 13 subthemes emerged from coding and categorizing the research data, and the study results clustered around the themes and subthemes. This section centers on how the themes that emerged from the research data

supported, confirmed, and extended the existing scholarly knowledge highlighted in Chapter 2.

Theme 1: The Effectiveness of Schema-Focused Therapy for Black Americans with Panic Disorder

Participants in the current study reported that schema therapy was effective with Black Americans with panic disorder and improved their adaptive skills. The effectiveness of the therapy was variously rated 50% (P2), 60% (P8 and P9), 70% (P4, P5, P6, and P10), and between 75 and 95% (P1, P3, P7, P12, P11, P13, and P14). This finding is congruent with the findings across most studies regarding the effectiveness of schema-focused therapy on panic disorder. For example, Hoffart et al. (2002) examined schema change in participants (n = 35) with panic disorder and/or agoraphobia and personality disorder using schema therapy that emphasized self-understanding, empathy, and guided discovery. These researchers found that clients' self-understanding and therapists' empathy were associated with a significant reduction of maladaptive schemas and the symptoms of panic disorder and agoraphobia, whereas guided discovery did not impact the distress. Although, the current study does not include agoraphobia, all participants also perceived that schema-focused therapy had significant reduction of maladaptive schemas and panic disorder symptoms among Black Americans with panic disorder. For instance, P11 in the current study reported that "schema therapy really works with empathy as the key ingredient." Also, seven participants (P3, P4, P5, P6, P7, P12, and P14) noted that empathizing with their Back American clients, putting yourself in their shoes, understanding their feelings, and ensuring they did not feel guilty were

helpful. However, P12 advised clinicians not to over-empathize with clients so they can touch on the client's real problems. In his words, “attitudes, such as empathy is helpful in therapy, but therapists should not allow it to affect therapy negatively, such as jumping essential steps and omitting clients’ information.”

Hoffart and Sexton (2002) also reported that the healthy schema modes of optimism and empathy predicted decreased maladaptive schema and psychological distress in individuals with panic disorders with agoraphobia co-occurring with cluster C personality traits during schema therapy. Similarly, three participants (P3, P13, and P14) in the current study noted strengthening their Black American clients’ healthy adult modes and addressing their contented child modes (e.g., optimism, and resilient self-confidence) to reduce or eliminate panic disorder. Additionally, P6 reported that teaching Black Americans with panic disorder how to reparent themselves, in the sense of talking to themselves empathically and thinking about themselves positively, to build optimism and self-confidence decreased their panic symptoms. Although Black Americans were not the population of these previous studies (e.g., Hoffart et al., 2002; Hoffart & Sexton, 2002), their findings suggested that the current study’s finding on schema-focused therapy effectiveness with Black Americans with panic disorder might not be different. Therefore, the current study extended the knowledge regarding the effectiveness of schema-focused therapy to panic disorder in Black Americans.

The present study does not support the findings of Sibrava et al. (2013), who observed that Black Americans had low rates of recovery, especially in panic disorder with agoraphobia and social anxiety, with different treatment modalities. It is imperative

to indicate that the current study substantially differs from Sibrava et al.'s study because I focused on schema-focused therapy as the primary treatment modality and only on panic disorder in Black Americans, whereas Sibrava et al. focused on different treatment modalities and other anxiety problems. Schema therapy might also not even be part of the treatment modality as Sibrava et al. (2013) noted only general treatment modalities used, including individual psychotherapy, group therapy, family therapy, inpatient therapy, and medication management.

Subtheme 1.1: Schema-Focused Therapy Improves Clients' Adoptive Skills

Participants (e.g., P1, P5, P6, P10, P12, and P13) also reported that schema-focused therapy improved adaptive skills to manage panic disorder among Black Americans with panic disorder and enhanced their self-worth. Gude and Hoffart (2008) gave credence to this finding in their study when they examined two treatment modalities to treat patients with panic disorder and agoraphobia co-occurring with cluster C personality disorders. One group of patients (n = 24) underwent 5 weeks (daily group sessions) of cognitive agoraphobia treatment, followed by 6 weeks (eight group sessions and ten individual sessions) of schema-focused therapy. The second group (n = 18) underwent treatment as usual based on psychodynamic principles. The researchers observed that patients in the cognitive condition with schema-focused therapy showed greater improvement in interpersonal problems than their counterparts in the treatment as usual. Although these authors conducted a quantitative study, their findings aligned with the perception of four participants (P1, P5, P10, and P12) in the current study. For instance, P1 observed that schema-focused therapy is an effective way to help his "Black

clients understand how they were supposed to deal with mistrust and reduce panic disorder." Participant 5 noted that they acquired healthy skills to cope with their panic disorder and help others who are going through the same problem. In P10's perception, schema therapy improves his Black American clients' self-acceptance, self-esteem, self-worth, and interpersonal relationships. Also, reporting how schema therapy improves interpersonal relationships with clients with panic disorder, P12 stated:

> At the end of the therapy, they usually have adapted, they'll have gained the aspect of relating with people, good relationship with people. By the end of the therapy, they'll have cultivated the attitude of disclosing their problems to trusted people, maybe their friends, their parents and that's another benefit of schema therapy. You learn how to interact with people.

Theme 2: Early Maladaptive Schemas Associated with Black Americans with Panic Disorder

Subtheme 2.1: Relational Schemas

In the current study, all EMSs from the rejection/disconnection domain were reported as associated with panic disorder: abuse/mistrust schema (P1, P2, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14), shame/defective schema (P1, P2, P4, P6, P8, P11, P13, and P14), abandonment schema (P1, P2, P10, P11, P12, P13, and P14), social isolation/alienation schema (P2, P8, P10, P13, and P14), and emotional deprivation (P1, P2, P9, P11, P13, and P14). These results of the current study are consistent with previous studies that associated EMSs from the rejection/disconnection domain with panic disorder. For instance, Demir and Soygut (2015) observed that abandonment

schema, in addition to incompetent/dependent schema and vulnerability to harm, was a core culprit of a client with a panic disorder with severe agoraphobia. With a larger sample size of Chinese adolescents (*n* = 985), Yan et al. (2018) reported abandonment or instability as a key culprit of panic disorder in their study, in which they performed stepwise regression analyses to identify schemas associated with different types of anxiety disorder. Seven participants (P1, P2, P10, P11, P12, P13, and P14) in the current study also reported that abandonment schema was an essential EMS associated with panic disorder in Black Americans. For instance, P1 relayed: "Most of them really had the problem of abandonment when they were young. Their parents never cared anything." Also, P10 reported that "abandonment is a major one where the clients might feel like they've been left alone or they're losing support. They feel quite insecure, and that triggers panic symptoms because they have some kind of fear in relation to abandonment."

Sardarzadeh (2017) conducted an ex post facto (causal comparative) study with individuals (*n* = 109) with panic disorder with or without agoraphobia, specific phobia disorder, OCD, PTSD, GAD, or acute stress to examine the ability of EMSs to predict (maladaptive) emotional schemas. Among other things, the author found that, in addition to abandonment or instability, emotional deprivation and other schemas from other domains were predictors of emotional schemas (e.g., vulnerability to harm schema and vulnerable child modes, especially mistrustful child) in individuals with panic disorder with or without agoraphobia. In the current study, six participants (P1, P2, P9, P11, P13, and P14) also reported that emotional deprivation schema was a major culprit in panic

disorder among Back Americans. For instance, P14 observed that in the case of emotional deprivation, "clients feel that they are not worthy of love, attention, or care, leading to a lot of anxiety." According to P14, "People with this schema learn to withdraw, isolate, and avoid close relationships. For P9, emotional deprivation led to emotional repression or self-sacrifice in Black Americans with panic disorder. Narrating how emotional deprivation led to panic disorder, P11 shared that her client's mother favored the older sister and gave her all the attention." Consequently, this client:

> Had such low expectations of people being kind to her and caring for her, especially in romantic relationships. And she would sort of accept the crumbs, I guess I would say. And so there was anxiety about not having people be kind to her, care about her, or listen to her in romantic relationships. And when she did get it, there was always a sense that it was going to be fleeting.

Therefore, the observation in the previous studies that the rejection/disconnection schemas of abandonment/instability and emotional deprivation were strongly associated with panic disorder might not be different from the current study's finding on the association of these EMSs with panic disorder in Black Americans with panic disorder. However, the finding that abuse/mistrust, shame/defective, and isolation/alienation schemas were associated with panic disorder was unique to the present study. Therefore, more studies are needed to support this finding. Also, the current study finding that one schema in the domain of rejection/disconnection schemas predicts other schemas in this domain in individuals with panic disorder is unique. For example, P13 highlighted that her Black client with panic disorder "also has abandonment, social isolation, shame, and

defectiveness because they often all go together." Similarly, P11 noted the connection among all maladaptive schemas within the disconnection/rejection domain in her Black client with panic disorder. Hence, more research is also needed to support this finding.

Another group of relational schemas reported in this study belongs to the other-directed domain. Regarding this domain, participants reported the following: emotional inhibition (P9 and P14), self-sacrifice/over-responsibility or overcompensation (P9, P11, and P13), approval-seeking schema (P13), and subjugation schema (P10 and P11). These results resemble the findings of many previous studies regarding schemas from other EMS domains associated with panic disorder. Sardarzadeh (2017) supported most of these findings when he reported that subjugation, self-sacrifice, and dependence or incompetence were among the active EMSs predicting emotional schemas in individuals with panic disorder with or without agoraphobia. Yan et al. (2018) reported that subjugation schema was associated with panic symptoms among Chinese adolescents (n = 985). Similarly, Kwak and Lee (2015) provided support to the current study when they examined the association of EMSs with participants with panic disorder (n = 46), OCD (n = 51), and normal controls (n = 70) and reported that overresponsibility/self-sacrifice, in addition to vulnerability to harm, was highly activated in participants with panic disorder compared to participants with OCD and normal controls.

In the current study, four participants (P9, P11, and P13) also observed that their Black American clients used self-sacrifice schema to cope with other schema activations (especially emotional deprivation), leading them to panic disorder. For example, P9 observed that her Black American clients used self-sacrifice, in addition to emotional

repression to cope with emotional deprivation. In her words, “Childhood emotional deprivation led Black American clients to “respond either by learning to repress their emotions or learning to work so hard to get that attention.” Participant 13 reported that her Black American client had “self-sacrifice and approval seeking as a way to try to get people to meet his needs, pay attention to him, care about him, or treat him better. He often tried to rescue people or impress people.”

Similarly, P11 explained that, like other clients, Black American clients with childhood emotional deprivation learned to care so much, meet others’ needs, and not pay attention to their needs to attract attention, care, and support from others. Hence, she stated: “Self-sacrifice/overresponsibility is a way of almost coping with these things. If I give more, if I am really kind, if I'm meeting everybody's needs, If I'm not paying attention to my needs, maybe people will pay attention to me.” Participants 10 and 11 also reported that subjugation was a vital EMS among Black Americans with panic disorder. For example, P10 reported that “Black Americans have always felt inferior in some way because of discrimination. So, you have to help them explore and process these schemas and address racial experiences.” Participant 11 reported how her Black American client “felt like she needed to do more or work harder than her Caucasian colleagues because she felt like she was more likely to take the heat or possibly be let go off because she was a Black American.”

Therefore, the observation in the previous studies that the other-directed schemas of self-sacrifice, subjugation, and emotional and emotional inhibition were strongly associated with panic disorder might not be different from the current study’s finding on

the association of these EMSs with panic disorder in Black Americans with panic disorder. Additionally, the current study revealed two other-directed schemas not indicated in the reviewed literature as associated with panic disorder: emotional inhibition and approval-seeking schemas from the other-directed domain. For example, P9 observed that her Black American clients used emotional repression or inhibition, in addition to self-sacrifice, to cope with emotional deprivation. Participant 13 noted that her Black American client utilized approval seeking, in addition to self-sacrifice, to get people meet his needs, pay attention to him, care about him, or treat him better. More studies are needed to confirm these additional findings.

Subtheme 2.2: Self-Concept Schemas

The study results also revealed that within the domain of impaired autonomy, participants in the current study reported the following EMSs: vulnerability to harm and illness (P4, P5, P6, P7, P9, P10, P12, P13, and P14), failure scheme (P1, P4, and P8), and incompetent/dependent schema (P4 and P8). In the hypervigilance domain, negativity and pessimism schema (P5, P6, P7, P12, and P13) and unrelenting standards (P8 and P11) were reported. These findings align with previous studies. For instance, Sardarzadeh (2017) also reported unrelenting standards as active EMSs predicting emotional schemas in individuals with panic disorder with or without agoraphobia. Similarly, P4 and P8 in the current study shared that unrelenting standards and dependence/incompetence were associated with panic disorder in their Black clients. For example, P8 reported that “most of them have set for themselves unrealistic standards of what they want to attain. And so,

this causes a bounce back." Participant 4 shared that his Black American client developed the belief that he was a failure because he could not defend himself as a child.

In another study, Yan et al. (2018) reported that vulnerability to harm, in addition to subjugation schema, was associated with panic symptoms among Chinese adolescents (n = 985). Also, Demir and Soygut (2015) reported that vulnerability to harm/illness and incompetence or dependence were core culprits of a client with a panic disorder with severe agoraphobia. In an earlier study, Hedley et al. (2001) reported that vulnerability to harm predicted the fear of physical symptoms, beliefs about losing control, and avoidance behavior in individuals (n = 59) with panic disorder and agoraphobia. The study results further revealed that vulnerability to harm predicted the incompetence and dependence schema in individuals with panic disorder and agoraphobia. In the current study, nine participants (P4, P5, P6, P7, P9, P10, P12, P13, and P14) reported that vulnerability to harm/illness schema (in the impaired autonomy) was associated with panic disorder in their Black American clients. For instance, P5 observed that experiencing natural calamities, road accidents, and violence or abuse from parents disposed Black American clients to a heightened sense of vulnerability to danger and to anticipate always that something harmful was about to happen. This heightened sense of vulnerability, continued P5, was "very fundamental in triggering panic attacks." Another participant (P12) reported that, "after experiencing a tragic situation, such as abuse, rape, or witnessing the death of a loved one during childhood, and it got into their head, any time they encountered similar situations, it triggered panic attacks and other forms of anxiety." Participant 14 reported that her Black American clients were vulnerable to harm because

they lacked a defense mechanism. Thus, “if anything is negatively thrown to them, they don't have the power to defend it. They become vulnerable to harm and pain and eventually anxious.”

Hence, these findings from previous studies on the association of vulnerability to harm, incompetence/dependence, subjugation, self-sacrifice/overcompensation, and unrelenting standards might not be different from the current study’s finding on the association of these EMSs with panic disorder in Black Americans with panic disorder. However, the present study did not confirm Sardarzadeh’s (2017) findings that the grandiosity/self-centered schema (i.e., the belief that one should have whatever one wants regardless of its cost without showing any empathy toward others) was associated with panic disorder. Additionally, the current study revealed two self-concept schemas not indicated in the reviewed literature as associated with panic disorder: negativity/ pessimism from the hypervigilance domain and failure schema from the impaired autonomy domain. For example, P5 noted that harsh parental punishments for mistakes and verbal abuse were the cause of this negativism and pessimism in his Black American clients, and similar current actions trigger panic attacks because they were severely punished and criticized when they were kids. More studies are needed to confirm these additional findings.

Theme 3: Schema Modes Associated with Black Americans with Panic Disorder

Subtheme 3. 1: Unhealthy Child Modes

Participants in the current study acknowledged that vulnerable child modes were commonly associated with this population. Specifically, participants reported anxious

mode (P1, P2, P7, P9, P10, and P12), lonely/neglected child (P3, P4, P7, and P10), rejected child (P1, P5, and P6), terrified child (P1, P4, P11, and P14), abused child (P3 and P6), humiliated child (P6), mistrustful child (P1 and P7), confused child (P1), and helpless child (P7). These findings are consistent with the findings from previous studies on the vulnerable child modes associated with panic disorder. Demir and Soygut (2015) reported that the lonely or neglected child, terrified or frightened child, and weak and powerless child (helpless surrender) were among schema modes associated with a client diagnosed with panic disorder with severe agoraphobia. Also, Oguz et al. (2019) reported that the maladaptive emotional schema of uncontrollability (i.e., helpless child and helpless surrender) was associated with panic disorder. Additionally, Sardarzadeh (2017) reported that individuals with panic disorder exhibit emotional schemas of vulnerability to harm schema and vulnerable child modes, especially the mistrustful child.

Similarly, P10 in the current study related that feeling neglected was an important vulnerable child mode Black Americans with panic disorder shared with him and that neglect, emotional deprivation, abandonment, social isolation, or invalidation in the early stages of life were the family dynamics driving this mode. In the experience of P4, “some feel they are so lonely; they are abandoned, and this results in fear, anxiety, and panicking.” For P7, “feeling left out by the people that you love or cared for” was an important mode her Black clients with panic disorder struggled with. Also, three participants (P1, P5, and P6) reported the rejected child mode. For example, P1 reported that Black clients with panic disorder struggled with rejected child mode. These patients “experience a lot of mixed emotions.” The rejected child mode, continued P1, was

associated with “fear of intimacy, distrust, anxiety, depression, and people-pleasing behaviors.” Regarding the helpless surrender mode among Black Americans with panic disorder, P7 reported that “most of them felt helpless in response to vulnerability to harm.” Participants 1 and 7 also reported observing mistrustful child mode among their Black American clients with panic disorder. Additionally, P11 reported that her Black American client with panic disorder had the terrified child mode. In her report: “She was terrified of lizards and birds. It was a full-blown phobia, which was really difficult because, in her area, they're everywhere. And she had had that phobia for a very long time.” Similarly, P1 observed that some of his Black American clients with panic disorder struggled with “the fear of intimacy and distrust.

Based on these previous studies (e.g., Demir & Soygut, 2015; Oguz et al., 2019; Sardarzadeh, 2017), the helpless child, lonely child, terrified child, and mistrustful child were common vulnerable child modes associated with panic disorder. Therefore, the current study finding on the association of these vulnerable child modes with panic disorder in Black Americans with panic disorder might not be different**.** However, two vulnerable child modes reported in the current study as associated with panic disorder are unique to the study: the abused child (P3 and P6) and the confused child (P1). Similarly, the current study’s results on angry or unsocialized modes associated with panic disorder: angry child (P1, P3, P7, P8, P10, P12, P14), aggressive child (P2, P5, P8, P10, P11, P13), enraged child (P8 and P14), complaining child (P5), and frustrated child (P7) are unique. No previous study indicated that these modes were associated with panic disorder. More studies are required to support these unique findings of the current study.

Subtheme 3.2: Parent or Inner Critic Modes

Within the category of parent modes, the present study's findings revealed that punitive parent mode (P5, P6, P8, P9, and P13), demanding and anxiety-inducing (P14), and guilty-inducing and pessimism in life (P5) were associated with Black American clients with panic disorder. For instance, P9 reported that some of her Back American clients with panic disorder were "overly critical of themselves, which may come from their childhood experience." Similarly, P5 reported that they blamed and condemned themselves for their panic disorder. Regarding other parent modes (i.e., demanding and anxiety-inducing, guilty-inducing, and pessimistic attitudes), P14 reported that, having internalized the demanding voice to be perfect, Black clients with panic disorder blamed themselves for their panic triggers and became anxious and ashamed of such triggers. Because of this demand to be perfect, they tried to avoid questions or complaints. Similarly, P5 reported that "they feel they are hated." These study findings are unique to the current study. No previous study indicated that these modes were associated with panic disorder. Therefore, more studies are needed to support these unique findings.

Subtheme 3.3: Coping Modes

In the current study, participants also reported hopeless surrender (P5, P7, P10, P13, and P14), compliance surrender (P11), and self-sacrifice/rescuer surrender (P13) within the surrender/rigid modes category. Additionally, participants reported self-soothing with self-harm, food, alcohol, marijuana, tobacco smoking, or other substances (P6, P7, P8, P9, P10, P11, P13, and P14), avoidant protector (P5, P8, P9, P10, P11, and P14), and detached protector (P10) within the flight/avoidance modes category; and

social overcompensator (P13) and perfectionism/punitiveness (P13) among fight or overcompensation modes. Demir and Soygut (2015) replicated most of these findings when they observed that hopeless surrender, obedient surrender, and detached shelter were schema modes associated with the same client diagnosed with panic disorder with severe agoraphobia. In the current study, P5 reported that "in some ways, her Black American clients with panic disorder surrendered to emotional deprivation, believing that they were never going to get their needs met. In P11's observation, a major compliance surrender mode was associated with this population. They utilized this mode to prevent bad things from happening. Commenting on detached shelter, P10 shared that his Black American clients with panic disorder used "defense mechanisms to prevent paying attention to the panic triggers and avoided "their own needs and emotions so that they would not feel anxious." Similarly, P5, P8, and P10 shared that some of their clients with panic disorder secluded themselves from the public and events that might trigger their panic anxiety.

However, most findings on coping modes associated with panic disorder are unique to the current study. These modes include self-soothing, social overcompensator, self-sacrificer/rescuer surrender, and perfectionism or punitiveness. For instance, P6, P7, P8, P9, P10, P11, P13, and P14 reported that their clients self-soothed with food or substance use, such as alcohol, marijuana, and tobacco smoking, to become distracted from their unpleasant feelings. Two of these participants (P6 and P9) added that their clients had reported self-soothing with self-harm. Additionally, P11 noted that her client self-soothed with food. Regarding other modes, P13 noted that her clients utilized

perfectionism, being a rescuer or a fixer, or self-sacrifice mode to overcompensate for shame or defectiveness, social isolation, and emotional deprivation. Also, P13 indicated that they utilized punitiveness, in addition to aggression, to overcompensate for vulnerability to harm.

Subtheme 3.4: Healthy Modes

Nine participants (P3, P4, P5, P6, P7, P11, P12, P13, and P14) in the current study reported that strengthening client's healthy adult modes (e.g., learning to be a good parent when reacting to problems, learning how best to talk and think about themselves, and showing empathy to themselves) and addressing their contented child modes (e.g., feeling loved, protected, safe, connected, fulfilled, and valued) helped these clients reduce or eliminate their maladaptive modes. Thus, a primary goal of schema therapy is to recover and strengthen clients' experience of healthy modes. These study results were consistent with the evidence in the previous studies on healthy adult modes reducing or eliminating maladaptive modes. For instance, Demir and Soygut (2015) also noted that activating the healthy adult mode reduced lonely, frightened, weak, and helpless child modes in a patient with panic disorder with agoraphobia. Dickhaut and Arntz (2014) also indicated the importance of paying attention to the happy mode during schema-focused therapy. In the current study, three participants (P3, P13, and P14) indicated strengthening their Black American clients' healthy adult modes and addressing their contented child modes (e.g., optimism, happy mode, resilience, self-confidence) to reduce or eliminate panic disorder. Also, P6 reported "teaching them how to reparent themselves, in the sense of how to talk to themselves, and how to think of themselves."

Explaining how she helped her client develop a healthy adult mode from the vulnerable child, P11 shared using the childhood picture of her Black American client with panic disorder to help her develop a healthy adult mode.

Hoffart and Sexton (2002) reported that strengthening healthy modes (e.g., through optimism and empathy) predicted decreased maladaptive schema and psychological distress in the process of schema-focused therapy and observed that increased optimism during schema-focused therapy predicted decreased maladaptive schema and psychological distress in individuals with panic disorders with agoraphobia co-occurring with cluster C personality traits. As already noted, Participant 11 in the current study also reported that "schema therapy really works with empathy as the key ingredient." Also, seven participants (P3, P4, P5, P6, P7, P12, and P14) noted that empathizing with their Back American clients, putting yourself in their shoes, understanding their feelings, and ensuring they did not feel guilty were helpful. Based on these previous studies, strengthening the healthy modes predicted decreased EMSs and maladaptive modes in clients with panic disorder, suggesting the same results in Black Americans with panic disorder as the current study revealed.

Theme 4: Schema-Focused Therapy Aspects and Strategies for Black Americans with Panic Disorder

Subtheme 4.1: Data Collection and Schema Identification Strategies

In the current study, 13 participants (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12, and P13) indicated that techniques to collect clients' data to identify maladaptive schemas (e.g., guided imagery, psychoeducation, behavior process identification, need

inventory, and conceptualizing a client's problem) were mostly helpful. This finding supported many previous studies on the importance of schema psychoeducation and other techniques for collecting data to identify maladaptive schemas. For example, Tan et al. (2018) explored 36 patients' experience of receiving schema therapy for at least 12 months and reported that 21 of the patients endorsed the usefulness of schema psychoeducation. In another study, Jalali et al. (2019) examined the effectiveness of schema-focused therapy in reducing depression in prisoners (n = 42) living with HIV, with half of the number (n = 21) assigned to the experimental group and the other half (n = 21) to the control group. They reported that psychoeducation sessions, serving as the first phase of the therapy, were beneficial. In the current study, P13 also reported using psychoeducation upfront to help her Black American clients buy into the therapy process and become willing to take the inventories or schema questionnaires. Similarly, P10 reported frequently using with Black Americans with panic disorder "schema psychoeducation, where you tell them about the concepts of their problems that helped them understand and learn how it impacted their lives.".

Skewes et al. (2015) conducted short-term group schema-focused therapy for mixed personality disorders. They reported that using the first group session to educate clients about the schema model helped them focus on their top three schemas and modes and rate their severity each week with a focus on reducing the severity over the therapy duration. In the current study, P11 also reported using psychoeducation frequently earlier to help her Black clients "cognitively understand their maladaptive lenses just from a conversational, explaining pros and cons, the sort of rational piece of it." Rashidi and

Rasooli (2015) examined the schema therapy's effectiveness in reducing anxiety and depression in individuals with major depressive disorder. These researchers indicated that utilizing several schema identification strategies, including schema maladaptive schema identification, behavior pattern identification, and schematic styles identification, was helpful in the effectiveness of the entire schema therapy. In the current study, P8 and P12 also noted that using behavioral pattern analysis, including mode exploration, to identify maladaptive schemas when treating Black Americans with panic disorder helped them develop adaptive coping strategies. For example, P8 regarded behavioral pattern identification as the most desirable strategy for this population. In using this strategy, continued P8, "I identify one by one, the maladaptive behaviors that reinforce these kinds of schemas and hinder their well-being. So, by exploring the consequences of these behaviors, I will be able to allow these clients to develop adaptive coping strategies."

These previous studies (Jalali et al., 2019; Rashidi & Rasooli, 2015; Skewes et al., 2015; Tan et al., 2018) indicated that psychoeducation as a schema data collection technique was most helpful in the effectiveness of the entire schema therapy and that maladaptive schema identification, behavior pattern identification, and schematic styles identification were also schema data collection techniques helpful in the effectiveness of schema-focused therapy. Hence, the current study extends the knowledge of using these data collection techniques in treating Black Americans with panic disorder. However, some participants in the current study (e.g., P4, P7, P13, and P14) were concerned about schema questionnaires and schema mode inventories because of their length, clients' ability to comprehend them, and the tendency to leave out much information because of

these difficulties. For instance, P13 shared: “Questionnaires that assess schemas and modes are long, and they're a lot of words.” In continuation, P13 noted that because we have a very bad school district in some states and many people who even have high school diplomas or college degrees have limits in their literacy and comprehension, those questionnaires could be a lot for them to read and comprehend if they have had poor education. In contrast, previous studies revealed that these data collection strategies were essential in schema-focused therapy (e.g., Cockram et al., 2010; Dickhaut & Arntz, 2014; Peeters et al., 2021; Tan, 2015; Van Vreeswijk et al., 2014; Videler et al., 2014). However, these studies did not center on panic disorder. Therefore, based on the perception of participants in the current study, schema questionnaires should not be difficult for clients with panic disorder to comprehend and complete. Clinicians should also develop methods to track when clients’ essential information is omitted.

As already indicated, guided imagery was another important schema data collection strategy reported in the current study. Ten participants (P1, P2, P3, P6, P7, P8, P9, P11, P12, and P13) in the present study reported that guided imagery (for schema identification) and imagery rescripting (for schema change) were helpful and frequently used for Black Americans with panic disorder. Several previous studies regarding the importance of imagery work (e.g., guided imagery and imagery rescripting) in schema therapy confirm these findings. For example, Videler et al. (2017) extensively examined the effect of schema therapy on an older adult with personality disorders using schema therapy language, the case conceptualization diagram, imagery rescripting, chairwork, and case contextualization. Videler et al. noted that imagery rescripting with guided

imagery was very helpful. Similarly, Shibuya et al. (2018) found a significant reduction of distress from traumatic images, memories, and encapsulated beliefs in patients (n = 16) with severe panic disorder with the imagery work. Participant 6 in the current study also reported using guided imagery to help Black American clients with panic disorder imagine themselves at a particular age and connect to the root cause of their panic disorder. Participant P6 expressed: "I find the imagery very helpful because you're able to actually describe the feelings they were feeling in that state that had caused these narratives that are in their head, making their panic attacks continue to occur frequently." Similarly, P7 shared using the imagery work to help them "picture or imagine how life was when they were growing up to connect them to occasions that might have contributed to their current panicking." Participant 9 related using "a lot of imagery and child dialogues to really immerse them into those emotions and into how they felt the first time they experienced some of these things that might have informed these false schemas." Participant 11 also reported the usefulness of the imagery work as most helpful in treating clients. In her words:

> But really, the piece of schema therapy that I think is the most helpful is the imagery work where you're really helping your client to take their current triggers and anxieties and beginning to connect them to where they originated from and not from the prefrontal cortex and an irrational place, but from the other part of the brain where emotion is stored. And getting them in touch with that connection of why they feel what they feel and where it came from. It's incredibly powerful.

Considering previous studies (e.g., Shibuya et al., 2018; Videler et al., 2017), guided imagery was helpful and frequently used in schema-focused therapy. The findings from these studies suggested that the current study's finding on the frequency and usefulness of guided imagery for Black Americans with panic disorder might not be different. Hence, the current study extends the knowledge of guided imagery to Black Americans with panic disorder. However, some participants in the current study had concerns that the imagery work took clients to the root of their pain and could rekindle emotional wounds. For instance, P4 and P5 reported that guided imagery was useful, but it reminded their clients of their problems and opened their pains. These participants recommended that clinicians help clients understand this pain before using imagery work. Similarly, P14 recommended that imagery work should be used only when clients are fully informed and ready because "it works better after you've gone on with clients for a while and their minds are calmer." In this light, De Klerk et al. (2017) reported that many patients endorsed suffering from very intense emotions during the process of change because therapists did not inform them about it in advance. Bosch and Arntz (2021) underscored some ways to utilize imagery work more fruitfully: caring for the patient's vulnerable child, ensuring its safety and protection, confronting the source of the vulnerable child, breaking through the patients' avoidance by talking about it, helping patients recognize their emotions and thoughts about traumatic events, and encouraging them to keep taking their therapy as required. Thus, when appropriately used, imagery work is helpful for clients with panic disorder and other anxiety problems.

Subtheme 4.2: Schema Change Strategies

Experiential Techniques. In the current study, almost all respondents noted that imagery rescripting was helpful with their Black American clients with panic disorder and that they used it frequently. This finding resonates with previous studies. Among all the current study's findings, the usefulness of imagery work was reported most (e.g., Bosch and Arntz, 2021; Cockram et al., 2010; De Klerk et al., 2017; Jing, 2018; Tan et al., 2018; Ten Napel-Schutz et al., 2017). All these previous studies support the current study's finding on the effectiveness of imagery rescripting. For instance, De Klerk et al. (2017) examined the perspectives of patients (n = 15) and therapists (n = 8) on schema therapy for personality disorders and observed that imagery rescripting techniques, among other techniques, were perceived as helpful. Similarly, Bosch and Arntz (2021) explored the perspectives of patients (n = 10) and therapists (n = 9) on the schema-focused technique of imagery rescripting for PTSD due to childhood trauma. They reported that imagery rescripting was perceived as helpful. Tan et al. (2018) made the same observation when they explored 36 patients' experience of schema therapy and reported that, out of 17 patients who discussed the effectiveness of experiential techniques, 15 appreciated the use of imagery rescripting despite positing some difficulty at the beginning. In the current study, P1 stated: "Imagery rescripting is a helpful technique for my clients." Participant 9 acknowledged using imagery rescripting to train the minds of her Black American clients to visualize situations positively and to break their maladaptive cycle after asking them to remember a traumatic event in their childhood." Similarly, P8 shared that in using image rescripting to help Black Americans

with panic disorder create an image of each stage of their lives, reimagine, and rewrite their story. Therefore, the perceptions in previous studies on the usefulness of imagery rescripting might not be different from the current study findings on the usefulness of imagery rescripting for Black Americans with panic disorder. Hence, the current study extends the knowledge of imagery rescripting effectiveness to Black Americans with panic disorder.

Another important experiential technique reported in the current study as helpful for Black Americans with panic disorder was schema dialogue, including role reversal, mode dialogues, and chairwork. Six participants (P3, P4, P6, P9, P13, and P14) shared using schema dialogues frequently and acknowledged that they were helpful. This finding agrees with many studies regarding the helpfulness of other experiential and emotional techniques in schema-focused therapy. For example, Skewes et al. (2015) reported that role plays with healthy adult modes vs. maladaptive modes (i.e., mode dialogues) and chairwork were beneficial for patients with mixed personality disorders. In the current study, P13 also reported using mode dialogues frequently in treating Black American clients. However, P13 indicated not using chairwork because she conducted sessions mostly on Zoom due to the pandemic, so it was hard to do chairwork. In the words of P13, “They did mode dialogues, without changing chairs like is often taught to do in schema therapy because of the setup in his apartment, and it just seemed too complicated.” In this light, Pugh et al. (2020) conducted an email survey to examine the experiences of expert therapists (n = 40), including schema-focused therapists (n = 9), to identify factors supporting and preventing the use of chairwork via teletherapy and the

adaptations these methods require in an online environment. They reported that tele-chairwork was as effective as in-person delivery when guidelines for initiating, facilitating, and concluding tele-chairwork were put in place. For instance, guidelines for initiating tele-chairwork include using warming-up exercises to evaluate auditory and visual connection quality, advising on optimal environments for tele-chairwork (e.g., private space), and having a shared plan for loss of connection (e.g., the therapist telephoning the client). Similarly, factors facilitating tele-chairwork include close monitoring of clients' bodily expressions and amplifying clients' emotions with process comments, such as reflection and repetition (Pugh et al., 2020). Hence, when appropriately utilized, tele-chairwork is helpful for clients with panic disorder and other anxiety problems.

Videler et al. (2017) also reported a significant improvement in symptomatic distress and EMSs with in-person chairwork. Similarly, in their study to explore 36 patients' perception of receiving schema therapy, Tan et al. (2018) reported that, out of 17 patients, 15 endorsed the usefulness of chairwork**.** Also, in treating a 25-year-old lady with major depressive disorder, Jing (2018) underscored the usefulness of chairwork, among other emotional strategies. In the current study, P6 noted that she used chairwork, a type of schema dialogue, to help her Black Americans with panic disorder "connect with their emotions and understand their negative thoughts." Similarly, P14 related that chairwork helped this population express their feelings, wants, and things affecting them, speak to their maladaptive schemas by playing the role of healthy schema modes, and control their anxiety. Ten Napel-Schutz et al. (2017) reported that schema therapists (*n* =

16) perceived chairwork, role play, and other experiential techniques, such as imagery rescripting, as decisive for therapeutic change. In the current study, P9 also reported using chairwork and imagery work frequently but underlined that "what's not very effective is going straight into the chairwork where you ask them very deep questions that may come in later."

Evidence from these studies (Jing, 2018; Pugh et al., 2020; Skewes et al., 2015; Tan et al., 2018; Ten Napel-Schutz et al., 2017; Videler et al., 2017) suggests that chairwork was the common schema dialogue technique used in schema-focused therapy, and it was also beneficial to patients with different health problems. Also, mode dialogue and role play were beneficial to patients. These observations might not be different from the use of chairwork, mode dialogues, and role play for Black Americans with panic disorder, as participants in the current study reported. However, P5 in the current study reported not using schema dialogue frequently because Black Americans with panic disorder usually feel ashamed of disclosing their health issues. Similarly, P8 and P2 reported using role-playing less frequently. In the words of P8, "Playing a role to be someone else who has a particular behavior and see things from the person's perspective was difficult for some of his Black American clients." Therefore, clinicians must determine whether role-playing, in-person chairwork, telechairwork, and other experiential techniques serve their Black American clients' needs and the best time to utilize them effectively during therapy.

Relational Strategies. All participants reported using limited reparenting in one form or another (e.g., empathy, nonjudgmental, validating clients' experience, empathic

confrontation, normalizing, providing safe havens, and building trust and hope) frequently because of its usefulness. This finding also echoes several previous studies that indicated the importance of limited reparenting in schema-focused therapy. For example, De Klerk et al. (2017) and Bosch and Arntz (2021) reported that therapists and patients perceived positive therapeutic relationships as a means of therapeutic change in schema-focused therapy. In the current study, P4 reported that "schema therapy emphasizes much on the relationship," insisting that it was a very important strategy with his Black American clients with panic disorder. Similarly, P5 reported that the relationship-oriented aspect of the therapy helped him build a secure attachment with clients and be in their situation or in their shoes to know how they are feeling. Thus, he reported: "The aspect that allows me and the client to be connected is very helpful." Also, P7 noted that the connection strategy of schema-focused therapy is the most helpful aspect because it helped him "be in a position to know that this person feels this way and he needs this kind of assistance." According to P11, once clinicians are meeting the client's needs appropriately using conceptualization, there's real healing in positive therapeutic relationships because the client feels that sense of curiosity and care from their therapist in a way that goes beyond just a neutral approach of other therapies.

In another research, Boterhoven de Haan et al. (2019) examined the effectiveness of a schema therapy approach in treating a patient with posttraumatic stress disorder. The researchers reported that empathic confrontation and nurturing were effective therapy components. In the current study, P9 also noted using empathic confrontation. Thus, P9 stated: "We also use the confrontation, but we use it in an empathetic way so that you can

also challenge some of the negative behaviors or the maladaptive modes they've been using to cope." However, P13 advised clinicians to use empathic confrontation sparingly and carefully to avoid becoming too confrontative, especially if clients are anxious and clinicians are trying to build trust. Reporting empathic confrontation in relation to her Black American client, P13 noted: "I think empathic confrontation if it's done well and not too often, can be helpful. But if it's not done well or done too much, I think the client can feel like they're not understood, or they're being criticized."

Many other previous studies also indicated that limited reparenting (e.g., positive therapeutic alliance, empathy, empathic confrontation, validating clients' subjective experience, and providing safe havens) was a crucial means of therapeutic change. For instance, Jing (2018) reported utilizing limited reparenting to coach a 25-year-old lady with a major depressive disorder to form a healthy response to avoidant protector mode via modeling. Jing (2018) also noted that limited reparenting was useful in reinforcing the formation of healthy adult modes. In the current study, P13 also stated that in treating her Black American client with panic disorder, "limited reparenting, having a good connection with the therapist is critical, particularly in this one because you're basically modeling healthy adult." Consequently, P13 advised schema-focused therapists to "always take care of themselves so they really be modeling what a good parent would model when working with clients because of the limited reparenting aspect."

In a different study, Tan et al., 2018 reported that the therapist's role in schema therapy involves limited reparenting, in which therapists relate to providing emotionally corrective experiences for patients, meeting their core needs that were missed in

childhood within professional boundaries. In the current study, P11 also reported: “We're a limited reparenting model,” which involves “clinicians “really trying to understand what the unmet need is and to respond, not like a therapist would, but a parent would, but obviously in a limited capacity.” So, “there's a real sense of warmth and empathy and care that comes with the therapy that I think in of itself is healing very different from other therapies that try to be a little bit more distanced or neutral.” Also, P10 related that one aspect of schema-focused therapy that was helpful for Black Americans with panic disorder was “limited reparenting where you provide empathetic responses to the clients and modeling healthy interactions.” P10 maintained that limited reparenting helped his clients “develop a more compassionate and nurturing inner voice.”

The above-stated evidence from previous studies suggests that limited parenting is inevitable and essentially useful in schema-focused therapy. Therefore, this observation might not be different when treating Black Americans with panic disorder with schema-focused therapy, as revealed in the current study. However, participants in the current study reported several other aspects of limited reparenting as beneficial to Black Americans with panic disorder. These aspects include empathic listening (e.g., P2, P4, P5, P6, P11, and P12), patience (P6 and P14), nonjudgmental, validating clients’ views (P10), providing safe havens (P1, P2, P3, P6, P12, and P13) with Black Americans with panic disorder, remembering what they shared during therapy (P14), and normalizing their concerns (P1, P2, and P12). For instance, P11 stated that “empathy is the key ingredient. And so, I think that is so important, especially understanding why Black Americans are going to be more likely to encounter panic disorder, especially in the

world we live today." Participants 6 and 14 noted the importance of being patient, putting yourself in the client's shoes, and understanding their feelings, especially when they are unwilling to open up. However, P12 warned clinicians not to over-empathize with clients so they can touch on the client's real problems. Participant 10 noted that "not validating clients' subjective perspectives was not helpful." Participants 3 and 8 reported that ensuring this population was in a safe environment where they would not feel judged was beneficial. Participant 13 reported that being sensitive to the Black Americans' sense of shame and the stigmatized mental health helps create a sense of comfort with them and noted: "I think it is stigmatized still going to a therapist in the black community. So, being sensitive to that and asking what it's like to be in therapy is helpful." In this regard, P1 recommended virtual therapy for Black American clients who do not like sharing their emotions face to face as a good alternative to maintaining safe havens during therapy.

Another aspect of the schema therapy relational strategy reported in the present study as helpful to clients with panic disorder was clinicians' availability to clients during sessions (in person) and in between sessions (via text messages, email, and phone calls). This finding aligns with one previous study. In their study to explore 36 patients' experience of receiving schema therapy, Tan et al., 2018 reported that 13 patients who discussed the value of having email contact with therapists outside office hours endorsed that such therapist accessibility increased their sense of security and support. In the current study, P11 reported clinicians' availability to clients during sessions (in person) and in between sessions (via text messages) as a helpful aspect of limited parenting over her Black American clients with panic disorder. Thus, P11 stated:

> Another one that sort of sets us apart from other therapists is that we make ourselves more available to our clients than other therapists do. And so, in between sessions, if something comes up or one of my clients is struggling, they're free to text me. I mean, I'm not going to spend hours, but I will certainly spend time outside of the session connecting with them. And that also helps to strengthen the bond and the sense of care I think that the therapist has.

However, this result did not support Nadort et al.'s (2009) findings on patients with telephone support. Nadort et al. examined the success of implementing outpatient schema-focused therapy for borderline patients in regular mental healthcare and whether therapist telephone availability outside office hours in case of crisis had added therapeutic value. They found, among other things, a relatively small number of phone contacts outside office hours except for two patients and no added value of therapist telephone availability. Because patients in Nadort et al.'s study generally failed to utilize telephone support, the research needed more evidence to refute the usefulness of clinicians' availability to clients during and between sessions, as reported in the present study.

Cognitive-Behavior Interventions. Participants in the present study also reported that schema flashcards (P3, P4, P5, P7, P9, P11, P13, and P14), schema diaries, and other homework (P4, P5, P9, P12, and P13) were helpful and frequently used among Black Americans with panic disorder. These study results are consistent with previous studies regarding specific cognitive-behavior interventions associated with schema-focused therapy. For example, Jing (2018) observed that utilizing a schema diary to record daily stressful events that triggered the strong, unpleasant emotions of a 25-year-old lady with

major depressive disorder helped explore and identify her maladaptive schema modes. Cockram et al. (2010) reported that using schema flashcards and other homework assignments was helpful for veterans with PTSD. Similarly, P7 noted the usefulness of completing schema flashcards with his Black American clients to track their current feelings, modes, things that trigger them to panic, and negative thoughts about these triggers and to underline healthy responses to specific schema triggers (e.g., healthy cognitive thinking and behavior). Also, P14 noted the usefulness of using schema flashcards to guide his Black American clients with panic disorder "to organize the everyday experiences of their schema modes and identify the schema modes and when the modes are triggered, what triggers them, what they are doing to cope effectively with the triggers." Because they carried them about and read them during schema triggers, they had tangible rational responses that readily defeated irrational and unhealthy responses. Additionally, P13 reported giving her Black American clients audio or video recordings of therapy sessions and audio flashcards so the therapist's voice would remind them of the healthy adult ways of thinking discussed during therapy. This finding is unique to this study as none of the studies reviewed reported this aspect of schema strategy. Further studies are needed to support this finding.

Skewes et al. (2015) reported using schema mode diaries and flashcards to help patients with mixed personality disorder identify mode triggering, challenge schemas, and work on behavioral change within and outside the therapy group. In the current research, P13 reported that she gave her Black American clients "a schema diary card, as homework, to fill out when they get activated during the week, and that helped prevent

them from dysfunctional behavior or after they've done something they regret." Participant 13 observed that schema diaries helped them identify the triggered mode, what led to it, and the alternative healthy adult mode. Similarly, P12 reported using a schema diary frequently with this population because it helped them record their behavior patterns, including time, cause, or the circumstances when panic occurs. Also, P5 reported allowing his Black American clients to fill some diaries about their behaviors, the schema activation, its frequency, and healthy ways of coping with the triggers.

Like Cockram et al. (2010), Dickhaut and Arntz (2014) endorsed the importance of using homework assignments during schema-focused therapy. Similarly, P9 in the current study also observed that homework assignments (e.g., journaling, letter writing, and schema flashcards) "helped her Black American clients with panic disorder be aware of their emotions and behavior and respond in healthy ways." Participant 9 also reported using letter writing to help this population address the person that caused them the negative emotions, for example. She underscored that writing "a letter as if they are addressing that person and telling them how they feel their needs are unmet, how they made them feel in childhood and what they wished they could get from their them" was helpful. However, P4, P5, P7, P8, and P12 observed that Black American clients did not always complete their homework assignments homework. For instance, P4 reported that it was "because they were doing it alone and became disinterested." In this light, P7 and P12 insisted that when clients follow instructions, these strategies will be effective and improve their mental health. Similarly, P8 noted that Blacks generally do not feel comfortable when others know they are seeing a therapist. "So, when you give them

homework assignments, they are not gonna feel comfortable discussing their mental health issues with their loved ones, including children, parents, relatives, and friends." Hence, P8 advised that using cell phones for schema flashcards, diaries, journaling, and other homework will improve this situation since cell phones provide some privacy.

Other schema therapy cognitive-behavior interventions reported in the current research as helpful among Black Americans with panic disorder were cognitive restructuring, reattribution, reframing (P1, P2, P3 P4, P6, P8, P10, P12, and P14), and relaxation techniques (P1, P2, P4, P9, and P14). These findings agree with previous studies. For example, in exploring the therapeutic effects of imagery rescripting on patients (n = 15) with personality disorder, Shibuya et al. (2018) used cognitive restructuring of patients' encapsulated beliefs to establish a new perspective on their early traumatic memory as a significant step toward imagery rescripting. The researcher reported a significant reduction of distress from traumatic images, memories, and encapsulated beliefs in patients (n = 16). Similarly, Videler et al. (2014) used, among other schema therapy techniques, workbooks in which cognitive techniques were applied to test and challenge distorted views associated with EMSs for a group of elderly patients (n = 31) with chronic mood or adjustment disorder comorbid with personality disorder. The researchers confirmed that these cognitive techniques were helpful for the patients. In the current study, P1, P2, P8, and P10 acknowledged using cognitive restructuring strategies frequently for Black Americans with panic disorder and underlined that it helped them generate a list of alternative explanations to disprove unhealthy and dysfunctional evidence supporting maladaptive schemas. In their observation,

restructuring thinking patterns was helpful for this population and reduced relapse rates. Also, P3, P6, and P14 recounted using the reattribution technique, which is essentially replacing some negative thoughts with more positive ones, and they also recommended it for clinicians working with this population. Hence, the observation in the previous studies that cognitive restructuring, reattribution, and reframing were strongly associated with significantly reducing mental health problems might not be different from the current study result on treating Black Americans with panic disorder using these strategies.

Subtheme 4.3: Multicultural Strategies

In another finding from the present research, six participants (P8, P10, P11, P12, P13, and P14) underlined the importance of culturally responsive schema-focused therapy for Black Americans with panic disorder. For example, P8 reported that "acknowledging and validating the impact of racial trauma on individuals' schemas and panic disorder" was helpful for Black Americans with panic disorder. Participant 12 recommended that clinicians learn and understand their clients' personalities and cultural backgrounds to treat them effectively. Additionally, P13 shared that getting a sense of her Black American clients' preferences and needs in therapy was helpful. For P14, open-mindedness to their cultural values and welcoming new ideas from them were helpful. However, multicultural strategies were not reported in the studies reviewed in Chapter 2. However, multicultural strategies are not limited to schema therapy. They apply to all therapies. In any case, more studies are needed to support these findings on multicultural strategies with Black Americans with panic disorder.

Subtheme 4.4: Clinicians' Self-Improvement

Four participants (P7, P10, P13, and P14) reported that clinicians' continuous knowledge update in schema-focused therapy was helpful for effective therapy. For example, P13 encouraged schema-focused therapists to join the schema therapy community. Participant 7 recommended an online course for schema-focused clinicians. Similarly, P14 recommended clinicians to read empirical research on schema-focused therapy regularly to "find out what other therapists are doing, what has been working for them, and what hasn't been working." Additionally, seven participants (P5, P8, P9, P10, P11, P13, and P14) reported the importance of self-care for schema-focused therapists treating Black Americans with panic disorder. For example, P10 stated: "I do personal therapy sometimes with very qualified and nonjudgmental therapists just to explore my own EMS." Participant 9 echoed the same thing when she said, "It is important for therapists to seek therapy if they feel their EMSs are being activated." Similarly, P8 endorsed "seeking consultation and collaboration with other healthcare professionals, such as psychiatrists or primary care physicians, to gather additional insights and perspectives on managing emergencies." However, these two strategies (i.e., clinicians' continuous knowledge update and therapy and self-care) were not reported in the studies reviewed in Chapter 2. Like multicultural strategies, these strategies are not limited to schema therapy. They apply to all therapies. Nonetheless, more studies are needed to support these findings.

Theme 5: Challenges of Schema Therapy for Black Americans with Panic Disorder

In the present study, participants' reports on the challenges of schema-focused therapy for clinicians and clients were consistent with two previous studies. For clinicians, these challenges include vicarious trauma, schema activations, rupture, clients' transference, feeling bad because of clients' current emotional problems, cultural challenges, lengthy therapy, and commitment and engagement throughout the therapeutic relationship. For clients, the challenges include shame, stigma, feeling judged, trust issues with the therapy process, and the tendency of the therapy to rekindle clients' past emotional pains. De Klerk et al. (2017) reported that therapists perceived therapeutic relationships as hard and taxing, although vital for therapeutic change. In the current study, P7, P9, P10, and P13 reported that the therapy involved commitment, dedication, and engagement with clients. For example, P13 acknowledged that the therapy takes work and commitment. Similarly, P10 endorsed that the therapy involves a lot of therapists' expertise. Like De Klerk et al. (2017), these participants also reported that such commitment, dedication, and engagement contributed to the efficacy of the therapy. For example, P9 reported that the therapy "takes some time to really start to see progress compared to other techniques, but it's effective in the long run." Similarly, P13 shared that schema-focused therapy involves "different types of therapeutic interventions, which is like learning to play all instruments in the orchestra. But overall, it is rewarding and positive." However, participants in the current study indicated that the lengthy nature of schema-focused therapy was challenging. For example, P7 endorsed that schema therapy was time-consuming. Also, P10 reported that it involved many regular sessions. In

contrast, De Klerk et al. reported that some therapists felt that about 50 sessions were too short to realize significant improvement. Similarly, many patients believed 50 sessions were insufficient to effect a substantial change (De Klerk et al., 2017). Therefore, clinicians need to appreciate the long nature of schema-focused therapy.

De Klerk et al. (2017) also reported that many patients endorsed suffering from very intense emotions during the process of gaining understanding and undergoing change brought on by therapy because therapists did not inform them about it in advance. In the current study, participants (e.g., P4, P5, P6, P10, P12, P13, and P14) reported the tendency of the therapy to reenkindle clients' past emotional pains. For example, P5 stated: "Schema therapy is emotionally challenging because it takes clients back to the root of their pain." In this light, P5 underlined imagery work as a primary means of such emotional pain. From the perspective of P10, taking his Black American clients to their past experiences was challenging to them because it usually brought up very painful memories. Similarly, P14 simply remarked that imagery work was emotionally challenging to her Black American clients with panic disorder. Reporting the same emotional pains, P12 shared: "When they narrate their stories, they inevitably remember what they passed through, what caused them to develop that panic disorder, and they usually get emotional, very, very emotional. And they may even end up panicking." However, some participants (P6, P9, and P13) noted that the emotional pain was a process of healing therapeutic. For example, P6 reported that "schema therapy can be very intense for clients because it goes into troubling memories but very effective over time." For P13, clients might feel emotionally overwhelmed when telling their stories or

when going back through imagery scripting, but that was part of the healing. Like De Klerk et al. (2017), P4 and P5 also recommended that clinicians help clients understand this pain before using imagery work. Similarly, P14 recommended that imagery work should be used only when clients are fully informed and ready.

In another study on the challenges of schema-focused therapy for clinicians, Pilkington et al. (2022) reported therapists' perception of their EMSs and modes that usually activate during therapy. These EMSs include abandonment, unrelenting standards, defectiveness/shame schemas, emotional deprivation, enmeshment, self-sacrifice, subjugation, and approval-seeking. The modes include avoidant protector, over-controller, compliant surrender, demanding mode, punitive parent, angry child modes, and vulnerable child modes**.** In the current study, P11 endorsed battling regularly with failure schema, which affected her therapy. She says, "The major challenge that I have battled is the failure schema, the sense that I'm not smart enough and that I am pale compared to my peers." In continuation, P11 shared: "Because I never feel like I am good enough, it affects my work." Participant 13 admitted experiencing unrelenting standards, self-sacrifice, and approval-seeking during schema therapy. Participant 7 acknowledged dealing with mistrust schema when his Black American clients refused to open up during therapy. In this situation, he judged them harshly, thinking they discriminated against him. Participant 9 reported helpless surrender mode, leading to canceling sessions when overwhelmed emotionally.

Pilkington et al. (2022) also reported countertransference resulting from clinicians' EMS activations (e.g., feeling rejected and incompetent or anxious when

abandonment, unrelenting standards, or defectiveness/shame schemas were triggered) and mode activations (e.g., perfectionism, detaching, becoming argumentative or aggressive, and over-functioning). Like this observation, P14 in the current study shared that she might be angry when her clients were not cooperating or responding to instructions (e.g., not completing their homework, such as schema diaries), or acting frustratedly and angrily. Similarly, P10 endorsed becoming blunt when his schemas got triggered. Thus, he stated: "Sometimes I will be blunt a little bit; I don't go straightforward because maybe I was the problem, and I pushed them a bit too much." Personal triggers continued P10, "could interfere in the present, and you are not attuned to the client's needs. Participant 9 reported that resistance from clients is the biggest challenge she faced during therapy. Similarly, P8 relayed experiencing emotional challenges when his Black American clients did not respond positively to instructions during therapy or stop coming to therapy because the therapist indicated their real problems Also, P11 admitted the challenge of negative countertransference to clients' negative reactions. However, P11 noted that rupture and similar emotional challenges are where some of the deepest work and healing occurred, irrespective of its challenges. Thus, she stated: "When there is a rupture, which is difficult, I think for most therapists that deal with it, especially when it relates to the therapist, that is where some of the deepest work happens, healing."

Pilkington et al. (2022) also related that a participant described how the vulnerability of mistrust caused clients' defenses. In the current study, P1, P8, P12, and P14 also shared that some of their Black American clients had the problem of trusting the therapy process or therapists. For example, P1 observed that some had "the problem of

trusting the therapy process, leading to withholding information during therapy." Similarly, P8 relayed: "When you ask them some personal questions, and they look at you for about two minutes and decline to answer that question, it is because they mistrust the therapy." Commenting on such mistrust, P12 reported that "schema-focused therapy is a new therapy, and clinicians are learning to use it most efficiently, and some do not yet have full trust in it." Engaging in culturally responsive therapy is another important recommendation to help Black American clients build trust in therapeutic relationships. In this light, P13 advised clinicians to be culturally humble, learn about Black American clients' culture, and not make assumptions or have biases. Also, P13 emphasized that getting a sense of her Black American clients' preferences and needs in therapy was helpful. Additionally, empathy, active listening, and validating their subjective experiences are other essential means of building client trust (Teyber & Teyber, 2017).

One essential emotional challenge among clinicians scarcely reported in the reviewed literature but heavily reported in the current study was vicarious trauma. About three quarters of the participants (P1, P2, P3, P4, P9, P10, P11, P12, P13, and P14) admitted suffering vicariously when treating this population. For example, P1 narrated that listening to his clients' stories on panic disorder rekindled his childhood experience of panic disorder, shame, and associated disturbing thoughts. Similarly, P2, P3, P4, and P12 reported that listening to different clients and their stories sometimes had an emotional toll on them, especially when clients shared some health issues clinicians had experienced. Also, P10 shared: "When a client is telling you about panic disorder and trying to narrate her own story, that may actually activate in you something you have

passed through during your childhood, it might begin to activate certain pains in you." Participant 11 reported that she used to vicariously suffer while treating clients in the first ten years of her career as a therapist. Similarly, shame and stigmatization were an important emotional challenge among clients reported in the current study but not reported in the reviewed literature. In this light, P12 reported that most of his Black American clients "usually find it hard or maybe they feel ashamed when they were telling their stories." Also, P7 observed that some of his Black clients had difficulty disclosing their problems because of shame. Thus, P7 stated: "It's hard for some of them to give out their full information because some might be very shameful and others disgusting. So, they usually tend to hide some information." Additionally, no previously reviewed study noted cultural challenges during schema therapy. In contrast, one participant in the current study reported some challenges due to culture, including cultural humility, learning about Black American culture, and not making assumptions or having biases. Culturally responsive therapy is necessary for effective treatment (e.g., Cardemil & Battle, 2003; Neville et al., 2009).

Subtheme 5.1: Effects of Clinicians' Schema Activation and Other Emotional Challenges on the Therapy

Some participants (P2, P4, P6, P7, P9, P10, P11, P13, and P14) in the current study noted that clinicians' schema activations and other emotional challenges during therapy improved therapeutic relationships with clients and facilitated clinicians' development of mechanisms to handle their emotional challenges and assist clients. Pilkington et al.'s finding on the effect of clinicians' schema activations and other

emotional challenges on the therapy supports this finding. Pilkington et al. reported that schema activations in clinicians helped several clinicians to understand and help clients' schema activations. Precisely, the activation helped clinicians to reconnect with the client's vulnerability, understand the client's story, calm down, and detach from their (clinicians) schema activation (Pilkington et al., 2022). In the current study, P2 also reported that experiencing emotional pain connected him to the feelings of his Black American clients with panic disorder and put him in their shoes "to understand them, advise them, and to know exactly what they want. Similarly, P10 stated: "The EMS activation will bring about a deeper understanding of the client's difficulty during the schema-focused therapy. It brings a different understanding of the specific needs of clients." Participant 6 also indicated: "My emotional challenges made me be in their shoes, understand their pains, and empathize with them. Also, P4 noted that schema activation helped him have personal feelings about clients' experiences and know how to help them. Additionally, P13 admitted that specific schema activations, including unrelenting standards, self-sacrifice, and approval seeking, in some ways, helped her really try to do a good job for clients. Also, P10 reported that schema activations helped him "learn essential skills, get more from clients, and make a better response to them."

Additionally, P11 and P13 acknowledged that schema-focused therapy provided them with the tools to alleviate their emotional challenges. In the words of P11, "My own schema therapy, which I continue to be in myself, also gives me the tools that I can pretty quickly manage what's happening internally when I do get triggered." In P13's experience, "Clients' traumatic stories probably affect my mental health, but as far as I

know, that's one of the things I like about schema therapy because it gives you something to do with it. You don't just feel helpless." For instance, P13 observed: "The imagery scripting helps you do something with these traumatic memories and traumatic scenes." Participants 2, 4, 6, 6, 9, and 14 reported that emotional challenges disposed them to know the exact solutions to overcome subsequent problems. For instance, P6 observed that emotional challenges helped her appropriate the tools she taught clients, including relaxation techniques in these words: "When those feelings come to head, sometimes you find yourself using the skills you teach clients, such as breathing techniques or other techniques. So, you find yourself also applying them." Therefore, schema activations and other emotional challenges during therapy appear to improve therapeutic relationships with clients and facilitate clinicians' development of mechanisms to handle their emotional challenges and assist clients in the current study and previous studies.

In contrast, some participants (P5, P9, P10, P12, and P14) in the present study reported two negative effects of schema activations and emotional challenges: therapy effectiveness reduction and therapy elongation. Pilkington et al. (2022) also supported this perspective when they reported therapists' perception of their EMSs and modes that usually activate during therapy and specific countertransference associated with such activations. One example of the countertransference resulting from EMS activations was feeling rejected and incompetent or anxious when abandonment, unrelenting standards, or defectiveness/shame schemas were triggered (e.g., by clients feeling worse or canceling their therapy sessions). The countertransference resulting from mode activations also includes perfectionism, detaching/avoiding, becoming argumentative or aggressive, and

over-functioning (Pilkington et al., 2022). In the current study, P9 also reported that she had to cancel sessions when overwhelmed emotionally. Similarly, P10 stated: "Sometimes I will be blunt a little bit; I don't go straightforward because maybe I was the problem, and I pushed them a bit too much." Participant 12 also relayed that the emotional challenge delayed the therapy procedure. The perception in previous studies on the negative impact of schema activations and emotional challenges might not be different the findings of the current study on these challenges when treating Black Americans with panic disorder. Therefore, clinicians need to develop strategies to manage emotional challenges and schema activations with negative impacts. These strategies include self-reflection, personal growth, caring for one's vulnerability and reconnecting with healthy adult mode, self-care, supervision, and personal therapy (Pilkington et al., 2022).

Subtheme 5.2: Managing Clinicians' Schema Activation and Other Emotional Challenges During and After Therapy Sessions

The current study results underscored how clinicians managed schema activations and other emotional challenges when treating Black Americans with panic disorder. These strategies include relaxation techniques (P1, P2, P4, P5, P6, P9, P10, P11, P12, P13, P14), physical activities (P2, P4, P5, P10, P12), seeking therapy and using schema-focused therapy tools (P3, P9, P10, P12; and P13) and self-awareness (P11, P13, and P14). Pilkington et al.'s (2022) findings on the strategies therapists use to manage their challenges during and after schema-focused therapy provide credence to this finding. As already indicated, some strategies therapists acknowledged utilizing to manage their

schema activations and emotional challenges were self-reflection, caring for one's vulnerability, and reconnecting with healthy adult modes. (Pilkington et al. et. 2022)**.** In the current study, P11, P13, and P14 reported that self-awareness, caring for one's vulnerability, and reconnecting with healthy adult modes were important means of coping with their emotional challenges during and after therapy. For example, P14 endorsed that her primary coping skill during therapy was knowing what triggers her maladaptive schemas and modes and developing strategies to soothe them. Similarly, P11 reported: "I think about what my little vulnerable child might be fearing or feeling. I try to shift from her into the adult me that can handle the situation and soothe the little child within me." Also, P13 noted that one important technique they learned in training was "to notice when you start to be overwhelmed, flooded or triggered and to soothe it with good parent behavior (e.g., empathic confrontation) against using angry or vulnerable child." In this situation, I might say, continued P13, "I'm putting this my vulnerable child over here, and I'm going to do what a good parent would do and manage this from my healthy adult and not from my angry child or my vulnerable child modes."

Other strategies reported by Pilkington et al. (2022) for managing schema activations and emotional challenges include personal growth and healing, engaging in supervision and training, personal therapy, self-care, and using one's own schema to understand and help clients' schemas to manage their schema activations, countertransference, and other emotional challenges. In the current study, P3, P9, P10, and P12 reported resorting to counseling or therapy at one point in time to alleviate their emotional stress. For example, P9 underscored the importance of seeking therapy

sometimes when her schemas were activated and advised other therapists to do the same. Similarly, P10 noted: "I do personal therapy myself sometimes with very qualified and nonjudgmental therapists just to explore my own maladaptive schemas." Also, P12 reported: "We're also humans. So, sometimes you may also need therapy because some of the stories you may hear from clients, especially stories of abuse, may be challenging to listen to." Regarding other self-care strategies reported in the current study, P1 noted listening to music, reading books, and practicing deep breathing and muscle relaxation as essential to coping with his emotional challenges. Similarly, P12 reported reading articles and playing cards to calm himself down. Also, P7, P9, P10, and P11 shared that breathing techniques and meditation were helpful in coping with their emotional challenges during and after therapy. Participants 2, 4, 5, 10, 12, 13, and 14 noted taking a break from the therapy to relax when their emotional challenges became so intense. Participants 2, 5, 10, and 12 endorsed engaging in physical activities (e.g., going to the gym, swimming, and yoga) to manage the emotional stress that ensued from therapeutic relationships.

Therefore, the findings from Pilkington et al. et. 2022 on strategies that clinicians can use to manage schema activations and other emotional challenges strongly support the findings of the current study regarding clinicians' strategies for managing their schema activations and other emotional challenges when treating Black Americans with panic disorder. In this light, clinicians struggling with schema activations can benefit from the following participant recommendations in the current study. Participant 11 advised that clinicians know their schemas, what triggers, and how to soothe them. In her words: "I think it should be mandatory to know your own schemas and to know what

triggers your own schemas and know how to soothe them." Similarly, P14 advised clinicians to address their unresolved maladaptive schemas in therapy to be more aware of their triggers: "If you have unresolved EMS, it's important to work on addressing them in your own therapy so that you can be more aware of the triggers."

Conceptual Framework

The integrated schema-focused model served as the conceptual framework for this research. The integrated schema-focused model is a convenient clinical model that integrates several models of schema therapy, including EMSs, schema modes, maladaptive emotional schemas, and schema therapy techniques (McGinn & Young, 1996; Young & Lindemann,1992). This model informed and connected the research question, interview questions, reviewed literature, and data collection into alignment.

Firstly, EMSs are grouped into five domains. These domains include: disconnection/rejection (abuse/mistrust, abandonment/instability, emotional deprivation, social isolation/alienation, and shame/defectiveness); impaired autonomy and achievement (dependence/incompetence, vulnerability to harm/illness, undeveloped self, and failure schema); impaired limits (insufficient self-control and grandiosity); other-directedness (self-sacrifice, subjection, approval-seeking); and hypervigilance and inhibition (unrelenting standards, pessimism and negativity, punitiveness, emotional inhibition). Participants reported different EMSs from four schema domains (disconnection/rejection, other-directed, hypervigilance, and impaired autonomy) as associated with panic disorder in Black Americans.

This present study aligns with this model for schema-focused therapy. Participants indicated that all EMSs from the disconnection/rejection domain were associated with panic disorder in Black Americans: abuse/mistrust (P1, P2, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, and P14), shame/defective (P1, P2, P4, P6, P8, P11, P13, and P14), abandonment (P1, P2, P10, P11, P12, P13, and P14), social isolation/alienation (P2, P8, P10, P13, and P14), and emotional deprivation (P1, P2, P9, P11, P13, and P14). In the domain of other-directed, participants reported that emotional inhibition (P9 and P14), self-sacrifice/over-responsibility or overcompensation (P9, P11, and P13), approval seeking (P13), subjugation (P10 and P11) were associated with panic disorder in this population. In the impaired autonomy, vulnerability to harm or illness (P4, P5, P6, P7, P9, P10, P12, P13, and P14), failure schema (P1, P4, and P8), and incompetent or dependent schema (P4 and P8) were reported. In the hypervigilance domain, participants reported that negativity and pessimism (P5, P6, P7, P12, and P13) and unrelenting standards (P8 and P11) were EMSs associated with panic disorder in Black Americans with panic disorder.

Secondly, schema modes are divided into four categories: unhealthy child modes, comprising vulnerable child modes (e.g., lonely child, rejected child, terrified child, abused child, humiliated and inferior child, subordinate child, victimized child, and dependent child) and angry/unsocialized child modes (e.g., angry child, enraged child, undisciplined child, defiant child, stubborn child, aggressive child, deceptive child, and spoilt/entitled child); parent modes (punitive parent mode, guilt-inducing parent mode, and anxiety-inducing parent mode); coping modes (flight or avoidance, flight or

overcompensation, surrender or schema rigidity, and repetitive, unproductive thinking); and healthy modes, comprising healthy child and adult modes (Edwards, 2022; Young & Lindemann, 1992). The results of the current study indicated clinicians' experiences with the schema modes associated with panic disorder, which Black Americans adopted to respond to their EMS activations. In the category of unhealthy child, participants reported addressing vulnerable child modes: anxious modes (P1, P2, P7, P9, P10, and P12), lonely/neglected child (P3, P4, P7, and P10), terrified child (P1, P4, P11, and P14), abused child (P3 and P6), humiliated child (P6), mistrustful child (P1 and P7), and helpless child (P7), rejected child (P1, P5, and P6), and confused child (P1). Similarly, participants reported addressing angry/unsocialized child modes, including angry child (P1, P3, P7, P8, P10, P12, and P14), aggressive child (P2, P5, P8, P10, P11, and P13), enraged child (P8 and P14), complaining child (P5), and frustrated child (P7).

In the parent mode category, participants reported addressing punitive parent mode (P5, P6, P8, P9, and P13), demanding and anxiety-inducing (P14), and guilty-inducing and pessimism in life (P5) in their Black American clients with panic disorder. In the coping mode category, participants observed that their Black American clients with panic maladaptive struggled with specific surrender/rigid modes: hopeless surrender (P5, P7, P10, P13, and P14), compliance surrender (P11), and self-sacrifice/rescuer surrender (P13). Participants also reported flight/avoidance modes as associated with this population in responding to schema activations: self-soothing with self-harm (P6 and P9), food (P11), and alcohol and other substances (P6, P7, P8, P9, P10, P13, and P14); avoidant protector (P5, P8, P9, P10, P11, and P14); and detached protector (P10). One

participant also reported that fight or overcompensation modes, including perfectionism and punitiveness, were adopted to respond to EMS activations. In the healthy mode category, participants noted that their Black clients began using healthy adult modes (P11, P13, and P14) or healthy child modes (P3, P6, and P13) as the therapy preceded, and these modes helped clients reduce or eliminate their maladaptive modes.

Thirdly, schema therapy techniques adopted to deal with maladaptive schemas are grouped into data collection and schema identification techniques (e.g., psychoeducation, behavioral pattern analysis, and guided imagery), relational techniques (e.g., limited reparenting, attunement, empathic confrontation), experiential or emotional techniques (e.g., imagery rescripting, chairwork, role-play, and mode sequencing), and cognitive-behavior intervention, such as behavior-pattern breaking, schema diary, flashcards, homework, relaxation training, cognitive restructuring, and flashcards (Dadomo et al., 2016; Jing, 2018; Gülüm & Soygüt, 2022; Videler et al., 2017; Young et al., 2003). The study findings revealed that schema-focused clinicians working with Black Americans with panic disorder utilize these strategies. For instance, participants (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11, P12, and P13) endorsed using guided imagery (for schema identification) and imagery rescripting (for schema change) frequently for their Black American clients. In addition to guided imagery, participants indicated using psychoeducation (P9, P10, P11, and P13), conceptualizing client's problems (P1, P3, P11, and P13), behavioral pattern analysis (P8 and P12), and need inventories (P9). Thirteen participants noted that data collection and schema identification techniques were mostly helpful. However, some participants (P4, P5, P7, P13, and P14) were concerned about the

length of schema questionnaires, the ability of clients to comprehend them, and the tendency for clients to leave out much information because of these difficulties.

Regarding relational techniques, all participants reported using limited reparenting in one form or the other (e.g., empathy, nonjudgmental, validating clients' experience, empathic confrontation, normalizing, providing safe havens, and building trust and hope) frequently because of its usefulness. Additionally, two participants (P11 and P13) noted the usefulness of audio recordings/flashcards and clinicians' availability to clients in and between sessions via text messages. Participants also shared using specific experiential techniques frequently and acknowledged that they were helpful: imagery rescripting (P1, P2, P3, P4, P5, P6, P7, P8, P9, P11, P12, and P13); and schema dialogues, including role reversal, mode dialogues, and chair work (P3, P4, P6, P9, P13, and P14). Finally, participants acknowledged using specific cognitive-behavior interventions frequently with Black Americans with panic disorder and admitted their usefulness: schema flashcards (P3, P4, P5, P7, P9, P11, P13, and P14); schema diaries and other homework (P4, P5, P9, P12, and P13); cognitive restructuring, reattribution, and reframing (P1, P2, P3, P4, P6, P8, P10, P12, and P14); relaxation techniques (P1, P2, P4, P9, and P14); and maladaptive behavior pattern breaking (P2, P8, P9, and P10); adaptive behavior rehearsal (P6); and clients' schema education (P8).

Some participants noted some difficulties and concerns with Schema flashcards (P8), schema diaries, and other homework (P4, P5, P7, P8, and P10) because their Black American clients hardly used or completed them at home. It is imperative to underscore that the study participants indicated the usefulness of other strategies not included in the

schema-focused therapy. Precisely, six participants (P8, P10, P11, P12, P13, and P14) underlined the importance of culturally responsive schema-focused therapy for Black Americans with panic disorder. Also, four respondents (P7, P10, P13, and P14) reported the importance of clinicians' continuous knowledge update in schema-focused therapy. Seven participants (P5, P8, P9, P10, P11, P13, and P14) also reported the importance of self-care for schema-focused therapists treating Black Americans with panic disorder.

Limitations of the Study

There were some limitations to the current study. The first limitation was the use of a convenient sampling strategy, which impacted the sample representativeness and the study's generalizability. Additionally, there was no participants' demographic information (e.g., states, ethnicity, and age). Such knowledge might have been useful in gaining a better understanding of the participants' backgrounds and biases. The next limitation of the current study was the small number of participants (Nassaji, 2020). Another limitation was the difficulty of accessing clinicians' performance on schema-focused therapy with Black Americans with panic disorder. This limitation reduced the opportunity to recruit clinicians with the best schema therapy records for Black Americans with panic disorder (see Hughes et al., 2022). Using Zoom video with the camera off to collect data was another limitation of the current study. While this method made participants more anonymous, encouraging them to be more objective, it prevented the ability to observe participants' physical expressions during the interview. In this way, a wealth of useful knowledge about the study was omitted.

Similarly, the researcher's bias (e.g., unconsciously influencing the interviewee's response by showing approval or disapproval with a smile, frown, or other body gestures) might have reduced the objectivity of the study findings (see Ghafouri, & Ofoghi, 2016; Nassaji, 2020). Furthermore, it is imperative to underscore that participant reported their experiences of schema-focused therapy with Black Americans with panic disorder retrospectively. Therefore, some of their reports might be subject to significant recall bias, especially because of the time lapses between the actual schema-focused therapy experience and the report (see De Klerk et al., 2017; Tan et al., 2018). The next limitation of this study was the impossibility of exploring how schema-focused therapy addressed some schemas among Black Americans. There are several schema modes in addition to EMSs and emotional schemas. It was not possible to obtain information regarding all these schemas during the interview on the experiences of schema-focused therapy in Black Americans with panic disorder. However, despite these limitations, the current study has a wealth of information about using schema-focused therapy for Black Americans with panic disorder that is consistent with previous studies. Although the findings of this study are not generalizable, the study interpretations and conclusions are transferable to other similar contexts (see Ghafouri & Ofoghi, 2016; Nassaji, 2020).

Recommendations for Future Studies

Many findings of the present research were consistent with the results of previous studies. For instance, the results of the current study suggested that schema-focused therapy is effective with Black Americans with panic disorder, indicated several EMS and schema modes associated with panic disorder in Black Americans, underlined helpful

schema therapy strategies, underscored ways to improve strategies that were not helpful, and highlighted several challenges clinicians and clients encountered during schema-focused therapy. Because this study was based on a convenient sampling strategy, future qualitative studies with Black Americans with panic disorder and quantitative studies using experimental and control groups of Black Americans with panic disorder are required to validate the specific findings of the present study. Such studies on the specific study results will provide more information on schema-focused therapy for Black Americans with panic disorder and enhance the effectiveness of schema-focused therapy for this population. Additionally, many findings of this study were unique (e.g., most schema modes reported as associated with panic disorder, including abused child, confused child, angry child, aggressive child, enraged child, complaining child, frustrated child, avoidant protector, self-soothing, self-sacrificer/rescuer surrender, social overcompensator, perfectionism or punitiveness, punitive parent mode, guilty inducing, anxiety-inducing mode, and pessimism in life)**.** Hence, further research is required to validate these new findings.

Moreover, future research needs to explore other areas (e.g., schema modes and schema-focused techniques) that participants did not report. For instance, panic disorder involves intrusive memories and thoughts of earlier trauma or panic attacks, though less frequently than PTSD (Shibuya et al., 2018; Pfaltz et al., 2013). Therefore, a good hypothesis will be that the schema mode involved reexperiencing earlier trauma and panic attacks (i.e., repetitive, unproductive thinking modes, including overanalyzer, denial ruminator, worrying overcontroller, pessimistic or depressive ruminator, and angry

ruminator) would be associated with panic disorder (Edwards, 2022). However, no participant indicated experiencing such schema modes among their Black American clients. Similarly, schema-focused therapy techniques depend on the client's needs and the therapist's preference. It is possible that other therapists might have used other techniques for Black Americans with panic disorder, which participants in the current study did not use for this population. Therefore, other studies on schema-focused therapy for Black Americans with panic disorder need to highlight these areas.

Implications

The results of the present study have several implications for positive social change. Primarily, this study has a wealth of information about using schema-focused therapy for Black Americans with panic disorder. It uncovered clinicians' perceptions of schema-focused therapy with Black Americans with panic disorder from different dimensions, including early EMSs and schema modes associated with panic disorder in Black Americans, helpful and unhelpful schema therapy strategies, ways to improve unhelpful strategies, and several challenges clinicians and clients encounter during schema-focused therapy. By obtaining an in-depth understanding of techniques, strategies, and practices of effective schema-focused therapy in Black Americans with panic disorder, the current study enhances knowledge and skills in professional practices regarding schema-focused therapy for Black Americans with panic disorder. In this way, the present study facilitates the effective implementation of schema-focused therapy with the population (Bach et al., 2018; Erving et al., 2019; Jones et al., 2020; Kisely et al.,

2017; Thomas et al., 2022). Additionally, improving schema-focused therapy among Black Americans with panic disorder increases their trust in health services.

Secondly, although the findings of this study are not generalizable, the study interpretations and conclusions are suggestive and transferable to similar contexts. Schema-focused clinicians can utilize a wealth of knowledge and skills from the present study when treating non-Black Americans with panic disorder. The knowledge and skills learned from this study can also be beneficial for schema-focused therapists when treating Black Americans and non-Black Americans with other anxiety disorders, including agoraphobia, PTSD, and acute stress disorder (Bosch & Arntz, 2021; De Klerk et al., 2017). Although the population of this study was Black Americans with panic disorder, several findings from the study were not limited to clinicians working with Black Americans with panic disorder. For instance, the importance of culturally responsive therapy, positive therapeutic alliance, positive countertransference, and continuous knowledge updates in therapy can benefit any clinician regardless of the treatment modality and the population they are treating.

Finally, several recommendations for effective treatment of Black Americans with panic disorder are evident from the results of this study. Clinicians working with the Black population need to understand and validate their Black American clients' world of having to deal with systemic racism and its association with panic disorder. Clinicians should also understand that it is still stigmatizing to go to a therapist in the Black community. Within this understanding, clinicians need to show empathy, walk in the shoes of their Black American clients, and use empathic confrontation in ways that will

not indicate criticism and a lack of understanding of their concerns **(**Gulum & Soygut, 2022; Kopf-Beck et al., 2020; Malogiannis et al., 2014; Skewes et al., 2015; Tan et al., 2018; Wampold, 2015). Additionally, getting a sense of their Black American clients' preferences and needs in therapy (e.g., their preferences for race, gender, and age in a therapist and their preference for virtual therapy) improves positive therapeutic relationships and the disposition to disclose health problems. Therefore, clinicians should be culturally humble and open-minded to learn about the client's cultural values and experiences and be willing to welcome new ideas.

Based on the findings of this study, using audio flashcards and being available to clients in between sessions improves the effectiveness of schema-focused therapy. Another important recommendation for schema-focused therapists is utilizing peer discussion, supervision, and experienced-aimed training (De Klerk et al., 2017; Ten Napel-Schutz et al., 2017). In this regard, joining the schema therapy community will be helpful. In this community, there are online sessions where therapists present almost weekly challenging problems they have with clients. Also, teachings on schema-focused therapy practice are presented regularly. Sometimes, there are interviews with experts. All these build clinicians' confidence and ability to stay in their healthy adult when dealing with challenging clients. The results of the current study also recommended several strategies therapists can adopt to keep their practice effective when they experience schema activations and other emotional challenges during and after therapy. These strategies include self-awareness of what triggers the schema and how to soothe

them, seeking therapy, using schema-focused therapy tools (e.g., imagery rescripting and relaxation techniques), and engaging in physical and social activities.

Conclusion

In this qualitative study, I explored clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. The research involved the generic qualitative research strategy, and participants' responses indicated that schema-focused therapy is effective with Black Americans with panic disorder. Additionally, participants indicated the EMSs associated with panic disorder among this population: all EMSs from domain of rejection/disconnection; vulnerability to harm and illness, failure schema, and incompetent/dependent schema from the impaired autonomy domain; emotional inhibition, self-sacrifice/over-responsibility or overcompensation, approval-seeking schema and subjugation schema from the other-directed domain; and unrelenting standards and negativity/pessimism schema from the hypervigilance domain.

Participants also associated many schema modes with panic disorder in this population. These modes include vulnerability child modes (anxious mode, lonely/neglected child, terrified child, abused child, humiliated child, mistrustful child, confused child, and helpless child) and angry/unsocialized child modes (angry child, aggressive child, enraged child, complaining child, and frustrated child, surrender/rigid modes including hopeless surrender, compliance surrender, and self-sacrifice/rescuer surrender). Other modes reported include flight/avoidance (self-soothing, avoidant protector, and detached protector), fight or overcompensation modes (social overcompensator and perfectionism/punitiveness), and punitive parent mode (demanding

and anxiety-inducing, guilty-inducing, and pessimism in life). Participants also reported helpful and unhelpful schema therapy strategies, recommended ways to improve unhelpful strategies, and underscored several challenges clinicians and clients encounter during schema-focused therapy.

Most findings of this study were consistent with previous research in which other populations were used. Therefore, the current study extended the knowledge of using schema-focused therapy to Black Americans with panic disorder in several areas. Some findings of this research are unique, and this calls for further research to validate their association with panic disorder in Black Americans. Based on the study results, essential recommendations were also provided for the effective use of schema-focused therapy with Black Americans with panic disorder. Finally, despite the limitations associated with the current research, including the non-generalizability of its results, its interpretations and conclusions are suggestive and transferable to similar contexts. Schema-focused clinicians can utilize a wealth of knowledge and skills from the present study when treating non-Black Americans with panic disorder.

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Appendix A: Interview Questions Guide

Date:

Time:

Location: Zoom Conference Meeting

Parts of Interview	Interview Questions
Introduction	Hi, I am --- Thank you very much for helping me with questions on clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. This interview will last between 60-90 minutes. I will not identify you in my documents, and no one will be able to identify you with your answers. You can choose to stop this interview at any time. Also, I need to let you know this interview will be recorded for transcription purposes. Do you have any questions? Are you ready to begin?
Question 1	1. Can you tell me about your experiences with schema therapy?

Question 2	2a. Which schema-focused therapy techniques do you consider most frequently used with Black Americans with panic disorder? 2b. Which schema-focused therapy do you consider least frequently used with Black Americans with panic disorder?
Question 3	3a. Which aspects of schema therapy do you think are most helpful to your Black American clients with panic disorder? 3b. Which aspects of the therapy do you think are least helpful to Black Americans with panic disorder?
Question 4	4. What are the specific benefits Black American clients with panic disorder gained in schema-focused therapy?
Question 5	5. Can you tell me the extent Black American clients' needs were met?

Question 6	6. What are the major Early Maladaptive Schemas (EMSs) addressed most in schema-focused therapy for Black Americans with panic disorder?
Question 7	7. What are the major schema modes addressed most in schema-focused therapy for Black Americans with panic disorder?
Question 8	8a. What are aspects of the therapy Black Americans with panic disorder perceive as emotionally challenging? 8b. Could you share aspects of the therapy you find emotionally challenging?
Question 9	9. Could you share how the activation of your EMSs and other schemas affect schema-focused therapy?
Question 10	10. What strategies do you apply to manage the EMSs activation during therapeutic relationships?

Question 11	11. Could you give your recommendation for effective schema-focused strategies for Black Americans with panic disorder?
Close	1. Thank you for your responses. Do you have anything else you'd like to share? 2. Do you have any questions for me? 3. Thank you for your time. Goodbye.

Appendix B: Recruitment Flyer

My name is Martin Akanaefu, and I am a doctoral student in Clinical Psychology at Walden University. I am currently seeking participants for my dissertation research under the supervision of Dr. Ethel Perry. This research aims to explore clinicians' experiences of using schema-focused therapy in Black Americans with panic disorder. Your participation in this study will help underscore unhelpful and helpful aspects of schema-focused therapy with Black Americans with panic disorder, leading to an effective schema-focused therapy with this population.

Individuals are eligible to participate in this research if they meet the following criteria:

1. Must be over the age of 18 years.
2. Licensed schema-focused therapists, counselors, and psychologists in the United States.
3. Currently conducting sessions with Black Americans with panic disorder or have conducted sessions with them in the last past 5 years.
4. Licensed schema-focused therapists, counselors, and psychologists in the United States do not include social workers and psychiatrists, even if they have had experience with Black Americans with panic disorder in the past 5 years.
5. Black Americans involved in the therapy must have been diagnosed with panic disorder according to the Diagnostics and Statistical Manual of Mental Disorders (DSM-5 or DSM-5-TR) criteria.

6. Black Americans diagnosed with panic disorder include Black racial and biracial groups in the United States, namely, African Americans, Caribbean Blacks, Africans, and other Black non-American descent.

Participation in this study will involve a set of interview questions lasting approximately 60-90 minutes. During these interviews, participants will be asked open-ended, semistructured questions regarding their experience of using schema-focused therapy in Black Americans with panic disorder. All interviews will take place via via audio-taped conversations, specifically Zoom conference meetings. You have the right to discontinue or decline participation in the research at any time without giving a reason and without costs. Your responses will be collected under a fictitious name to maintain your privacy and confidentiality. Participants will receive a $10 gift card as compensation for their time. This study has been approved by the Walden University Institutional Review Board (IRB).