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Sonya L. Britt
Kristy L. Archuleta *Editors*

Financial Therapy

Theory, Research, and Practice

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Foreword

It is an honor to be able to make a contribution to this long-awaited and important addition to the emerging field of financial therapy. To have a book of this type come to fruition is amazing, considering how the field of financial therapy has moved from an unknown entity into a well-recognized existence over the last decade. It reminds me of what scientists have suggested about the "Big Bang" when speaking of our universe's beginning: Bursting from an almost invisible seed of an idea into an identified movement.

It is rare to be witness and to be a part of the birth of a new field of study, but that is exactly what has happened. In 2004, there were a very few, relatively unknown practitioners representing the then unnamed, and for all intents and purposes invisible, field of what is now commonly known as financial therapy. As with any developing movement, there were a number of souls, following their hunches, intuition, and experience, believing that there was something to this "money as it relates to human behavior stuff." All toiling, for the most part, has been in isolation without knowledge of other financial therapists, with little support, little credibility, with little national interest, and even less knowledge about the issues that are now a part of this expanding field. At the time, reference by such practitioners to financial therapy issues were quickly doused with a good dose of dismissiveness, if not derision, from the behavioral health and professional financial world. For the most part, as is true with nearly all new ideas in the behavioral health field, practices that seemed to help clients preceded the establishment of theory and conducting of research.

Arguably, the events of the great recession acted as an accelerant to the field of financial therapy, as mainstream culture began to try to understand what had happened, both on systemic and individual levels. Increasing interest and curiosity became focused on the psychological and behavioral factors behind the disastrous decision-making that ended up hurting so many and threatening to destroy a way of life. Financial therapy began to be of interest in terms of what to do about human nature and financial behaviors.

A note of caution. Those pioneers still active as well as those newly recruited to the cause need to move forward cautiously and consciously. I've been around long enough to see creators exhibit a tendency to hang-on to a particular method or concept or approach, defending "it" as "the" approach. Historically, movements

such as financial therapy have witnessed this rigid, if not desperate clinging to one's ideology. Such efforts serve only to limit and delay the growth of a field, in some cases for a decade or more. In my experience, it is the second and third generation of researchers and practitioners who legitimize a field. Unlike the pioneers, they have no particular emotional investment or ownership in one particular approach and are open to other ideas and approaches that may have merit, and quite often blend ideas to develop a unique approach of their own. As research in behavioral finance has confirmed, if something is "ours," we tend to significantly overvalue it, regardless of the facts, and reject any evidence that may disconfirm our beliefs. This is true whether it is our coffee cup, our home, our idea, or our approach to financial therapy.

The challenge to the field of financial therapy is to stay open to all possibilities and not spend our time and energy building and defending our own sacred silos. To this point, I cannot give enough credit to the editors of *Financial Therapy: Theory, Research, and Practice*. This volume represents their awareness of and commitment to this inclusive spirit. They have modeled and done their part to aid this initial effort to keep the field from fragmenting and instead have focused on building a body of work based on the common denominators of the wisdom and experience of many. This book represents the current state of the field of financial therapy.

It is exciting to see how the editors and contributors have tapped into some well-established practices, as well as sharing innovative new tools. Since there are no clear "best practices" for the field of financial therapy at this time, each of the disciplines represented here have worked for some people at some time to some degree; so all can be assumed to have potential value. You'll find that the authors have carefully examined those approaches that have been effective in dealing with client issues in the realm of financial therapy, and have offered some specific tools of great value to researchers and practitioners.

Nonetheless, as we move forward on this journey together, it is important to continue to be led by research. As such, it is advisable to keep the old adage in mind: "There is nothing more unequal than the equal treatment of unequals."

April 14, 2014

Paul (Ted) Klontz, Ph.D.
President, Klontz Consulting Group

Preface

Financial Therapy: Theory, Research, and Practice is the first textbook in the field of financial therapy, an integration of the financial planning and mental health professions. Financial therapy is viewed as the integration of interpersonal and intrapersonal aspects of financial well-being. The field of financial therapy has been gaining popular attention with feature stories in major press outlets (Wall Street Journal, New York Times, Money Magazine, Kiplinger's, ABC News 20/20, etc.) in addition to the establishment of the Financial Therapy Association and the *Journal of Financial Therapy*.

This book targets four major audiences who are engaged in financial therapy, including (a) financial planners interested in the psychology of financial planning and investor behaviors, (b) mental health professionals who want tools to help clients deal with finances—the top stressor in their lives, (c) researchers in financial planning, financial psychology, and behavioral finance, and (d) graduate and undergraduate students in financial planning, psychology, counseling, social work, marriage and family therapy, and family studies in universities across the country.

Outline of Chapters

Financial Therapy: Theory, Research, and Practice is divided into three sections: (a) *Financial therapy theory*, which explores the emerging field of financial therapy, money scripts, money disorders, and assessment in financial therapy; (b) *Financial therapy research-based models*, which introduces specific financial therapy treatment approaches that have been developed and documented in the peer-review literature; and (c) *Financial therapy practice-based models*, which explores how established theories of psychotherapy can be used to develop new models of financial therapy. The authors of each chapter were carefully selected based on their research and/or practical expertise in each of the given areas. The sections on financial therapy models and theories are accompanied with financial therapy tools that can be used by readers. Research is integrated into theoretical explorations, which are further enhanced by case studies, to bridge the gap between theory, research,

and practice. We should note that as editors, we have included a variety of financial therapy theoretical models and approaches in this book; however, we do not necessarily ascribe to or agree with all aspects of these approaches. We each have our own preferences that inform our work. However, it was our intention to offer a wide range of approaches in hopes that our readers will come to their own conclusions about how these modalities and techniques fit or do not fit within their own training, schools-of-thought, belief systems, and ultimately with how they prefer to work with clients. With increased quality research, financial therapy will continue to evolve and help individuals overcome their issues with money.

Section I: Introduction to Financial Therapy

Chapter 1: *Financial Therapy: Establishing an Emerging Field* is written by Drs. Sonya Britt, Brad Klontz, and Kristy Archuleta and serves as the seminal work of the co-editors to address the current state of financial therapy. The chapter explores the origins of financial therapy, differentiates among financial therapy, financial coaching, and financial planning, explores ethical considerations, and discusses the importance of theory and evidenced-based practices in the development of the field of financial therapy.

Chapter 2: *Theories, Models, and Integration in Financial Therapy* is also co-authored by the co-editors (i.e., Drs. Sonya Britt, Kristy Archuleta, and Brad Klontz). This chapter explores theories of psychotherapy and how they can be used to conceptualize financial health, money disorders, and financial therapy. Understanding what theory is, why it is important, and how it can be useful to the area of financial therapy is essential to the development of the field. The purpose of this chapter is to provide practical understanding of theory to help inform readers about how to better utilize it in their financial therapy work.

Chapter 3: *Money Scripts* is written by Derek Lawson and Drs. Brad Klontz and Sonya Britt. The chapter reviews relevant literature on money scripts—those typically unconscious, contextually bound, partially true beliefs about money that are typically developed in childhood and drive adult financial behaviors. Four categories of money scripts will be explored: money worship, money status, money avoidance, and money vigilance. Techniques to help financial therapists identify and change client money scripts are presented.

Chapter 4: *Money Disorders* is written by Anthony Canale and Drs. Kristy Archuleta and Brad Klontz. The chapter focuses on nine money disorders that have been identified in the financial therapy literature: compulsive buying disorder, gambling disorder, workaholism, hoarding disorder, financial denial, financial enabling, financial dependence, financial enmeshment, and financial infidelity. Signs, symptoms, and treatment considerations are explored.

Chapter 5: *Assessment in Financial Therapy*, authored by Drs. Ron Sages, Timothy Griesdorn, Clinton Gudmunson, and Kristy Archuleta, begins with an overview of why assessment is important in financial therapy and continues by reviewing six

research validated financial therapy assessment instruments that have undergone the rigors of peer-review in academic journals. Each instrument is described in detail, including its psychometric properties and can be useful for both practitioners to implement into their practice with clients and scholars to utilize in research studies.

Chapter 6: *Seven Steps to Culturally Responsive Financial Therapy*, Drs. Pamela Hays and Brad Klontz with Randy Kemnitz examine the importance of culture in structuring financial therapy interventions. The authors describe critical steps for structuring financial therapy interventions in a multicultural context.

Section II: Models of Financial Therapy

Chapter 7: *Experiential Financial Therapy*, authored by Drs. Brad Klontz and Ted Klontz (with Derek Tharp), features the financial therapy approach seen in the Wall Street Journal, New York Times, Good Morning America, and ABC News 20/20. The theoretical underpinnings are described and research on the model's effectiveness is reviewed. A case study is presented to illustrate the application of experiential financial therapy.

Chapter 8: *Solution Focused Financial Therapy* (SFFT) is authored by Drs. Kristy Archuleta and John Grable with Emily Burr. Solution focused therapy has gained credibility for its effectiveness in other areas of mental health such as addictions, parent–child relationships, academic problems, aggression, and long-term illness to name a few. SFT is a pragmatic approach offering techniques to focus on clients' strengths in order to achieve clients' desired outcomes.

Chapter 9: *Cognitive Behavioral Financial Therapy* looks at the use of cognitive-behavioral theory and techniques in financial therapy. George Nabeshima and Dr. Brad Klontz review the research on the use of cognitive behavioral therapy to treat money disorders. Cognitive behavioral therapy concepts, such as automatic thoughts, underlying beliefs, behavioral techniques, homework, schemas, and thought records are explored.

Chapter 10: *Collaborative Relational Model* is authored by Drs. Martin Seay, Joe Goetz, and Jerry Gale. The collaborative relational model of financial therapy is based on the concept of utilizing two complimenting financial therapists, each with expertise in their individual areas, to provide in-depth and comprehensive financial therapy to clients. This chapter introduces the model, provides the foundation of its theoretical framework, and provides illustrations of its use in practice. Lastly, a discussion of its benefits, both for the counselors and clients, is provided.

Chapter 11: *Ford Financial Empowerment Model* (FFEM) is authored by Megan Ford. FFEM blends popular theoretical models used in family therapy with basic financial counseling techniques, helping to support the development of financial success and empowerment. The multi-stage model specifically integrates two theoretically-driven psychotherapy approaches, including cognitive-behavioral and narrative approaches, along with financial counseling skill development. The stages of the model, along with techniques, as well as empowerment and contextual considerations are given.

Chapter 12: *Stopping Overshopping Model*, authored by Dr. April Benson, is a comprehensive 12-week experience that draws from psychodynamic psychotherapy, cognitive behavior therapy, dialectical behavior therapy, motivational interviewing, mindfulness, and acceptance and commitment therapy. The program teaches specific skills and strategies to help overshoppers break the cycle that leads to compulsive buying and develop the capacity to lead a richer life in the process. A detailed description of the model illustrated by a vignette is presented. Finally, the results of a randomized controlled pilot study of the efficacy of this model are given.

Section III: Theories of Financial Therapy

Chapter 13: *Systemic Financial Therapy* explores the application of family systems theory to financial therapy and is authored by Dr. Kristy Archuleta and Emily Burr. Because relationships are so important and complex, especially when it comes to money, being able to explain the circular nature of family and couple relationships is essential to working effectively with clients. This chapter will provide a theoretical framework, along with a case study, rooted in systems theory to help researchers and practitioners better understand relationships and money, especially in regards to couples.

Chapter 14: *Narrative Financial Therapy* is authored by Megan McCoy, D. Bruce Ross, and Dr. Joseph Goetz. This chapter explores narrative therapy as applied to financial therapy. The authors present narrative and cognitive-behavioral interventions integrated with the six-step financial planning process. The approach is designed for both mental health and financial professionals to implement into their practices.

Chapter 15: *Feminist Financial Therapy* is authored by Drs. Roudi Nazarinia-Roy and Yolanda Mitchell. This chapter highlights a brief history and components of feminist theory as well as an application of feminist theory to financial therapy. The current state of gender roles in society, more specifically the evaluation of the shifts that have occurred for women in the workforce, are explored. Further discussion on the implications that these societal shifts have on the family system will be presented. The chapter concludes with a general discussion of the benefits and limitations and applications of Feminist Financial Therapy.

Chapter 16: *Acceptance and Commitment Financial Therapy for Women* is authored by Drs. Joni Klontz Wada and Brad Klontz. Acceptance and Commitment Therapy (ACT) was chosen as a theoretical foundation to create a treatment manual to help women move toward financial behaviors that are congruent with their values, despite their limiting beliefs and emotions. This chapter presents a seven-session group Acceptance and Commitment Financial Therapy model designed to teach women skills such as mindfulness, acceptance, and detachment from thoughts, to empower them to make financial choices based on their core values.

Chapter 17: *Psychodynamic Financial Therapy* is authored by Dr. Richard Trachtman. This chapter explores financial psychotherapy through the theories of development and personality that have evolved from the teachings of Sigmund Freud and his followers, or what is commonly referred to as psychoanalytical oriented psychotherapy. Common concepts from psychoanalysis and how these concepts can be helpful in understanding people's relationships are explored. A discussion about why people have difficulty communicating and rationally thinking about money, and why many psychotherapists (including Freud) as well as financial professionals have difficulty addressing money related problems is included.

Chapter 18: *Financial Therapy from a Self Psychology Perspective*, authored by Drs. Maggie Baker and Cécile Phillips Lyons, introduces a developmental process (based on an integration of Erik Erikson's psychological stages of development and Heinz Kohut's self-psychology) concerning money and the symbolism, beliefs, attitudes, and emotions that get embedded in money matters. Case examples from research and clinical practice help to illustrate this approach, which will help financial advisors and financial therapists better understand the internal forces surrounding external money decisions, enabling them to be more effective in their work with clients and to understand themselves better.

Chapter 19: *Humanistic Approaches to Financial Therapy* is authored by Drs. L. Martin Johnson and Kelly Takasawa. The strengths of the humanistic approach are discussed, including: (a) establishment of therapeutic alliance through empathy, unconditional positive regard, and congruence; (b) engaging and stimulating the patient's internal growth tendency; and (c) working through emotional blockages and resistance to therapeutic change. Specific humanistic approaches are reviewed (i.e., Gestalt, Existential, Person-Centered, and Emotion-Focused Therapies). The chapter demonstrates how these approaches can be applied to the treatment of financial disorders.

Finally, Chapter 20: *Stages of Change and Motivational Interviewing in Financial Therapy* is authored by Dr. Brad Klontz, Edward Horowitz, and Dr. Ted Klontz. This chapter explores the integration of Stages of Change and Motivational Interviewing models with financial therapy. Concepts, such as ambivalence to change, resistance to change, and techniques to work through resistance, are explored with specific suggestions on how financial therapists can structure interventions. A case study is presented to illustrate the application of the theory in financial therapy.

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We would also like to thank our students and colleagues at Kansas State University, many of whom contributed to this volume. Specifically, we would like to thank: Dr. Morey McDonald, Dr. Martin Seay, Anthony Canale, Randy Kemnitz, Derek Lawson, George Nabeshima, Edward Horwitz, Emily Burr, and Derek Tharp for their insights and efforts. Thanks also to our financial therapy colleagues in the academic, mental health, and financial planning fields, many of whom also contributed to this book. We would like to acknowledge Dr. Maggie Baker, Dr. April Benson, Dr. Roudi Nazarinia, Megan Ford, Dr. Jerry Gale, Dr. Joseph Goetz, Dr. John Grable, Dr. Clinton Gudmunson, Dr. Pamela Hays, Dr. L. Martin Johnson, Dr. Cecile Lyons, Dr. Yolanda Mitchell, Dr. Ron Sages, Dr. Kelly Takasawa, Dr. Richard Trachtman, and Dr. Dottie Durband, for their contributions to the field of financial therapy.

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Emily A. Burr M.S., PLMHP is an outpatient therapist working with youth and families at the Child Guidance Center in Lincoln, Nebraska and a doctoral student in the Personal Financial Planning program at Kansas State University where she also earned a master's degree in Marriage and Family Therapy. While at K-State,

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Joseph Goetz Ph.D. is an associate professor of financial planning at the University of Georgia, co-founder of the ASPIRE Clinic, and a founding principal at Elwood & Goetz Wealth Advisory Group. He is a past president of the Financial Therapy Association and serves on the editorial boards of the Journal of Financial Counseling and Planning, *Journal of Financial Planning, Journal of Financial Therapy,* and *Journal of Personal Finance*. He was recently recognized as the 2013 Financial Counselor of Year from the Association of Financial Counseling and Planning Education, and as the recipient of the 2012 Richard B. Russell Excellence in Teaching Award. He received his bachelor's degree from the University of

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rate groups teaching supervisory communication skills to improve productivity. His list of credits also extends to publishing where he's co-authored: *Mind Over Money, the Financial Wisdom of Ebenezer Scrooge, Wired for Wealth, Facilitating Financial Health,* and served as a contributing author of *Chicken Soup for the Recovering Soul,* as well as numerous professional articles. He has shared his expertise on *The Today Show, Good Morning America, Larry King Live,* ABC News' *20/20*, ABC's "*Good to Know*" and has been quoted in *The Wall Street Journal, Money Magazine, CNN, Time, Parade, and The New York Times* and has been interviewed on NPR Marketplace, Martha Stewart Morning Living Sirius Radio, and many local and syndicated radio and television shows.

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Part I
Financial Therapy Theory

Chapter 1
Financial Therapy: Establishing an Emerging Field

Sonya L. Britt, Bradley T. Klontz and Kristy L. Archuleta

Introduction

Financial therapy is an emerging field interested in the evaluation and treatment of cognitive, emotional, behavioral, relational, and economic aspects of financial health.

The Financial Therapy Association (FTA) was formed in 2009 to provide a forum for financial and mental health practitioners and researchers to share their vision of financial therapy.

Of all aspects in life, money is one area that cannot be avoided—we rely upon it for food, shelter, and clothing. Not only do we rely on money to meet our basic needs, money is a fundamental aspect of our sense of safety, security, quality of life, goals, and aspirations. Despite the importance of money and money management, very few high schools or colleges require a money management course. As of 2014, about half of all states in the USA either require a full-semester course on financial education or more likely require that personal finance topics be integrated within an existing high school course (JumpStart 2014). The impact of poor money management can range from overspending and missed credit card payments, to partner and family conflict, to gambling disorder and hoarding, to bankruptcy and legal

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problems. These issues can be influenced by one's attitudes towards and relationship with money. Financial therapy is an emerging field consisting of mostly financial and mental health professionals that addresses the interpersonal and intrapersonal facets of money by "integrating cognitive, emotional, behavioral, relational, and economic aspects to promote financial health" (Financial Therapy Association (FTA) 2014). The major objective of financial therapy is not only to improve financial well-being but to ultimately improve quality of life (Archuleta et al. 2012).

As an emerging field, very few financial therapy training programs have been established to date. Kansas State University has the only known academic program specifically in financial therapy (ipfp.k-state.edu/grad/ft-certificate), although a number of schools offer counseling courses to financial planning students. In regard to traditional mental health programs, none appear to require a course in personal finance (American Association for Marriage and Family Therapy 2004; American Psychological Association 2009; Council on Social Work Education (n.d.), creating a void in a mental health clinician's ability to work with clients experiencing financial issues. This void in psychotherapy training has been identified as problematic by educators, practitioners, and researchers alike (Klontz et al. 2008; Trachtman 1999). However, a core competency requirement of social workers is to "advance human rights and social and economic justice" (p. 5), which lends itself well to the vision of financial therapy.

Financial professionals have traditionally been trained in fields of finance, accounting, business administration, and financial planning, to name a few. The most well-known financial planning programs are registered with the Certified Financial Planning Board of Standards (CFP Board). In 2012, the CFP Board added interpersonal communication skills to their list of principle topics covered in the examination; however, academic programs are still not required to offer an exclusive course on counseling techniques (CFP Board 2014), presenting a gap in technical knowledge and delivery, and implementation of services. Furthermore, financial planning and other financial training programs do not currently address behaviors and attitudes that drive financial decision making.

As with any new field, empirical data and scholarly writings are necessary to establish the area as a field. Since the formation of the FTA in 2009, financial therapy has been rapidly gaining momentum in academic writing. The *Journal of Financial Therapy,* the FTA-sponsored journal, featuring cutting-edge research and the latest theoretical developments in financial therapy, is one such outlet for scholarly publications. Figure 1.1 shows a historical trend of the number of research references related to financial therapy in the past decade and the number of total references on a popular Internet search engine. The number of unique entries was capped at 1000 starting in 2011. While the uniqueness of the references cannot be authenticated past 2011 (i.e., duplicates could have been reported), the number of results related to "financial therapy" in 2013 was over 1500.

As leading researchers and practitioners in financial therapy, we have attempted to gather other leaders to help us explain what financial therapy is and where it is going. This book provides empirical data and theoretical frameworks from which

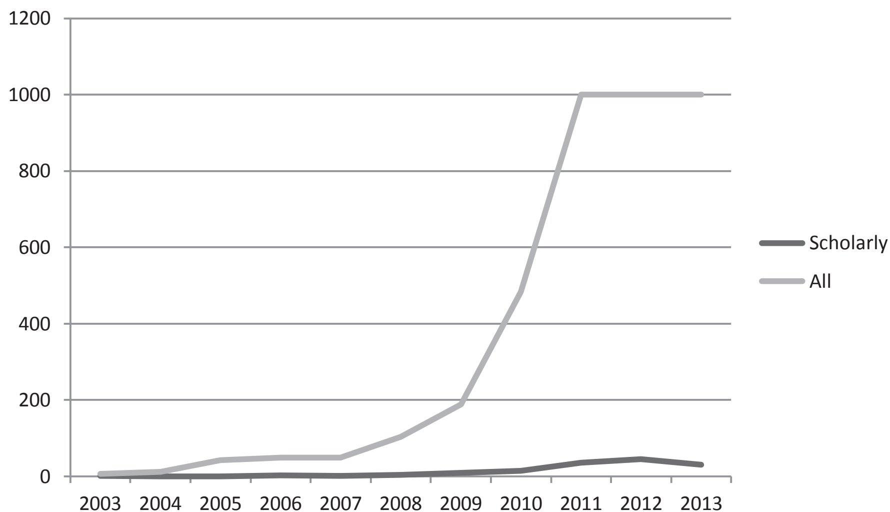

Fig. 1.1 Financial therapy references

the field can build upon in future work. Sections 2 and 3 review practice models that are based on research findings (Section 2) and others that are theoretically based only and in need of empirical testing (Section 3).

Historical Perspective

While it is unknown how early people began using the term "financial therapy" or who should be credited with coining the term, references to financial therapy are found as early as 2001 in Internet searches. A growing number of financial and mental health professionals and scholars who were practicing and studying financial therapy joined together and formed the FTA in 2010, to provide a forum to share their vision of financial therapy. The *Journal of Financial Therapy* was developed shortly after the establishment of the FTA, in which a more thorough historical perspective of the FTA was published in the inaugural issue (McGill et al. 2010).

Financial therapy is a uniquely defined, growing field and can be distinguished from other fields and professions, like financial life planning, financial counseling, and financial coaching. In general, financial planning tends to be proactive and future oriented, utilizing products and services to meet an individual's and family's financial goals (Archuleta and Grable 2011). To become a Certified Financial Planner™, one must meet certain education requirements that address insurance, tax, estate, retirement, and investment planning; write and present a comprehensive financial plan; pass a comprehensive exam; and gain three years of experience. An

offshoot of financial planning is financial life planning. The Kinder Institute of Life Planning, an institute practicing and training others in financial life planning, states financial life planning "is based on the premise that advisors should first discover a client's most essential goals in life before formulating a financial plan, so a client's finances fully support those goals" (The Kinder Institute of Life Planning 2014). In other words, life planning is value based. While financial therapy is also based on the premise of values guiding financial goals, it considers beliefs, behaviors, and relationship dynamics that identify, further clarify, or otherwise impact the ability to carry out financial goals. Money and the interpersonal and intrapersonal aspects of one's life are considered to be inseparable (Archuleta et al. 2012). Financial goals cannot be fully achieved and financial well-being cannot be attained without considering the whole person and their relationships with others around them.

Financial counseling tends to be focused on debt and credit counseling, mostly engaging in helping individuals and families change negative situations and behaviors to achieve financial stability (Archuleta and Grable 2011). The Association for Financial Counseling, Planning, and Education certifies Accredited Financial Counselors, who must undergo a rigorous training, examination, and supervision process. Accredited Financial Counselors take two exams—one on financial counseling and another on personal finance (AFCPE 2014). While a financial counselor is likely to approach a client situation from a semi-holistic perspective, the focus is still on financial-specific goals. Financial therapy can be both proactive, like financial planning, and reactive, like financial counseling, all the while considering both financial matters and the psychological and systemic impediments to achieve financial well-being.

In *Facilitating Financial Health: Tools for Financial Planners, Coaches, and Therapists,* Klontz et al. (2008) created a "Financial Facilitation Decision Tree" to help financial professionals differentiate between the services of financial planning, financial coaching, and financial therapy. They suggested that financial stress prompts individuals to seek professional financial advice in any form. This financial stress could be the result of a financial crisis, an inheritance, starting a business, fear about retirement, etc. If the client's financial stress is not associated with significant psychological distress (e.g., anxiety, depression, relationship problems), then traditional financial planning may be all that is needed to help the client achieve financial health. If traditional financial planning advice does not lead to permanent changes in financial behavior, then financial coaching—which might entail identifying and exploring money scripts—could be beneficial. If the client's financial stress is associated with significant psychological distress at the outset of the engagement and/or if financial coaching is not sufficient to facilitate financial health, Klontz et al. (2008) suggested that financial therapy targeting "unresolved emotions and dysfunctional thoughts that keep maladaptive behaviors in place" would be recommended (p. 59).

Klontz et al. (2008) made a clear distinction between "coaching" and "therapy." They argued that coaching is focused on solutions, aimed at optimizing behaviors, and fits into an advisory model, a model quite familiar to financial planners. In

contrast, Klontz et al. (2008) wrote that therapy is based on a medical model and involves the diagnosis and treatment of mental disorders. Since the publication of *Facilitating Financial Health,* the financial therapy field has developed to include financial planners, counselors, coaches, and therapists. While we agree with Klontz et al. (2008) that the term therapy has its roots in a medical model, we suggest that the term "psychotherapy" more accurately reflects this type of medically-based intervention. With regard to financial therapy, we see the term therapy as much more inclusive and not limited to the diagnosis and treatment of money-related mental disorders. In fact, *therapy* has multiple definitions and has been defined as both "psychotherapy" and "any act, hobby, task, program, etc., that relieves tension" (Dictionary.com 2014). Furthermore, the term "therapy" has been applied to a range of nonmedically based tension reducing activities in popular culture (e.g., exercise therapy, music therapy, massage therapy, aroma therapy). We argue that financial therapy theory and techniques could be integrated into any and all of the financial professional roles within the constraints of each profession's scope and ethical standards of practice, including financial planning, financial counseling, financial coaching, and financial psychotherapy targeting specific money disorders (e.g., gambling disorder, hoarding disorder, compulsive buying disorder).

We often hear concerns about the use of the term *financial therapy*. These concerns include professional turf arguments about what *financial therapy* is and what it is not, and who should be allowed to use the term *financial therapist* and who should be excluded. For example, we have heard financial planners argue that psychotherapists need degrees or certification in personal finance in order to practice financial therapy. Conversely, we have heard arguments from psychotherapists that financial planners need degrees and licensure in mental health in order to use financial therapy. We encourage readers to not get bogged down in these disputes. Instead, we hope readers will focus on how financial therapy theory, research, and practice may be useful in your financial planning, mental health, coaching, counseling, and/or research work within the scope of your professional practice.

Financial therapy is a young field. As the field continues to mature, additional training programs are likely to develop. As this happens, it may become necessary to regulate the use of the terms "financial therapy" and "financial therapist." Therapy is not a protected term in most states given the wide usage of the word in a variety of professionals and activities, as previously mentioned. To promote financial health—an objective defined by the FTA—it is necessary to evaluate the client holistically. To address cognitive, emotional, behavioral, and relational aspects of financial health, some training in counseling is necessary. To address economic aspects, a basic understanding of personal finance is necessary. Throughout this book, you will be exposed to a number of financial therapy techniques that address the components of the definition set forth by the FTA. Each requires a unique skill set, which typically involves advanced training in cognitions, emotions, behaviors, relationships, and personal finance. While not currently regulated to obtain formal academic training and/or professional experience, formal degree and/or certificate programs in financial therapy are available. In the future, financial therapists may

eventually need to be certified or licensed through a regulatory board that has specific educational experience, exam, and continuing education requirements. The following section highlights a few of the reasons we believe that financial therapy is a much-needed field and will continue to grow.

Need for Financial Therapy

> Despite the significant increase in scholarly attention financial therapy has received in recent years, very little empirical research exists on the behavioral aspects of financial problems.

Comments from the inaugural financial therapy forum revealed that an association was needed because (McGill et al. 2010):

- "A need exists to look for what works and how treatment plans can be implemented and incorporated into financial planning practice" (p. 3).
- "There is a lack of research on the effectiveness of practice techniques" (p. 4).
- "There is a lack of teaching materials related to financial counseling and financial therapy. An interdisciplinary approach to helping clients, through a new association, would be a great place to start in filling this gap in teaching materials" (p. 4).

These same comments relate to our rationale for writing this book. A number of pre-FTA research findings demonstrated the link between financial and relational/ emotional/behavioral issues. We have highlighted just a few of these findings here to show what we know about financial therapy and what is yet to be empirically explored.

Despite the significant increase in scholarly attention financial therapy has received in recent years, very little empirical research exists on the behavioral aspects of financial problems. This is surprising given that money is the number one source of stress in the lives of Americans (APA 2014). Researchers have also found that money is one of the topmost frequently argued topics among couples (Britt et al. 2010; Zagorsky 2003), and the number one reason for divorce in the early years of marriage (Oggins 2003). Others have found financial problems to be among the primary stressors for women seeking therapy for marital distress (Cano et al. 2002). Borooah (2006) suggested that standard of living is highly associated with life satisfaction; when one spouse is unsatisfied with life (i.e., sad/ depressed), it is highly likely that the other spouse will be negatively influenced (Halford et al. 1999). Others have found similar results of how perceptions of financial issues impact the quality of interpersonal relationships, specifically noting an association between relationship satisfaction and financial satisfaction (Dean et al. 2007; Grable et al. 2007).

Fitch et al. (2007) noted a financial effect that resembles an addictive process. In their study, they found that individuals suffering from a mental health disease were

three times more likely to have debt problems than individuals not suffering from a mental health issue. They proposed a conceptual framework that views debt as a spiraling process, where clients progress from manageable to overwhelming levels of debt. This appears similar to the disease concept of addiction, in that compulsive spending, hoarding disorder, and gambling disorder often worsen over time without intervention. The behavior starts out as manageable and progresses into abuse and dependence. It is not uncommon for people in drug recovery to develop money disorders because of the initial perception that financial problems are normal, socially acceptable, and easily hidden from view. Apart from the credit card companies (to a certain extent), nobody cares if an individual maxes out his or her credit card each month and continually fails to make minimum payments because the individual does not have an immediate and direct impact on society. Clearly, that is a misconception, but it is easy to transfer addictive patterns from one behavior to another one that is more socially acceptable.

Potential Uses of This Book

This book is designed for students, practitioners, and researchers of financial therapy. Our goal is to share a historical perspective of financial therapy and lay a foundation for future theoretical and empirical work in financial therapy. *Financial Therapy: Theory, Research, & Practice* is the first textbook of financial therapy, targeting four major audiences who are engaged in financial therapy, including: (a) financial planners interested in the psychology of financial planning and investor behaviors; (b) mental health professionals who want tools to help clients deal with financial stress and treat money disorders; (c) researchers in financial planning, financial psychology, and behavioral economics; and (d) graduate and undergraduate students in financial planning, finance, business, addictions, psychiatry, psychology, counseling, social work, marriage and family therapy, and family studies in universities across the country.

Ethical Considerations

Sections 2 and 3 chapters include ethical issues that should be considered before implementing the techniques or recommendations presented in that chapter. Some of the themes you will see throughout the chapter are similar to what Gale et al. (2012) believe to be the top ten considerations for developing financial therapy into a profession. According to Gale et al., the task of developing financial therapy as a recognized field is monumental due to the vast diversity of professionals practicing some form of financial therapy. Gale et al.'s ten considerations include the following:

- Establishing successful outcomes of financial therapy services
- Developing theoretical models

- Identifying the client of financial therapy
- Defining professional boundaries
- Developing a financial therapy skill set
- Developing assessment tools
- Ensuring knowledge expertise
- Acknowledging power dynamics
- Addressing cultural and spiritual diversity
- Adhering to a code of ethical behavior, professional standards, and best practices

Another notable addition to Gale et al.'s list includes the payment for financial therapy services. When financial therapy is practiced by more than one professional, does one professional accept full payment (possibly through insurance if the person is a licensed mental health professional), and subcontract the services of the other professional? Or do both professionals bill separately? Even if one professional is a licensed mental health professional, should services be billed to insurance as a mental health disorder? What ramifications might this have on the client to be diagnosed with a mental health disorder? If the professional is a financial advisor, should fees be accepted through assets under management? What ramifications might this have on the recommendations presented by the financial therapist? These are all issues that need to be addressed as financial therapy becomes an established field. The FTA is currently working to address these issues and regularly conducts research with its members to help create a viable field and profession. The FTA membership profile is a regular survey sponsored by the FTA, and published in the *Journal of Financial Therapy* as a mechanism to provide a platform for discussion to move the field forward.

The second version of the FTA membership profile (Asebedo et al. 2013) addressed many of the considerations set forth by Gale et al. (2012). In particular, they found that of the 68 responses received, about half of financial therapists are paid by salary or hourly rate and half are paid through fee for service or commission-type arrangements. However, half of those respondents reported that financial therapy made up less than a quarter of their income. About 50 % of mental health professionals surveyed work with a financial professional, whereas 26 % of financial professionals work with a mental health professional. When collaborating with other professionals, the majority of respondents either abided by their own code of ethics or the most stringent of ethics among the professionals. Only 11 % of respondents did not belong to a professional association that required them to abide by a code of ethics. While no formal code of ethics exists for financial therapists, the ethical standards set forth by the American Psychological Association (APA) and the Code of Ethics and Professional Responsibility of the CFP Board of Standards are useful references for setting standards in the field of financial therapy (Klontz et al. 2008). Both sets of standards place an emphasis on providing services in a competent manner, based on adequate education and knowledge. Both also put an emphasis on providing services with integrity and doing one's best to protect the client from harm (Klontz et al. 2008).

One ethical consideration is of particular concern to the integration of financial planning and financial therapy services and worthy of discussion: Mental health

professionals providing psychotherapy—including psychologists, social workers, counselors, and marriage and family therapists—are strictly prohibited from entering into "multiple relationships" with their clients (Klontz et al. 2008). For example, a multiple relationship would exist if a psychologist was treating a person for depression and was also engaged in another relationship, such as a romantic relationship or business partnership. This blurring of boundaries is strictly forbidden, due in part to the power differential that exists in the therapeutic relationship, which could lead to undue influence and exploitation of the client as a result of the emotional vulnerability inherent in psychotherapist–client relationships. For example, in the realm of financial therapy, a potentially unethical multiple relationship could exist if a mental health professional was treating a client for hoarding disorder and was also managing that client's investments. In this circumstance, the mental health professional would need to either: (a) refer the client to a different financial planner for asset management services and treat the client's hoarding disorder, or (b) manage the client's assets and refer to a different mental health provider for treatment of the client's hoarding disorder. Attempting to provide both services simultaneously to a client would be unethical.

Ethical considerations become more important when dealing with the integration of professions, specifically around the definition of roles. This is of special concern in financial therapy, which may include financial planners trained in financial therapy and mental health professionals trained in financial therapy and/or financial planning. In these circumstances, it is critical that roles be defined at the onset of a relationship with clients. For the nonmental health financial planning professional trained in financial therapy, it should be made clear to the client that while financial therapy theory and techniques may be a part of the engagement, the financial planner is acting in an advisory role and is not providing psychotherapy for a mental health disorder. A similar distinction should be made when a mental health-trained financial planner is acting in the role of a financial advisor. He or she may be drawing on financial therapy theories and techniques in service of the client, but is acting in an advisory role and is not providing psychotherapy for a mental health disorder.

Future Directions

> Financial therapists reading this book must do their part by educating the public on who they are, what role they are serving for the client, what they do, and what ethical guidelines they are required to follow.

As a developing field, there are a number of areas in which to grow. As mentioned earlier in the chapter, there are not yet education, experience, ethics, and continuing education requirements for financial therapists. This lack of unified standards can be confusing for consumers. Financial therapists reading this book must do their

part by educating the public on who they are, what role they are serving for the client (e.g., acting as a mental health provider or a financial advisor), what they do, what they don't do, and what ethical guidelines they are required to follow.

Public awareness of financial therapy will also aid in helping individuals find the right professional to help with their needs. It takes courage to seek help and not feeling helped is frustrating and may lead to refusal of future help seeking. It is advantageous to society to help individuals find the right services the first time to help individuals better themselves and their relationships at home, work, and school.

Lastly, it is critical that more research be conducted in financial therapy. As approaches to financial therapy are developed and refined, it is important that efforts be made to measure the impact these approaches have on client's financial, emotional, and relational well-being. Until the effectiveness of financial therapy interventions can be established, in both the financial planning and mental health worlds, the field of financial therapy will be at risk of irrelevance. However, what may be most promising to the field of financial therapy are the major strides that have been taken within just a few years in regard to theoretical development and research as well as the organization of a formal forum for professional development and information dissemination. This progress is quite remarkable for an emerging field in an infant stage. Both scholars and practitioners who are passionate about financial therapy and want to see the field move forward and succeed have joined forces and are at the helm of these groundbreaking advances that seek to understand how to deal with financial issues in a variety of contexts.

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Chapter 2
Theories, Models, and Integration in Financial Therapy

Sonya L. Britt, Kristy L. Archuleta and Bradley T. Klontz

Introduction

The practice of financial therapy has a long and somewhat undefined history. Research related to the practice of financial therapy is much more recent and easier to track. This chapter identifies one of the largest gaps in the literature—the lack of theoretical frameworks used to frame the research and practice of financial therapy. Theory helps guide practitioners' approaches to improving client behavior and enables the replication of what works. Theory frames how to conduct and evaluate financial therapy.

> Theory helps guide practitioners' approaches to improving client behavior and enables the replication of what works.

In order for work to be replicable and have its effectiveness evaluated, a standardized approach must be developed. To be standardized, theory is generally used to help explain expected outcomes given certain assumptions. To date, there are very few effectiveness studies in financial therapy. A notable exception is in the area of pathological gambling. At least 14 randomized psychotherapy trials have been published on the treatment of pathological gambling (Cowlishaw et al. 2012). However, the treatment approaches are strictly psychological in nature and do not include financial

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planning components. Perhaps the first study to integrate psychotherapy with financial planning was conducted in 2008, when Klontz and associates completed a study of the treatment of disordered money behaviors. His team tested a specific model of financial therapy that integrates personal finance education with experiential group therapy treatment within a short (6 days) residential program. The treatment focused on identification of problematic financial behaviors and resolution of associated unfinished business (Klontz et al. 2008). Immediately following treatment, the participants showed a decrease in psychological distress, anxiety, and worry about finance-related situations and showed an increase in general financial health. These improvements were retained at a 3-month follow-up testing. A critical aspect to making Klontz et al.'s treatment approach replicable is their use of a theoretical base.

Evaluating research can be a tricky task without a philosophical and practical base. Klontz et al. (2008) approached their study from an experiential therapy practice framework. This framework is grounded in an existential-humanistic philosophy and has been applied to other problematic behaviors. Their unique contribution was applying an existing framework (i.e., experiential therapy) to a new problem (i.e., financial issues). While this is a great way to advance the field, it is possible that new theories could be developed specifically for financial therapy. However, this is a much more cumbersome task. In this book, the authors of Sections 2 (Financial Therapy Research-Based Models) and 3 (Financial Therapy Practice-Based Models) have applied existing theoretical frameworks to financial therapy practice. In Section 2, the models presented have some evidence to support the use of the framework in financial therapy, while Section 3 is more exploratory and hypothetical in nature. Both sections need further testing to validate their effectiveness in financial therapy practice and to become evidence-based models of practice.

What is Theory?

Critics may argue that theory is boring, impractical, not related to reality, and therefore irrelevant. Theory is often thought of as something only scholars care about because they have no practical experience. However, theory is incredibly important to the development of a field as it serves as the foundational building blocks that provide common ground. Theory can be useful to summarize knowledge, to help people do things, and to guide research (Shoemaker et al. 2004). Bengston et al. (2005), in describing family-oriented theories, emphasized that theory is crucial to the expansion of knowledge about families and family relationship processes. Without theory, the application of research findings is limited and the advancement of knowledge in a field is stunted. This directly applies to financial therapy. As an emerging field, theory will help shape the knowledge, understanding, and explanation of how psychological, emotional, and relational aspects of individuals and families intersect with finances. Financial therapy theory will provide the framework for conceptualizing the etiology of such things as financial stress, money disorders, and financial struggles in couples and families. Financial therapy theory

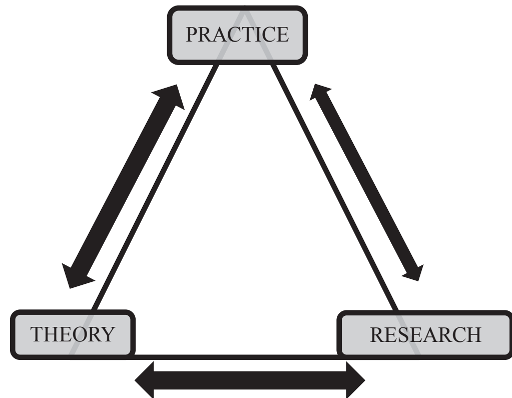

Fig. 2.1 The interrelationship of theory, research, and practice

will provide the lens through which researchers explore such things as financial attitudes, financial behaviors, and their consequences. Financial therapy theory will provide the foundations from which financial therapy interventions are developed, modified, and evaluated.

> Theory is essentially an organized set of interconnected ideas (White and Klein 2002).

Theory is essentially an organized set of interconnected ideas (White and Klein 2002), with the ultimate goal of explaining and predicting a phenomenon (Shoemaker et al. 2004). Without good theory, researchers cannot conduct sound research, and practitioners cannot implement effective interventions or provide helpful recommendations to their clients. At the 2011 Financial Therapy Association annual conference, Archuleta and associates depicted (as shown in Fig. 2.1) the importance of theory and how theory, research, and practice are interrelated rather than isolated functions. Theory and practice have traditionally been thought of as opposites where one is focused on how to "think" and the other is focused on how to "do." Figure 2.1 shows that (a) practice should inform theory and what research is being conducted, (b) research should be informed by theory and what practitioners are doing, and (c) theory should inform practice models and research design. This integration allows for theory to evolve and expand in response to new findings and ideas on how to do things, allowing for better explanatory power, improved predictability, and, ultimately, increased usefulness.

Imagine if research was conducted without theory. There would be no way to coherently approach or explain the findings of a study. Now, picture a practitioner not using theory. How does a practitioner make sense of clients' behaviors? How does a practitioner know what kind of technique to use when a client behaves in a certain way or brings up a particular issue? Without having a lens through which to explain

what is going on or predict what will happen if a client continues down a certain path of behavior, a practitioner is simply guessing as to what to do next. Does theory require us to have only one way of looking at a phenomenon? Absolutely not. In a diverse field like financial therapy, our professional training and backgrounds are very different, which may allow us to look at the same situation from different points of view. A mental health clinician may look at a situation using a different theoretical lens than a financial practitioner. However, neither professional would be wrong; they are simply making different assumptions and describing different aspects of the same phenomenon because they are using two different theories. Our theory of choice will depend on our point of view and how we see the world (Ingoldsby et al. 2004). The majority of this book is dedicated to various types of theory or theoretically informed practices.

> Our theory of choice will depend on our point of view and how we see the world (Ingoldsby et al. 2004).

To understand what theory is, it is important to understand that scientific theory can vary in scope of content, ranging from narrow to broad, and level of abstraction from low to high (Doherty et al. 1993), and is comprised of *assumptions, concepts,* and *propositions*. Assumptions are theoretical statements that are taken for granted or assumed to be true and may or may not be testable (Shoemaker et al. 2004). Assumptions serve as the core of a theory (Ingoldsby et al. 2004). A concept is a general idea that serves as a building block for a theory. A concept is sometimes used interchangeably with the term construct (Shoemaker et al. 2004). Generally speaking, a concept refers to an abstract idea and a construct refers to a broader abstract idea. Variable is another term used when referring to concepts of theory. Variables measure concepts and can take on two or more values (e.g., male or female; Shoemaker et al. 2004). Propositions describe the relationship between two or more concepts. More than one proposition must exist for a theory to be formulated (White and Klein 2002). If only one proposition is present, it is simply a hypothesis rather than a theory.

Good theory should be able to describe in detail, predict with accuracy, and be applied to a broad range of cases (Ingoldsby et al. 2004). According to Doherty et al. (1993), there are 17 criteria to evaluate good theory, which include the following:

- Richness of ideas
- Clarity of concepts
- Coherence of connections among concepts,
- Parsimony
- Clarity of theoretical assumptions
- Consistency with its own assumptions
- Acknowledgment of its socio-cultural context
- Acknowledgment of theoretical forebears

- Acknowledgment of underlying value positions
- Potential for validation and current level of validation
- Acknowledgment of limits and points of breakdown
- Complementary with other theories and levels of explanation
- Openness to change and modification
- Ethical implications
- Sensitivity to pluralistic human experience
- Ability to combine personal experience and academic rigor
- Potential to inform application for education, therapy, advocacy, social action, or public policy (see Doherty et al. for a complete discussion on each of these criteria)

> Theory allows practice to be tested for effectiveness, which ultimately improves client satisfaction and outcomes.

Although all of these criteria are important, the most salient to financial therapy is related to richness of ideas, clarity, coherency, parsimony, and potential to inform application. Without these criteria, theory will be difficult to develop and implement as well as to teach consistently to future financial therapists.

In summary, theory can be used to help explain or predict relationships between variables. It helps explain what may happen under given circumstances. It helps explain why certain behaviors and processes occur as they do. It helps us understand and measure phenomenon of interest. Basically, theory helps a practitioner and researcher see the trees through the forest by providing a consistent way to approach a situation. Theory allows practice to be tested for effectiveness, ultimately improving client satisfaction and outcomes.

Theoretic Integration and Technical Eclecticism

The use of theory in practice has been a central aspect for psychotherapy training programs. Training for psychotherapists involves learning many distinct clinical theories that can be used to help clients achieve goals. Like psychotherapists, financial therapists can benefit from training in multiple theories and theoretically informed modalities. As mentioned previously, theory can help financial therapists make sense of what is going on and know what to do when working with a client. However, it is rare for a psychotherapist to adhere to just one theory of psychotherapy in their work with clients. Even if they happen to work from just one theoretical base, many will borrow techniques from other theories to use with clients. Technical eclecticism describes an approach to the integration of theories and techniques, which predominates the actual practice of psychotherapy (Consoli and Jester 2005)

and can be useful for financial therapists as they try to find a theoretical lens that fits for both the financial therapist and the clients they serve. Financial therapy can borrow from many of the clinical theories already developed.

Hundreds of theories of psychotherapy are in existence (Consoli and Jester 2005). While some theories of psychotherapy have been researched more extensively than others, there is no universally accepted theory of psychotherapy. As many as 75 % of psychotherapists admit to being eclectic in their work with clients and do not strictly adhere to one theoretical approach or set of techniques (Consoli and Jester 2005; Lazarus and Beutler 1993). Most meta-analytic studies have failed to demonstrate the superiority of one approach over another (Consoli and Jester 2005), which helps explain the diversity of approaches. Technical eclecticism has emerged as an integrative approach that allows for the borrowing of evidenced-based techniques from various therapeutic approaches in a systematic, theoretically sound way.

Technical eclecticism is defined as an eclectic, systematic, integrative therapy approach that "provides strategies for developing relationships, interviewing, assessing, generating ideas and alternatives, developing insight, handling cases, managing behavior, evaluating, and terminating" (Gilliland et al. 1994, p. 554). Technical eclectics are typically grounded in a particular theoretical approach (e.g., cognitive-behavioral therapy), but may borrow techniques that have been shown to be effective from other orientations without necessarily subscribing to the theory from which the technique emerged (Lazarus and Beutler 1993). In terms of integrative therapy, Brown (2010) noted that therapists can: (a) work with only one model of therapy, (b) work with more than one model sequentially, or (c) work with more than one model simultaneously. However, it should be noted that attempts to integrate disparate psychotherapy theories and techniques in an unsystematic, haphazard way are ill-advised (Lazarus and Beutler 1993).

This book was designed, in part, to provide a reference for financial therapists to draw theoretically sound financial therapy case conceptualizations and interventions. Financial therapy, by name, represents the integration of financial planning concepts with theories of psychotherapy. As such, to varying degrees, the theories presented in this book are theoretical integrations. They all describe one or more theories of mental health applied in service of improving client/s' financial health. The techniques offered can be used in a technical eclectic manner provided the financial therapy practitioner is operating from a sound theoretical base. Although research in financial therapy is in its infancy and much more is needed, some of the financial therapy approaches presented have empirical data speaking to their effectiveness.

Ethical Considerations

Without doubt, those trained in mental health fields receive greater exposure to theoretical frameworks. There is no known theory of financial planning, making it more difficult for financial professionals to grasp the practicality and necessity

of theory in their work. There are no professional guidelines restricting financial professionals from using the assumptions, concepts, and propositions of theoretical frameworks developed in the mental health fields. However, financial professionals are typically bound by ethical guidelines to work within their scope of practice. Extensive reading and possibly training programs should be used to gain knowledge to appropriately apply various theoretical frameworks.

Within these ethical considerations is perhaps one of the most widely asked questions related to financial therapy—can one person be a financial therapist or does one have to involve a financial professional *and* a mental health professional? This is a theme one will see repeated throughout the book. Depending on the training and comfort level of the financial therapist, a joint professional approach may be required. However, it is the belief of the authors that one person—trained in both financial and mental health issues—can, indeed, practice financial therapy. However, there are some ethical caveats as pointed out in Chapter 1. For example, a financial therapist treating a client's hoarding disorder should not also be managing the same client's investments. You will note throughout the book that some theoretical and practice models described conflict with our belief and do require two or more professionals to work effectively.

Future Directions

All of the frameworks presented in this book are in need of additional testing with larger, more diverse samples. Effectiveness of the models can only be confirmed when rigorous testing has consistently shown improved results among clients. Section 2 (Financial Therapy Research-Based Models) of this book outlines six practice models that have had preliminary testing and have the potential to develop into financial therapy theoretical frameworks with additional research. These research-based models consist of Experiential Financial Therapy (Klontz et al. 2014), Solution Focused Financial Therapy (Archuleta et al.), Cognitive Behavioral Financial Therapy (Nabeshima and Klontz), Collaborative Relational Model (Seay et al.), Ford Financial Empowerment Model (Ford), and Stopping Overshopping Model (Benson).

Effectiveness of the models can only be confirmed when rigorous testing has consistently shown improved results among clients.

The book concludes with an overview of eight theories that can be applied to financial therapy in Section 3, including Humanistic Approaches to Financial Therapy (Johnson and Takasaki), Narrative Financial Therapy (McCoy et al.), Feminist Financial Therapy (Nazarinia Roy and Mitchell), Acceptance and Commitment Financial Therapy for Women (Klontz Wada and Klontz), Psychodynamic Financial

Therapy (Trachtman), Financial Therapy from a Self Psychological Perspective (Baker and Lyons), Systemic Financial Therapy (Archuleta and Burr), and Stages of Change and Motivational Interviewing in Financial Therapy (Klontz et al. 2014). These chapters showcase theoretical approaches that have potential to develop into practice models, but have had no testing to date.

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Chapter 3
Money Scripts

Derek Lawson, Bradley T. Klontz and Sonya L. Britt

Introduction

Money scripts are underlying assumptions or beliefs about money that are typically only partially true, are often developed in childhood, and are unconsciously followed throughout adulthood (Klontz et al. 2006; Klontz and Klontz 2009). Money scripts are derived from "financial flashpoints—an early life event (or series of events) associated with money that are so powerful, they leave an imprint that lasts into adulthood" (Klontz and Klontz 2009, p. 10). Money scripts are often passed down from generation to generation within families and cultures and shape financial behaviors. Cude et al. (2006) found evidence that the financial decisions of parents play a large role in their children's financial behaviors. Unless dealt with, the unfinished emotional problems and behaviors associated with problematic money scripts will become highly resistant to change (Klontz and Klontz 2009). Failure to recognize client resistance to change due to ingrained money scripts can further strengthen them and their associated negative financial behaviors (Horwitz and Klontz 2013; Klontz et al. 2008a; Miller and Rollnick 2002). Money scripts are gender neutral, are associated with net worth, income, and other financial indicators, and can predict money disorders (Klontz et al. 2011; Klontz and Britt 2012).

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Money scripts are underlying assumptions or beliefs about money that are typically only partially true, are often developed in childhood, and are unconsciously followed throughout adulthood (Klontz et al. 2006; Klontz and Klontz 2009).

Money scripts are often passed down from generation to generation within families and cultures and shape financial behaviors.

Unlike previous research that found money attitudes to be independent of one's income (Yamauchi and Templer 1982), money scripts have been found to be associated with net worth, income, credit card debt, socioeconomic status in childhood, and a host of financial behaviors (Klontz et al 2011; Klontz and Britt 2012). The Klontz Money Script Inventory (KMSI) was designed to assist practitioners in helping clients increase their awareness of their underlying beliefs about money to improve their relationship with money. The items used with the KMSI were reported and obtained directly from clients themselves (Klontz et al. 2011). When used in financial therapy, the KMSI may aid practitioners by allowing them to focus their discussions with those who score high on one or more categories of money scripts. For example, discussions on why the clients experience anxiety or stress around money could allow for the clients to uncover their "financial flashpoint" that led to their avoidance beliefs. Consistent financial care and a healthy relationship with money over the course of one's life can help mitigate the financial distress caused by events out of one's control, such as a job loss, economic collapse, or health issues (Lowrance 2011). Once a person's money scripts are uncovered, the irrational behaviors they had been exhibiting can begin to make sense (Klontz and Klontz 2009). When money scripts are identified, their origins understood, and their impact on financial behaviors and outcomes acknowledged, individuals can create more accurate and functional money scripts (Klontz and Britt 2012). Four categories of money scripts have been identified by Klontz et al. (Klontz et al. 2011; Klontz and Britt 2012), and will be reviewed in this chapter. They include money avoidance, money worship, money status, and money vigilance.

Money Scripts

Money Avoidance

Jennett and Hagopian (2008) described the term phobic avoidance as anxiety or fear in specific situations, which are avoided or encountered with much distress. This is consistent with past research on avoidance behavior (Bandura 1969; Leventhal

2008). People with money avoidance scripts systematically avoid dealing with their money while rejecting personal responsibility for their financial health (Klontz and Klontz 2009). They attempt to blame others and believe that money is bad or a source of evil (Furnham and Okamura 1999; Klontz and Klontz 2009; Klontz et al. 2011; Klontz and Britt 2012). The belief that money is evil and should be avoided could be in part due to the pervasive belief that money is taboo and one should not discuss personal financial matters with others (Kershaw 2008; Trachtman 1999). Consistent with Tang (1992), Klontz et al. (2011) concluded that lower-income and lower-net-worth individuals, as well as young people, had a higher prevalence of money avoidance scripts. Additionally, people who did not know their net worth consistently scored higher for money avoidance scripts than those with lower levels of self-reported net worth.

> People with money avoidance scripts systematically avoid dealing with their money while rejecting personal responsibility for their financial health (Klontz and Klontz 2009).

Research suggests that as people age, their money avoidance score decreases. For example, people between the ages of 18 and 30 scored 23 % higher on the money avoidance subscale of the KMSI than people 61–80 years of age (Klontz et al. 2011). This could be attributed to the onset of retirement and the realization of their current financial situation being inadequate. Klontz and Britt (2012) also found that profession may be associated with higher levels of money avoidance scripts—specifically, mental health professionals, when compared to financial advisers, are more likely to be money avoidant.

Psychological and Financial Correlates People who develop, or inherit, money avoidance scripts succumb to fear, disgust, or anxiety when it comes to money. Money avoiders associate negative feelings with money, label the wealthy as greedy, believe that money corrupts, and believe they are better off having less money (Klontz and Britt 2012). Instead of facing the issues and feelings they have with money, they run away from their money problems (Klontz and Klontz 2009).

Money avoiders may severely underspend even on necessary items while other money avoiders may overspend, or give much of their money away, so that they have as little as possible. This results in fewer chances at financial success or worse, bankruptcy (Klontz et al. 2011). Indicative of a complicated and contradictory relationship with money, while reviling money on the one hand, on the other hand money avoiders also report wishing they had more money (Klontz and Britt 2012). Those who underspend generally do so because they are unsure and/or anxious about the future. They may forgo entertainment with friends, skip necessary medical appointments, skimp on meals, and/or eat with unhealthy habits (Williams 2013). Ultimately, underspending could lead to extreme anxiety about money as well as depression. Rubinstein (1981) found that underspenders had lower self-esteem, less

financial and personal satisfaction, and reported symptoms such as headaches, anxiety, and a decreased sexual drive (Furnham and Okamura 1999). Klontz and Klontz (2009) hypothesized that financial rejection, financial denial, excessive risk aversion, and underspending are associated with money avoidance scripts. Research has shown that money avoidance scripts predict financial dependence, workaholism, financial enabling, and financial denial behaviors, including avoiding looking at bank statements, trying to forget about one's financial situation, and not sticking to a budget (Klontz and Britt 2012).

Money Worship

Some people buy into the notion that if they had more money they would be happier. They believe that a financial windfall or increased income will be the solution to all of their problems (Klontz et al. 2011). While that may be partially true, Kahneman and Deaton (2010) found that beyond an annual household income level of US$ 75,000, the incremental increase in happiness is minimal. This is not to say that people with lower incomes are not happy. If needs are being met, income is generally perceived to be adequate. For the money worshiper, a perception exists that needs are never met—there is always some dollar amount or physical item that they believe would make them happier.

Some people buy into the notion that if they had more money they would be happier.

Forman (1987) classified people who are obsessed with money as tycoons—those who see money as a way to gain power and status. The more money they have, the more power they feel and the happier they believe they are (Forman 1987; Furnham and Okamura 1999). Money worshipers "will never really be able to afford the things they want in life" (Klontz and Britt 2012, p. 40). To that extent, money worshipers focus on earning, saving, or spending their money and, consequently, they associate it with safety, happiness, and/or power (Klontz and Klontz 2009; Klontz and Britt 2012).

Klontz et al. (2011) provided demographics of those who are most likely to be money worshipers. Such criteria include being young, single, having revolving credit card balances, and having lower net worth (or an unknown net worth). Money worshipers tend to believe things, such as "there is never enough money," "more money will make me happy," and "life is short so we must live a little" (Klontz and Klontz 2009).

Psychological and Financial Correlates Klontz and Klontz (2009) expressed that money worshipers feel as if they must work extremely hard and excessive hours to make money. Money worshipers also believe that they need to spend their money to show others love.

Money worship scripts could lead to financial behaviors and/or disorders such as hoarding, workaholism, and an endless pursuit of money or those who have it (Klontz and Klontz 2009). Klontz and Britt (2012) hypothesized that the pursuit of more money and more possessions may be a result of people trying to buy their happiness, often leading to chronic overspending or compulsive buying. Other financial symptoms are similar to money-avoidant scripts such as trying to forget about their finances, giving money away while not being able to afford to give, and being financially dependent upon others (Klontz and Britt 2012). Research has found that being overconcerned with financial success and being materialistic is associated with lower levels of well-being (Tatzel 2002).

Focused discussions on why clients feel that more money would solve all of their problems even when research points that it will not, could allow for revelation of their "financial flashpoint" that led to their money worshiping behaviors. The mere recognition and understanding by a client that they do have certain money scripts can help them understand why they do the things they do with money. Ultimately, it will allow the practitioner to better help the client through financial therapy interventions, which can improve the financial health and lower psychological distress clients have around money (Klontz and Britt 2012).

Money Status

People who endorse money status scripts are overly concerned with the notion that their self-worth equals their net worth. They believe that money gives them status and relate money to their socioeconomic class (Klontz et al. 2011). Additionally, they feel as if they must always have the next new, big-ticket item (Klontz and Britt 2012). Money status is distinguished from money worship in that money worshipers are focused on the inward value of the accumulation of money whereas those who hold money status scripts are interested in outward display of their wealth to others. According to Pullen (2010), people link money and products to net worth because consumerism is much more profound in today's culture than ever before. He stated, "if we can afford the latest plasma television or in-dash GPS navigation system, we must be doing pretty well in life. If not, then we must be losers" (p. 50).

People who endorse money status scripts are overly concerned with the notion that their self-worth equals their net worth.

Klontz et al. (2011) concluded that those who see money as a status symbol were more likely to have the following characteristics: (a) young, (b) single, (c) less educated than their peers, and (d) have lower levels of net worth. Additionally, Klontz and Britt (2012) expressed that people who grow up in lower socioeconomic classes are more likely to have a money status script. As has been the case for the preceding scripts, those not knowing their net worth also score high on the money status

subscale of the KMSI. Interestingly, Klontz et al. (under review) found that when compared to other high-income and high-net-worth individuals, the top 1 % of earners score significantly higher on the money status subscale of the KMSI. In their sample, the top 1 % were most often first-generation earners who reported a fundamental drive to increase their net worth and reported higher workaholic tendencies.

Psychological and Financial Correlates Previous research by Kasser and Ahuvia (2002) found that clients who believe that their money equals their status suffer from lower levels of self-actualization, vitality, and happiness. It has been confirmed by other researchers that those who are materialistic end up being less happy and have lower levels of life satisfaction (Richins and Dawson 1992; Sirgy 1998). As a result, they experience increased anxiety and physical symptoms. Klontz and Britt (2012) found that money status scripts are predictive of pathological gambling—individuals with money status scripts may see gambling as a way to suddenly win large sums of money in an attempt to increase their worth and therefore, their socioeconomic standing.

Viewing money as a status symbol has been associated with having a lower net worth and lower income (Klontz et al. 2011). Money status scripts have also been associated with higher income and net worth, as they are thought to drive workaholic behaviors (Klontz et al. under review). Those with money status scripts believe that they are only as successful as the amount of money they have and that the world will take care of their financial needs (Klontz and Britt 2012). Money disorders associated with money status scripts include overspending, and excessive risk taking (Klontz et al. 2011). People with money status scripts have a tendency to lie to their spouses about their spending (Klontz and Britt 2012).

Money Vigilance

> The money vigilant tend to be watchful, alert, and concerned about their finances.

Vigilance or attentiveness to financial affairs is generally considered to be a positive characteristic. The money vigilant tend to be watchful, alert, and concerned about their finances. Those who are money vigilant are significantly less likely to avoid their financial matters, overspend, gamble, and engage in financial enabling (Klontz and Britt 2012). Non-Whites, those who pay off their credit card balances monthly, and those with higher net worth and higher income tend to be more vigilant with their money (Klontz and Britt 2012). As compared to financial planners, business professionals tend to have higher scores on the money vigilance scripts (Klontz and Britt 2012).

Psychological and Financial Correlates Individuals with money vigilance scripts are discrete with their money, may suffer from excessive wariness and anxiety, and

can be distrustful of others around money (Klontz et al. 2011; Klontz and Britt 2012). While approximately half of all spouses believe it is okay to hide financial information from their spouse (Medintz et al. 2005), individuals with money vigilance scripts are less likely to lie to their spouses around spending (Klontz and Britt 2012). Money-vigilant people feel that is necessary to save their money. Although generally a good thing, excessive anxiety could keep them from enjoying the many benefits and security that money provides (Klontz and Klontz 2009; Klontz and Britt 2012). Klontz and Britt (2012) mentioned that money-vigilant people want to work for their money and do not care for handouts. In this regard, money-vigilant people could potentially suffer from workaholism. The money vigilant have a distrust of other people not close to them and do not generally use credit cards, rather opting for cash only transactions. As a result, they generally have higher incomes and higher net worth (Klontz and Britt 2012).

Changing Money Scripts

Klontz and Britt (2012) recommended that financial planners assess their clients' money scripts during the data-gathering process. This allows the practitioner and client to begin a conversation around the impact that money beliefs have on financial success. By knowing which script is most dominant, practitioners can begin to challenge that script with the client to interrupt any destructive financial behaviors and begin to promote healthy financial behaviors with the client (Klontz and Britt 2012). The KMSI can be a useful tool in assisting practitioners in identifying their clients' money scripts. What follows are several additional money script exercises identified in the literature, developed to help clients become aware of their money scripts and challenge and change those that are having a negative impact on a client's financial health.

> Klontz and Britt (2012) recommended that financial planners assess their clients' money scripts during the data-gathering process...to begin a conversation around the impact that money beliefs have on financial success.

Money Script Log

The money script log (see Table 3.1) is a useful technique for identifying, challenging, and changing dysfunctional money scripts (Klontz et al. 2006, 2008a; Klontz 2011). The money script log is an adaptation of a cognitive-behavioral therapy technique that helps clients identify feelings, behaviors, and unconscious thinking patterns around money (Klontz et al. 2006). While versions may vary, the money script log asks clients to write down: (a) the situation or behavior around money

Table 3.1 Money script log

Behavior or situation	Physical sensation or feeling	Money script/s	Alternative money script and/or adaptive behavior
I am spending too much money, but I avoid setting up a spending plan	I have muscle tension, fear, anger when the topic is brought up by my spouse	I work hard so I deserve to have what I want If I have a budget, I will live in deprivation	If I follow a saving and spending plan, I can retire comfortably Buy a self-help book on spending plans and begin next month

that led to distress or concern, (b) the accompanying feeling or physical sensation, (c) the associated money script, and (d) an alternative, more accurate money script and/or adaptive behavior as the example below demonstrates (Klontz et al. 2008a, p. 88).

Klontz et al. (2008a) asserted that generating alternative money scripts can be challenging for clients who should be encouraged to write down whatever alternatives come to mind, which can later be processed with their financial planner or therapist. The money script log can be useful for identifying patterns and helping clients "actively challenge" their "limiting and/or inaccurate beliefs about money" (p. 87).

Money Script Word Associations

Klontz et al. (2006, 2008a) provided a list of words to be used as catalysts for uncovering money scripts. They described the money script brainstorming exercise as a "stream of consciousness" exercise (Klontz et al. 2008a, p. 85). In this exercise, the facilitator reads the cue words and the client is asked to write as quickly as possible, without stopping to think or analyze, the first responses that come to mind. Clients are encouraged to write complete sentences in response to the cue words to "access your subconscious storehouse of beliefs around money" (p. 85). Examples of cue words include spending, marriage, investments, love, power, work, etc.

After the list of money scripts are generated, Klontz et al. (2006) indicated that it is helpful to have the client go back and circle the statements that the client feels are the most accurate or truthful, which are identified as an individual's most dominant money scripts. For example, they described a client who identified the following money scripts: "The rich got that way by taking advantage of others," "Getting ahead at work is all politics," "I'll never be happy because I'll never have any money," "Money is unimportant; only family is important," and "The poor got that way because the rich take advantage of them." In their work with this client, Klontz et al. (2006) noted his self-defeating money behaviors, which included not saving for retirement even though he knew he should, were a direct result of his money scripts. For this particular client, after years of financial struggle and self-defeating

financial behaviors, becoming aware of these money scripts helped him take immediate action and start saving for retirement (Klontz et al. 2006).

Money Script Incomplete Sentences

Klontz et al. (2008a) developed a 30-item incomplete sentence instrument to help clients identify their money scripts. This is different from the Money Script Word Associations exercise, as rather than responding to just a word, a sentence stem is provided as a stimulus. Individuals are encouraged to complete the sentence fragment presented with the automatic thoughts that come to mind. Facilitators should encourage clients to not evaluate, judge, or censor the automatic thoughts that arise as, "they are important clues to a client's underlying and often unconscious money scripts" (p. 82). Examples of incomplete sentence fragments include the following:

a. Wealthy people got that way by ____________________
b. Poor people are poor because ____________________
c. One should never spend money for ____________________
d. I could never afford to ____________________

A client's responses can give insight into their automatic thoughts about money. The responses provide fodder for therapeutic discussions. For example, a client might complete the sentence stem as follows:

e. "Wealthy people got that way by taking advantage of others."
f. "Poor people are poor because they were born into poor families."
g. "One should never spend money on frills."
h. "I could never afford to retire in comfort."

Creating a New Money Mantra

A mantra is a word or phrase that is typically repeated over and over again in an effort to interrupt or replace unhelpful self-talk (Klontz and Klontz 2009). Klontz and Klontz (2009) described a money mantra methodology for overcoming self-defeating money scripts. The premise of the new money mantra is that clients create a financial statement, in which they include new, healthy ways to think about money. Any time they begin to think about their old thoughts regarding money, they are encouraged to state their new money mantra. Over time, that person's negative thoughts about money should begin to subside and the new, healthy thoughts will emerge and strengthen. Klontz and Klontz (2009) recommended that people write down their new money mantra and carry it with them throughout the day as a powerful tool that can help remind someone to make healthier financial choices. For example, a client prone to workaholism could interrupt this behavioral pattern with the money mantra: "I can work hard *and* spend time with my family. They are what matters most."

Ethical Considerations

This chapter clearly demonstrates that money scripts influence the way people handle money. The KMSI was designed to assist practitioners in identification of underlying money beliefs. A copy of the instrument with scoring instructions can be found in the *Journal of Financial Therapy* (Klontz et al. 2011). While no formal training is necessary to use the assessment tool, it should not be used unless the practitioner is prepared to follow through with addressing clients' underlying beliefs about money. This can be an emotional experience and may require collaboration with a trained mental health professional. However, an average financial planner may find it useful to assess for underlying beliefs about money that could interfere with the planning process and refer clients to a financial therapist trained in mental health if issues are noted.

While no formal training is necessary to use the assessment tool, it should not be used unless the practitioner is prepared to follow through with addressing clients' underlying beliefs about money.

Future Directions

Additional research is needed to determine the validity of the KMSI. Shortened versions of the assessment tool have been developed, although further testing is needed before they are available for wide-scale use. The techniques mentioned in this chapter, such as the money script log and incomplete money script sentences, are easy ways to introduce the idea of money scripts to clients. Using one of these techniques or the KMSI in the initial client meetings is recommended. This will help identify potential roadblocks to client progress early in the process and normalize the process of discussing the impact of beliefs on financial behaviors and outcomes.

Financial therapists may benefit greatly by utilizing the KMSI and/or one of the other techniques mentioned in this chapter. An understanding of money scripts is also important for financial planners. For example, when meeting with clients, a financial planner is dealing with nonfinancial issues approximately 25 % of the time (Dubofsky and Sussman 2009). However, approximately 40 % of financial planning practitioners have no training in how to deal with nonfinancial issues (Dubofsky and Sussman 2009). With the rise of robo-advisors (technology platforms that can provide asset management solutions for a fraction of the cost and reach more people, particularly younger, tech-savvy individuals) and the fact that technology continues to increase the amount of information available for clients to research and find on their own, financial planners will need to shift to model in which they can provide further value to their clients. Incorporating the KMSI may be one way in which to provide value.

More research will need to be conducted in a practice setting to explore the full utility of the KMSI in financial therapy, but anecdotal evidence suggests it may allow the client to become more engaged in the overall process and therefore, enhance the client—practitioner relationship and add value to the client—practitioner engagement.

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Chapter 4
Money Disorders

Anthony Canale, Kristy L. Archuleta and Bradley T. Klontz

Introduction

According to the American Psychological Association (APA), the number-one stressor in people's lives is money, above work, health, and children (APA 2012). While most Americans find money to be a source of stress in their lives, for some, this stress is a consequence of disordered money behaviors. Klontz and Klontz (2009) defined money disorders as "persistent, predictable, often rigid, patterns of self-destructive financial behaviors that cause significant stress, anxiety, emotional distress, and impairment in major areas of one's life" (p. 129). Isolated financial mistakes or periods of overspending are not money disorders. Money disorders are not caused by the lack of money (Klontz et al. 2008a) and therefore the solution is not about having more money. People with money disorders typically have faulty beliefs about money and cannot change their behavior even though they know they should (Klontz and Britt 2012; Klontz and Klontz 2009). For some, money disorders are the result of emotional difficulties that cause them to act out financially to avoid feeling unresolved emotions (Gallen 2002).

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> Money disorders are “persistent, predictable, often rigid, patterns of self-destructive financial behaviors that cause significant stress, anxiety, emotional distress, and impairment in major areas of one’s life” (Klontz and Klontz 2009, p. 29)

Psychotherapists can diagnose at least two money disorders using the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5™; APA 2013), namely, pathological gambling and hoarding disorder (HD). DSM-5™ disorders can typically be treated by qualified psychotherapists who can seek third-party insurance reimbursement for their services. The majority of the money disorders in this section, however, have not yet been identified by the mental health community. It is not surprising that money disorders have gone relatively unrecognized in the mental health field, as there is some evidence that mental health professionals are more likely to be money avoidant themselves (Klontz and Britt 2012). Financial planners will often come into contact with clients or the family members of clients who struggle with disordered money behaviors. While they will not “treat” the money disorder in the clinical sense, financial planners will often be called upon to intervene, provide recommendations, and provide referrals for individuals impacted by money disorders.

The money disorders explored in this chapter are compulsive buying disorder (CBD), gambling disorder (GD), workaholism, HD, financial denial, financial dependence, financial enmeshment, financial enabling, and financial infidelity. These money disorders are among the most prevalent, reported, and studied in the financial therapy literature. For each money disorder, diagnostic criteria will be reviewed, prevalence rates presented where available, related psychological and financial symptoms explored, and research on interventions presented.

Money Disorders

Compulsive Buying Disorder

> Compulsive buying is repetitive and associated with adverse psychological and financial consequences (Billieux et al. 2008)

Buying is a routine part of everyday life, but for some it can be unplanned, spontaneous, and associated with feelings of pleasure and excitement (Lejoyeux and Weinstein 2010). When buying is repetitive and associated with adverse psychological and financial consequences, it is identified as compulsive buying (Billieux et al. 2008). Compulsive buying is different from normal buying and is not about

the items purchased, but about the need to obtain short-term relief from tension or negative feelings (Faber 2011). People who buy compulsively have a strong, uncontrollable preoccupation with buying, which causes significant personal and interpersonal distress (Kellett and Bolton 2009; Davenport et al. 2012; Dittmar 2004; O'Guinn and Faber 1989). The consequences of their buying patterns trigger emotional difficulties that are exacerbated by mood and anxiety disorders (Black 2001; de Zwaan 2011). Compulsive buyers use buying binges to enhance mood or relieve distress (Billieux et al. 2008; Kellett and Bolton 2009; Kukar-Kinney et al. 2009; Miltenberger et al. 2003; Thornhill et al. 2012); however, these feelings are generally followed by guilt and remorse (Faber 2011). Mueller et al. (2010) reported associations between compulsive buying and lifetime mood disorders, anxiety disorder, substance use disorder, substance dependence disorder, eating disorder, impulse control disorder (ICD), and obsessive– compulsive disorder (OCD).

Diagnostic Criteria Researchers have typically considered compulsive buying as an impulse-control disorder not otherwise specified (ICD-NOS) in previous iterations of the DSM (Mueller et al. 2010), which could be classified as other specified disruptive, impulse-control, and conduct disorder, CBD, or unspecified disruptive, impulse-control, and conduct disorder in the DSM-5™ (APA 2013). Diagnostic criteria for compulsive buying were first proposed in 1994 and refined over time (McElroy et al. 1994). McElroy's et al. (1994) diagnostic criteria for compulsive buying include the inappropriate preoccupations or impulses with buying or shopping as indicated by at least one of the following: (a) frequent preoccupations with buying or impulses to buy that are experienced as irresistible, intrusive, and/or senseless; (b) frequent buying of more than can be afforded, frequent buying of items that are not needed, or shopping for longer periods of time than intended; (c) the buying preoccupations, impulses, or behaviors cause marked distress, are time-consuming, significantly interfere with social or occupational functioning, or result in financial problems (e.g., indebtedness or bankruptcy); or (d) the excessive buying or shopping behavior does not occur exclusively during periods of hypomania or mania.

McElroy et al. (1994) reported that 70% of patients presenting with compulsive buying described buying as pleasurable, resulting in a buzz, a high, or excitement. Compulsive buying can be assessed using a variety of screening instruments, including: (a) the Compulsive Buying Scale (CBS; Black 2007), (b) Yale–Brown Obsessive–Compulsive Scale–Shopping version (Y-BOCS-SV) (Monahan et al. 1996), (c) Questionnaire About Buying Behavior (QABB) (Lejoyeux et al. 1997), (d) The Canadian Compulsive Buying Measurement Scale (Valence et al. 1988), and the Klontz-Money Behavior Inventory (KMBI) (Klontz et al. 2012).

Psychological Symptoms The diagnostic criteria for compulsive buying are used to describe symptoms of craving and withdrawal applied to buying behavior (Lejoyeux and Weinstein 2010). Although impulse purchases can be influenced by factors that promote a positive mood state, compulsive buying frequently occurs in response to negative emotions in an attempt to decrease the intensity of that emotion. The psychological consequence is usually a feeling of euphoria or relief from the negative emotion. This relief is generally short term and is followed by

increased anxiety (Lejoyeux and Weinstein 2010). Compulsive buyers experience repetitive overpowering urges to purchase goods similar to the way that substance abusers experience feelings for their substance of choice. The goods purchased are in many cases useless (Lejoyeux and Weinstein 2010). Compulsive buyers are more interested in the acquisition than the product itself and typically have higher levels of sensation-seeking behaviors (Lejoyeux and Weinstein 2010).

According to Lejoyeux and Weinstein (2010), both impulsivity and compulsivity may play a role in compulsive buying. Due to their impulsivity, compulsive buyers are not able to abstain from purchasing. The high levels of impulsivity among those with CBD support the inclusion of CBD as a behavioral addiction with problems of impulse control. Higher impulsivity distinguishes compulsive buyers from individuals with OCD (Lejoyeux and Weinstein 2010).

Financial Symptoms Availability of the Internet may promote compulsive buying, because it avoids face-to-face transactions and allows purchases to remain hidden. In addition, the Internet provides up-to-date information on products and pricing (Lejoyeux and Weinstein 2010). Adverse consequences of compulsive buying include substantial financial debt, legal problems, interpersonal conflict, marital conflict, and psychological distress, such as depression or guilt. For compulsive buyers, money and the opportunity to purchase are equivalent to a drug (Lejoyeux and Weinstein 2010).

Etiology and Prevalence The behavioral manifestation of CBD may be due in part to socialization and trial and error learning that a particular behavior can provide relief from tension or negative feelings. The best estimate of the prevalence of compulsive buying in Western nations is between 5.5 and 8% of the adult population (Faber 2011). Faber (2011) reported that when using the most extreme criteria, at least 1.4% of the population suffered from compulsive buying. The vast majority of those with CBD are women, and the average age of onset is typically 30 years (Lejoyeux and Weinstein 2010). Klontz and Britt (2012) found that the money scripts (see Chapter 3) of money status, money worship, and money avoidance are significant predictors of CBD.

Interventions Poor emotional self-regulation is integral to compulsive buying (Rose and Segrist 2012). Because of the false notions of compulsive buyers, such as fear of missing a buying opportunity or the tendency to overestimate the importance of an item, cognitive-behavioral therapy (CBT) may be an effective way to treat CBD (Lejoyeux and Weinstein 2010). Lejoyeux and Weinstein (2010) suggested that patients should first be evaluated for psychiatric comorbidity, especially depression, so that appropriate psychopharmacological interventions can be explored. Mitchell et al. (2006) found compulsive buying patients who received CBT showed significant reductions in the time spent buying and in the number of compulsive buying episodes. The treatment was designed to interrupt and control the problem buying behavior, establish healthy buying patterns, restructure maladaptive thoughts about buying, and develop coping skills. There have been few studies that assessed the effects of pharmacological treatment and none have shown

any medication to be effective in treating CBD (Lejoyeux and Weinstein 2010). A specific treatment approach to compulsive buying is provided in Chapter 12.

Gambling Disorder

Gambling disorder is a "persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress" (APA 2013).

Pathological gambling was first identified as a psychiatric disorder in 1980 (Petry and Blanco 2012), although it is now referred to as GD and classified as an addictive disorder in the DSM-5™ (APA 2013). GD involves risking something of value in an effort to obtain something of greater value (APA 2013). Prior to the release of the DSM-5™, Jiménez-Murcia et al. (2013) characterized GD as persistent and recurring maladaptive patterns of gambling behavior. GD has high rates of comorbidity with mental disorders such as substance use, depressive disorders, anxiety disorders, and personality disorders (APA 2013).

Diagnostic Criteria The criteria set forth by the DSM-5™ (APA 2013) defines GD as "persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress" (p. 585). It is characterized by at least four out of nine behaviors during a 12-month period, including: (a) restlessness or irritability when attempting to slow or stop gambling, (b) unsuccessful attempts to slow or stop gambling, (c) preoccupation with gambling, (d) chasing losses, and (e) dependence on others for money as a result of gambling.

Psychological Symptoms Studies suggest that GD is associated with poorer health across all age groups and illnesses. Backaches, joint pain, and heart problems are all significantly related to gambling (Faregh and Derevensky 2012). Gambling among young people has been associated with disruptions in social relationships, substance use, delinquency, and criminal behavior (Hardoon et al. 2004). In addition to physical symptoms, disordered gamblers may experience negative psychosocial consequences, including debt, shame, guilt, depression, and loss of control (Shaffer et al. 2004). Evidence suggests that gambling is associated with autonomic arousal, such as rising blood pressure, heart rate, and mood (Shaffer and Martin 2011). Shaffer and Martin (2011) reported that individuals with psychiatric disorders are 17 times more likely to develop GD. They also found that individual's with GD are: (a) 5.5 times more likely to have a substance abuse disorder, (b) 75 % have had an alcohol disorder, (c) 38 % have had a drug use disorder, (d) 60 % have a nicotine dependency, (e) 50 % have a mood disorder, (f) 41 % have anxiety disorder, and (g) 61 % have a personality disorder.

Financial Symptoms Since money is the catalyst for gambling, the biggest problem faced by gamblers is debt (Grant et al. 2010). As a result, debt can lead to bankruptcy. While there is little research regarding GD and bankruptcy, as more states in the USA have legalized gambling, bankruptcies have increased remarkably (Grant et al. 2010). According to the Gambler Impact and Behavior Study(GIBS), 19 % of individuals with GD have filed for bankruptcy (Gerstein et al. 1999). Grant et al. (2010) found that individuals who filed for bankruptcy were more likely to have been raised in a dysfunctional family where gambling was used as a coping mechanism. Declaring bankruptcy for many individuals with GD could be due to the inability to cope with financial debt (Grant et al. 2010).

Etiology and Prevalence The lifetime prevalence of individuals with GD ranges between 0.5 and 10 % in the general adult population of North America (Jiménez-Murcia et al. 2013). Early studies suggested that approximately 3–5 % of a given population have some level of gambling problems (Faregh and Derevensky 2012). The proliferation of gambling opportunities and gambling's widespread legalization have contributed to greater social acceptance of gambling (Petry and Blanco 2012). Most of the studies seem to indicate that males are more likely to exhibit gambling behavior. Males are also more likely to gamble in their youth, while the age of onset for females is over 40 years (Jiménez-Murcia et al. 2013).

As with any addiction, there are shared neurobiological, psychological, and social risk factors that influence GD (Shaffer and Martin 2011). The syndrome model of addiction (Shaffer et al. 2004) posits that addictions manifest into a specific form as a result of desirable subjective experiences associated with the objects of addiction (Shaffer and Martin 2011). The risk factors for activity-based addictions (e.g., gambling) are similar to substance-based addictions (Shaffer and Martin 2011). Genetics also plays a role in the risk of developing a gambling (Shaffer and Martin 2011). Environmental factors are also significant. Data from a national sample showed a greater prevalence of problem gambling with individuals living within 10 miles of a casino (Welte et al. 2001). However, recent empirical evidence has suggested that individuals adapt well to gambling opportunities and problematic gambling only increases during the short term, when people are exposed to new gambling opportunities (Shaffer and Martin 2011). Demographic risk factors for problem gambling are younger ages, males, unemployment, social welfare, large urban communities, lower academic achievement, and ethnicity, with African-Americans, Hispanics, and Asian-Americans being at higher risk (Johansson et al. 2009). Klontz and Britt (2012) found that money status scripts (i.e., beliefs associating net worth with self-worth) are a significant predictor of pathological gambling behaviors.

Interventions Treatment for addictions, including GD, often involves a 12-step program (Petry and Blanco 2012). Organizations, such as Gamblers Anonymous (GA), have meetings in every state. According to Petry and Blanco (2012), a randomized study found that CBT in addition to attending GA meetings improves outcomes, suggesting that a combination of professional intervention and GA may be effective.

Petry and Blanco (2012) also found that GD predominately affects lower socioeconomic groups and suggested the need for a short, reliable, valid screening tool that could help uncover gambling problems early so that brief interventions could be instituted before more significant problems develop. Cognitive-behavioral interventions have shown some promise in treating GD, but training is needed in the use of manualized interventions because few providers are familiar with this approach (Petry and Blanco 2012). CBT style interventions include imaginal desensitization, cue exposure or cognitive restructuring, and debiasing techniques used by trained clinicians (Delfabbro and King 2012). Despite the many perspectives toward GD, treatment options typically consist of inpatient or outpatient therapy and self-help groups (Shaffer and Martin 2011).

A large portion of individuals with GD do not seek treatment, but incorporate self-initiated cognitive and behavioral control strategies to deal with problem gambling (Moore et al. 2012). Slutske (2006) reported that 40 % of pathological gamblers recovered without treatment. Self-help strategies to recover from GD include: (a) avoiding gambling venues, (b) stopping cold turkey, (c) lifestyle changes, (d) replacing gambling with other activities, (e) reminding oneself of the negative consequences, and (f) support from family and friends (Moore et al. 2012).

Although there are some medications that show promise in treating pathological gambling, there are no drugs approved by the Food and Drug Administration (FDA) for treating it. Pharmacological research is necessary because psychiatric comorbidity is associated with gambling severity and treatment for dual diagnoses is especially important (Petry and Blanco 2012). Part of the problem with treating GD is that it may not be covered by some insurance plans in the USA (Petry and Blanco 2012). An important future direction for GD research is to identify and test behavioral markers that can predict the development of GDs (Shaffer and Martin 2011).

Workaholism

> Workaholism is a pattern of overindulgence in work, long work hours, working more than is expected, self-absorption in work, and compulsiveness to work, all which result in problems with relationships and health.

The term workaholism was derived from alcoholism and was first identified as an addiction to work, or a compulsion to work incessantly (Oates 1971). The terms workaholism, work addiction, or excessive work are now used interchangeably (Andreassen et al. 2012). Most definitions in current literature describe workaholism as a chronic pattern of overindulgence in work, long hours at work, working more than is expected, and self-absorption in work (Andreassen et al. 2012). Some researchers have modified workaholism by adding the caveat that the time spent working is not due to an external necessity (Snir and Zohar 2000). Some regard

workaholism as a positive attribute, which indicates a person's high level of motivation, while others emphasize the negative attributes of compulsiveness and rigidity (Andreassen et al. 2012). A distinction is also made between workaholism and engaged workers, with the difference being that engaged workers enjoy their work while workaholics are driven not by enjoyment but by a compulsive drive that is characteristic of most addictions (Taris et al. 2010).

> Some view workaholism as a positive attribute.

As an addiction, workaholism is described as an uncontrollable motivation for work, in which an individual spends so much time and energy working that it hinders their personal relationships, leisure, and health (Andreassen et al. 2012). Workaholism is characterized by a repetitive search for pleasure, which comes from a specific dependency associated with abuse, craving, clinically significant stress, and compulsive dependence actions (Caretti and Craparo 2009).

Diagnostic Criteria Scott et al. (1997) reported three central characteristics of workaholics: (a) they spend a great deal of time on work, (b) they are preoccupied with work even when not working, and (c) they work more than is reasonably expected to meet their job requirements. Taris et al. (2010) further characterized workaholics by the inability to detach themselves from their work and by the number of hours spent working. Mosier (1983) defined it as working at least 50 or more hours per week. One of the problems with identifying workaholics is that besides number of hours worked per week there are few, if any, commonly used measures of workaholism other than those that are self-reported (Sussman 2012).

Caretti and Craparo (2009) proposed new diagnostic criteria for addiction, which may have implications for workaholism. They suggested that workaholics suffer from clinically significant impairment or distress caused by persistent and recurrent maladaptive addiction behaviors. An individual must have behaviors from the obsessivity, impulsivity, and compulsivity categories. In addition, addictive thoughts occur frequently or daily and interfere with social functioning and relationships. Klontz et al. (2008a, b) noted that workaholics share common characteristics of individuals with obsessive–compulsive personality disorder, including a preoccupation with control, perfectionism, orderliness, inflexibility, reluctance to delegate tasks to others, and excessive devotion to work at the expense of friendships and leisure.

Psychological Symptoms Robinson (2000) conceptualized workaholism as a progressive addiction that attempts to resolve psychological needs, which can lead to an unmanageable life, family breakdown, and serious health issues. Interestingly, workaholism is associated with reduced actual physical well-being but not perception of physical well-being, which indicates that workaholics do not understand the impact their behavior is influencing their physical well-being (Britt et al. 2013). Workaholics develop a pathological connection to their work as a way to avoid intimacy and augment self-esteem (Nakken 1996). Workaholism has been associated

with diminished levels of well-being, greater work–family conflict, and higher levels of job stress (Bovornusvakool et al. 2012). Scott et al. (1997) described some workaholics as those who have symptoms of OCD and engage in work related activities to remove obsessive thoughts. It is common that aspects of workaholism include perfectionist tendencies in addition to obsessive– compulsive elements that compel individuals to be meticulous in carrying out job functions (Bovornusvakool et al. 2012).

According to Scott et al. (1997), workaholics are typically isolated from others, do not spend time interacting with others, and have low levels of satisfaction with friends and family. Workaholics feel a sense of guilt when not working, cannot relax during leisure time, experience boredom in leisure activities (Oates 1971; Scott et al. 1997), and have high levels of worry and distress (Clark et al. 2010). Workaholics tend to have lower life satisfaction, which can be a consequence of being compulsive and dependent. Chamberlin and Zhang (2009) found that workaholism may be associated with physical health problems and lower levels of psychological well-being and self-acceptance. They also found that children of workaholic parents can be psychologically affected by their parents' workaholic behavior.

For workaholics, focusing on work may provide a socially acceptable way to act on perfectionist tendencies and achieve accolades, since workaholism is the most rewarded of all the addictions (Bovornusvakool et al. 2012). Attaining recognition and achievement may elevate one's mood; however, using work as a coping mechanism for negative emotions can lead to loneliness and dissatisfaction (Bovornusvakool et al. 2012). Van den Broeck et al. (2011) classified workaholism as a behavioral component of working excessively and a cognitive component of working compulsively. They found that the propensity to work compulsively is related to ill-health and is associated with feelings of coercion. In contrast, excessive work behavior is associated with joy and positive well-being (Van den Broeck et al. 2011).

Financial Symptoms Time invested in work has been found to be positively related to financial needs (Major et al. 2002). Klontz et al. (2011) found that workaholism is associated with not only higher income but also higher levels of revolving credit. The negative effects of workaholism can also include emotional pain or feeling burnt out, little social activity, family conflict, driving while preoccupied, driving while on the phone, and driving while sleep deprived (Sussman 2012). While these potentially dangerous issues are happening, the workaholic may be receiving job promotions, salary increases, and praise from their employer and colleagues (Sussman 2012). According to Sussman (2012), many workaholics may be delaying their planned retirement in an effort to continue their workaholic lifestyle.

Etiology and Prevalence Some of the literature suggests that workaholism is the result of feelings of insecurity, low self-worth, and avoidance of pain, fear, and intimacy (Chamberlin and Zhang 2009). Work may increase one's self-esteem and provide a source of self-validation. From an external perspective, workaholics might believe that their parents' love was contingent on their success and therefore work in an attempt to attain that love (Machlowitz 1980). Ng et al. (2007) suggested that disposition (i.e., desire for achievement and increased self-esteem), sociocultural experiences (i.e., use work as an escape for past experiences), and behavioral rein-

forcement (i.e., rewards for work, corporate culture that encourages overwork) lead to the precursors for workaholism. According to Ng et al., the antecedents to workaholic behavior are anxiety when not working, obsession with work, and working long hours, which affects personal life. Klontz and Britt (2012) found that money avoidance and money worship scripts (see Chapter 3) are significant predictors of workaholism.

Griffiths found that the integration of individual, situational, and structural characteristics of work can produce financial, social, physiological, and psychological rewards, which have the potential to induce addictive behavior due to the habitual reward and reinforcement. Piotrowski and Vodanovich (2006) suggested that workaholism develops from a combination of personality traits, home/family responsibilities, and internal and external stressors. The combination of individual and work factors leads to frequent and intense workaholic behavior. In the early stages of workaholism, praise and money at work are appreciated at home and the workaholic behavior is reinforced over time. This can eventually lead to work–home life imbalance.

Liang and Chu (2009) proposed that the key personality traits that lead to workaholism are obsessive compulsion, achievement orientation, perfectionism, and conscientiousness. While workaholism includes traits of high energy and achievement, it also includes negative traits such as narcissism, perfectionism, neuroticism, obsessiveness, and the tendency to blame others for work mistakes (Shimazu et al. 2010; Clark et al. 2010).

Interventions. Few researchers have compared nonchemical addictions against other substance-related addictions, which has fueled skepticism in the addiction research community about issues like workaholism (Griffiths 2011). It has been suggested that workaholism is encouraged and is a socially acceptable addiction (McMillan and Northern 1995), suggesting that addiction treatment programs could be modified for use with workaholics.

Cognitive-behavioral strategies might include instructions on goal setting, developing the ability to derive enjoyment from work, techniques to create work–life balance, problem solving skills, and time management. These techniques can be utilized to reduce the tendency to be hard driven and to control the tempo of tasks to increase enjoyment. The central treatment assumption is that in order to heal workaholism, restoration of balance in one's life is critical. Taking a holistic approach should include sleep, diet, exercise, relaxation, stress management, assertiveness training, and spiritual activity (Holland 2008).

Some researchers believe that rational emotive behavior therapy (REBT) is appropriate for workaholics. REBT is founded on the premise that dysfunctional behavior is caused not only by environmental factors but also by irrational thinking (van Wijhe et al. 2013). van Wijhe and colleagues suggested that irrational thoughts and cognitions play a critical role in self-defeating behaviors and workaholism. Chen (2007) argued that the root cause of workaholism was based on irrational beliefs, which causes the workaholic to be preoccupied with work. REBT offers a promising intervention because it focuses on restructuring a person's irrational beliefs to more functioning beliefs (van Wijhe et al. 2013).

Other strategies that have been used for workaholism include motivational interviewing, group therapy, family therapy, inpatient treatment that removes the workaholic from work for some period of time (Sussman 2012), and experiential therapy (Klontz et al. 2008a).

Hoarding Disorder

Hoarding disorder takes a positive behavior like saving to an extreme.

HD has been identified as a money disorder because it not only includes the acquisition and retention of objects but also takes a positive behavior like saving to an unhealthy extreme (Klontz and Klontz 2009; Klontz et al. 2012). HD poses a serious public health problem, social costs to the public, and strain on families (Tolin et al. 2008; Frost et al. 2000) as well having a profound effect on one's own health and safety (Frost et al. 2012). Relatively few studies have examined HD despite its prevalence and association with significant distress and functional impairment (Coles et al. 2003). Compulsive hoarders feel emotional attachments to their money and possessions, making it difficult for them to spend or discard accumulated items. Traditionally, hoarding has been seen as a symptom of OCD or obsessive–compulsive personality disorder (OCPD). However, hoarding behavior can be a problem in its own right and, as a result, HD was included as a mental illness in the DSM-5™ (APA 2013).

Diagnostic Criteria The DSM-5™ criteria for HD include the following: (a) persistent difficulty parting with personal possessions, regardless of actual value; (b) a strong need to save items and distress associated with discarding; (c) the accumulation of possessions that congest and clutter active living areas and substantially comprises their intended use; and (d) symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning. HD can be specified: (a) with excessive acquisition, (b) with good or fair insight, (c) with poor insight, or (d) with absent insight/delusional beliefs (APA 2013).

HD can lead to impairment of important areas of functioning, including maintaining a safe environment for oneself and others (Frost et al. 2012). Moving safely around the house can become difficult when the accumulation of possessions fill up and clutter the active living areas of the home or workplace and prevent normal use of the space (Frost and Hartl 1996). Klontz et al. (2012) found compulsive hoarding symptoms to be more common in men with lower levels of net worth.

Relating HD to finances, financial therapists have suggested that money hoarders have so much anxiety about not having enough money, that they may neglect even the most basic self-care activities and have great difficulty enjoying the benefits of accumulating money (Klontz et al. 2008b; Klontz and Klontz 2009). Forman (1987) described a financial hoarder as having a fear of losing money, distrust of others around money, and trouble enjoying money.

Psychological Symptoms Hoarders save items for reasons related to sentimental attachment, usefulness, and aesthetic qualities to a point that possessions become an extension of the self (Belk 1988). Getting rid of an item can feel like losing a piece of oneself or like the death of a friend. Objects serve as reminders of important past events and provide a sense of comfort and security. As a result, hoarders are unlikely to share possessions. The hoarder's identity is wrapped up in everything they own. Saving is not restricted to worthless or worn out things and many saved items are new and never used (Frost et al. 2012). Clinically significant impairment could also result from interpersonal stress related to the hoarding behaviors, including marital conflict and/or disapproval from family members or friends.

HD can resemble OCD in a number of ways—avoidance of discarding items for fear that it may be needed in the future, the avoidance of discarding because of an emotional attachment, and the fear of making a mistake as to what to discard. These avoidances and fears have been said to be similar to obsessions (Mataix-Cols et al. 2010). The difficulty in discarding possessions may be an obsession, while the avoidance of discarding a compulsion. However, unlike obsessions in OCD, thoughts related to hoarding or accumulating are not unwanted (Mataix-Cols et al.). Thoughts about possessions are not unpleasant to the hoarder and the distress they experience is usually due to the consequences of the hoarding (i.e., clutter, conflicts with loved ones) not the thoughts or the behavior. Hoarding is usually associated with positive emotions during acquisition and grief at attempts to discard (Mataix-Cols et al.). These emotions are not usually part of the OCD experience (Mataix-Cols et al.). It is believed that OCD behavior ebbs and flows over time, while hoarding begins early in life and exacerbates as time progresses (Tolin et al. 2008).

Financial Symptoms From the beginning of modern psychology, hoarding has been considered a human instinct (James 1890) and represented as a strategy of self-preservation (Bouissac 2006). Humans will use time and effort to acquire artifacts, such as newspapers, radios, and television sets (Lea and Webley 2006). Hoarding behavior is adaptive and has obvious value for contingencies and emergency situations (Lea and Webley 2006), representing a dilemma in the sense that money hoarding behavior seems to mirror positive financial behavior (e.g., saving) but is taken to an unhealthy extreme (Klontz and Klontz 2009). As pointed out by Klontz and Klontz, saving is good, but it is also necessary to spend, which is something that money hoarders may be reluctant to do even for the most basic of necessities. Someone who hoards money may have a difficult time parting with it, not necessarily for fiscal reasons but because of the emotional attachment, and the comfort and security it provides. Resources hoarded for no extrinsic purpose can include artifacts that are also nonmaterial, such as bank account balances (Booth 2006). Unlike the hoarder of objects, the hoarder of money need not have stacks of coins or cash cluttering up the house to cause difficulty. Rather, the money hoarder can have just cognitive clutter that leaves little room for other thoughts or pursuits and results in clinically significant consequences.

Etiology and Prevalence Studies show that hoarding develops as a result of conditional emotional responses to various thoughts and beliefs (Grisham et al. 2006).

Hoarders often have an apprehension to discard possessions, which represents anxiety, avoidance of decision making, and discarding. Hoarders can exhibit excessive saving behavior, which is reinforced through feelings of pleasure associated with possessions and collecting. Contributors to HD include deficits in information processing, beliefs about emotional attachment to possessions, emotional distress, and avoidance behaviors (Grisham et al. 2006). Neziroglu et al. (2004) identified fear of losing information, indecisiveness, fear of making mistakes, inability to prioritize, fear of loss, fear of memory loss, and lack of organization as common traits of hoarders. Hoarding or saving may become part of one's identity. Individuals who hoard tend to be single and often lack a personal connection with other people; therefore, they develop intensified attachments to possessions (Grisham et al. 2006). Some hoarders indicate that hoarding behaviors began as a result of a stressful event that occurred in the past, an event in which they had trouble coping with, and others report a slow and steady progression over their lifetime (Grisham et al.). Klontz and Klontz (2009) hypothesized that HD is a predictable response to a financial trauma and/or an early life of poverty or lack, and argue that the trauma of the Great Depression led to a generation of hoarders of money and objects. Klontz and Britt (2012) also found HD to be significantly correlated with other disordered money behaviors, including CBD.

Cromer et al. (2007) reported that hoarders are significantly more likely to have reported at least one traumatic life event. Prior to 1993, little research existed in the mental health literature related to hoarding behavior (Frost et al. 2012). Within the past two decades, hoarding has been identified as being a prevalent and serious condition (Mataix-Cols et al. 2010). Several studies have shown that the prevalence rate of clinically significant hoarding behaviors is 2–5% of the population (Iervolino et al. 2009; Mueller et al. 2009; Samuels et al. 2008), nearly twice as high as the prevalence of OCD (Samuels et al.).

Interventions Historically, interventions for hoarding behavior have been difficult because of poor response rates to therapy. When one considers the positive feelings about acquisition and the negative feelings about discarding associated with HD, poor responses to therapy are not difficult to understand. The most encouraging data have come from multimodal intervention that focuses on four main problem areas: (a) information processing, (b) emotional attachment, (c) behavioral avoidance, and (d) erroneous beliefs about possessions (Gaston et al. 2009). Motivational interviewing is used to address ambivalence and poor insight. CBT is used to help decrease clutter and resist the urges to accumulate. Cognitive restructuring is used to address the fear of discarding. This multimodal treatment is lengthy and success depends on the motivation of the patient (Gaston et al. 2009).

CBT has garnered the most support in the treatment of HD. An open trial of CBT designed for hoarding with 26 individual sessions and monthly home visits over 9–12 months revealed decreases in saving behavior and reduced clutter (Tolin et al. 2007). Turner et al. (2010) found improvements in clutter, reductions in acquiring and difficulty with discarding, and improvements in safety concerns with specialized CBT techniques for hoarding with a sample of elderly patients. Primarily home-based treatment, which lasted about 35 sessions, focused on motivational en-

hancement, cognitive skills, organization, decision making, and nonacquiring skills. In a waitlist, controlled trial of modified CBT hoarding treatment, Steketee et al. (2010) randomly assigned participants to immediate CBT treatment or a 12-week waitlist. After only 12 weeks, improvement from CBT was statistically greater than the waitlist on most hoarding severity measures.

CBT groups have also been shown to be effective. Muroff et al. (2012) found that weekly group CBT sessions along with nonclinician home visits over a 20-week period showed significant reductions in hoarding symptoms. Video-enhanced and web-based CBT has been an ongoing intervention since 1998 and appears to hold promise (Muroff et al. 2010). Some evidence has been shown to support the effectiveness of selective serotonergic reuptake inhibitor (SSRI) medications, such as paroxetine, clomipramine, fluoxetone, and sertraline in improving symptoms of HD (Saxena et al. 2007; Muroff et al. 2011). The efficacy of a combination of CBT and pharmacotherapy for hoarding requires further research (Muroff et al. 2011). Other modalities have shown promise in the treatment of HD. Klontz and Klontz (2009) advocated resolving unfinished business associated with trauma as an approach to the treatment of money disorders (including compulsive hoarding), using an intensive group experiential therapy approach that has some empirical support for its clinical utility (Klontz et al. 2008a). Pekareva-Kochergina and Frost (2009) found that bibliotherapy group intervention conferred considerable benefit over a 13-week group intervention. Muroff et al. (2012) found that weekly group alCBT sessions along with nonclinician home visits over a 20-week period showed significant reductions in hoarding symptoms.

Financial Denial

> Financial denial is a defense mechanism in which money problems are minimized or avoided to escape psychological distress.

Individuals exhibiting any type of money disorder, in order to cope with their difficulties, might avoid dealing with or not thinking about money (Klontz et al. 2008b). This can contribute significantly to financial difficulty. Klontz and Klontz (2009) described financial denial as a defense mechanism by which people minimize their money problems, or attempt to avoid thinking about them altogether to escape psychological distress. Burchell (2003) defined some individuals as having a somewhat confusing, irrational orientation toward their own personal finances, which leads to poor management and considerable cost. This avoidance phenomenon can be seen in other areas of finance as well. For example, Odean and Barber (1999) found that investors were much more willing to sell investments that were doing well rather than the poor-performing ones, also known as the disposition effect. Odean believed that the disposition effect has nothing to do with the investments, but more to do

with the fact that people do not like to admit mistakes and go into denial and regret avoidance (Nicol-Maveyraud 2003).

Diagnostic Criteria Burchell (2003) hypothesized three different ways to conceptualize dysfunctional orientations toward personal finance. First, the condition might be similar to dyslexia, where specific deficiencies are noted in only reading and writing, for instance. Second, irrational financial behavior may be caused by cognitive shortcomings in the way in which people process financial actions. Since people's lives are so busy and complex, in order to avoid overload, they often take shortcuts rather than fully engage in processing information. By doing so, they create biases and/or errors in judgment (Burchell 2003). Third, irrational financial behavior may have an emotional cause. If people have negative emotions when dealing with financial issues, they may simply avoid thinking about their finances leading to suboptimal decisions and performance (Burchell 2003).

Burchell (2003) conducted a survey of 1000 British adults to assess the prevalence, correlates, and nature of financial denial, using the Financial Aversion Scale. According to Burchell (2003), financial aversion includes avoiding thinking about matters related to personal finance as they are associated with negative emotions including boredom, guilt, or anxiety. Avoiders do not prudently review their credit card and bank financial statements (Burchell 2003). Klontz and Britt (2012) found that money avoidance scripts and money worship scripts are significant predictors of financial denial, which includes efforts to avoid thinking about money, trying to forget about one's financial situation, and/or avoiding looking at one's bank statements (see Chapter 3).

Psychological Symptoms Clinical pathology quite often involves excessive forms of avoidance. In many cases, the avoidance is an attempt to rid oneself of unwanted or undesirable feelings or emotions (Schlund et al. 2011). According to Burchell (2003), those in financial denial were not incompetent, spendthrift, impulsive, or unintelligent. Many were high achievers in other areas of their lives and understood the importance of sound financial management, but were entwined in a psychological syndrome, which made it unpleasant for them to deal with their issues of personal finance. According to Klontz et al. (2012), financial denial is a defense mechanism that is used to relieve anxiety that comes from financial stress. This is distinct from financial rejection, which is the act of ridding oneself of money and/or avoiding the accumulation of money (Klontz et al. 2012). People with low levels of self-esteem may be prone to this because they feel undeserving of having money (Klontz and Klontz 2009).

Financial Symptoms Burchell's (2003) study revealed some behavioral correlates of financial denial. Almost 30% of people in financial denial did not know how much they had in their accounts on a weekly basis, compared to only 18% in the rest of the population (Burchell 2003). Financial averse individuals were also five times more likely than the rest of the population to feel dizzy, physically ill, or immobilized by feelings and emotions regarding their finances. Klontz et al. (2011) found that financial denial was associated with lower levels of income, lower education, lower net worth, and higher revolving credit.

Etiology and Prevalence According to Schlund et al. (2011), recent conceptualizations of anxiety disorders, like post traumatic stress disorder (PTSD), indicate that dysfunctional avoidance coping comes from a shift in the part of the brain that processes reward motivated behavior, to a part of the brain responsible for supporting aversively motivated avoidance behavior. Adaptive functioning reflects a balance between approach and avoidance systems. These imbalances are believed to contribute to human psychopathology (Schlund et al. 2011), but limited research exists on the subject.

Medintz et al. (2005) reported that rather than dealing with financial problems, many individuals choose to ignore them. A survey in the USA found that 36 % of respondents avoided thinking about their financial troubles (Medintz et al. 2005). The survey also found that 36 % of people go to great lengths to avoid financial reality, 17 % said they avoid thinking about money by refusing to look at statements or balances, and 16 % ignore financial news as a way to avoid the reality (Medintz et al. 2005).

In a study of financial aversion in British adults conducted by Burchell (2003), 51 % of the sample rated at least one item on a financial aversion scale as very true, while 84 % of the sample answered at least one of the five statements as either *very true* or *mostly true*. By these criteria, at least half of the population showed some symptoms of financial avoidance. Burchell's study also divided the people with financial avoidance (or the "financial aversives") by category and found that there was a significant proportion of financial aversives in high social classes. This seemed to indicate that financial avoidance was caused by psychological or social factors to which no segment of society was immune (Burchell). The study also found that as the population got older, the proportion of financially avoidant dropped. This could be due to life-cycle phenomena or a sign of a generational shift that younger people born in recent years have higher levels of financial phobia (Burchell).

Burchell (2003) also conducted in-depth interviews with those with high levels of emotional aversion to personal finance. Three theories were put forth as possible causes of financial aversion. The first he called frustrated prudence. Some financial aversives had been cautioned about financial responsibility growing up and others had experienced scarcity and poverty in their lives. Many had the intentions and the ability to provide financial stability for themselves, but because of external events they lost or were cheated out of their hard earned savings. This left them with feelings of anger and injustice. The way that they dealt with their psychological dissonance was through avoidance.

The second theory was procrastination. Some respondents reported keeping up with their finances, but once they let it slip for a few months, they began avoiding those tasks which increased their feelings of guilt and anxiety. The avoidance of activities through procrastination is typical in situations that are time- and effort-consuming, frustrating, and low in reward (Burchell 2003). Third was lack of confidence in dealing with financial information. While these theories were tentative, more empirical longitudinal research is needed to verify these findings (Burchell).

Interventions In their experiential financial therapy approach, Klontz et al. (2008a) found stable and significant posttreatment reductions in participant's levels of anxi-

ety around money and improvements in financial health, which included one's tendency to avoid thinking about money (see Chapter 7 for a discussion of experiential financial therapy). With the exception of this study, no known research is available on treatment to alleviate financial denial. The financial planning industry is uniquely positioned to help in this area. For example, in Burchell's (2003) study, some of the participants were dismayed by the fact that someone who saves all of their life to purchase a home could have their home equity whittled away for long-term care needs. In this case, proper financial planning might avoid that scenario and the more people know about the techniques to accomplish that might alleviate some of the avoidance. More could also be done to protect consumers on the improper selling of financial products, which tends to intimidate the public and feeds their aversion. Greater importance can be placed on risk tolerance to make sure that people are not investing above their risk tolerance level, so that fluctuations in the market do not cause as much anxiety.

Financial Enabling

> Financial enabling is the inability to say no when people continually ask for money (Klontz et al. 2008b).

Klontz et al. (2008b) defined financial enabling as the inability to say no when people continually ask for money. Financial enabling can have significant effects on the enabler and on the one that is being enabled. Enablers can experience problems with their own financial situation, including filing for bankruptcy while attempting to cover their own expenses and those of someone else (Klontz et al. 2012). A good example is parents taking care of adult children who should be able to support themselves (Klontz and Klontz 2009). Enablers and dependents absorb a sense of money as a pervasive influence and both tend to hide their behavior out of shame or guilt (Klontz and Klontz 2009).

Diagnostic Criteria Klontz et al. (2012) identified financial enablers as individuals who give money to others even if they cannot afford it and have trouble denying request for money from friends and family. They developed a financial enabling scale, which included the following items: (a) I give money to others even though I can't afford it, (b) I have trouble saying "no" to request for money from family or friends, (c) I sacrifice my financial well-being for the sake of others, (d) people take advantage of me around money, (e) I lend money without making clear arrangements for repayment, and (f) I often find myself feeling resentment or anger after giving money to others.

> Financial enabling is the most common and chronic problems that financial planners witness among their clients (Klontz et al. 2008b).

Psychological Symptoms Klontz et al. (2008b) noted that financial enabling is often done with the intent to bring family closer together, but can create anger and resentment, and damage relationships. Financial enablers may give money to others even though they cannot afford it, leading to financial problems. Price et al. (2002) found that financial strain increases symptoms of depression and can create feelings of being out of control. These out of control feelings can be detrimental to role functioning, emotional functioning, and health.

Financial Symptoms Financial enabling has negative financial consequences. It has been found to be associated with lower net worth and higher credit card debt (Klontz et al. 2011). In financially hard times, it is more common for financial enabling to occur (Klontz and Klontz 2009). Because of economic hardships, more and more adults are relying on their parents for financial support. Unfortunately, this can have serious effects on the parent–child relationship as well as the financial health of both enabler and dependent. The relationships of financial enablers are so tangled up in money that they confuse emotional investments with money (Klontz and Klontz 2009).

Etiology and Prevalence It is believed that money issues begin with childhood experiences as well as cultural influences and early learning. This reinforces patterns of learned behavior that meet psychological and emotional needs rather than practical financial needs (Goldberg and Lewis 1978). Financial enabling often results from the belief that money is synonymous with love. This may be a result of financial enablers having grown up in poverty and not wanting their children to experience the same depravity or having been spoiled as a child and learning how to express love to their children with money. Klontz et al. (2012) found some empirical support for this hypothesis, with financial enabling being significantly associated with lower socioeconomic status in the financial enabler's childhood. An online poll by ForbesWoman and the National Endowment for Financial Education (NEFE) showed that almost 60 % of parents provide financial support to adult children who are out of school (Goudreau 2011b). Thirty-seven percent of the parents cited their own struggles and the fact that they do not want their children to struggle as they did (Goudreau 2011b). While no specific information on the prevalence of financial enabling is available, Klontz et al. (2008b) stated that “financial enabling appears to be one of the most common and chronic problems financial planners see among their clients” (p. 127).

Financial enablers use money as a way of compensating for guilt they feel from the past, to get closer to someone, and to feel important (Klontz and Klontz 2009). This is a way for the enabler to keep loved ones close and stay in control. While the intention may be good, the results often are not. Klontz and Klontz (2009) indicated that the longer that a dependent is supported financially, the more difficult it will be to develop their own financial skills. This can cause the dependent to become stunted both emotionally and financially. Financial enabling does not only apply to parent–child relationships but also to partners, spouses, friends, etc. Financial enablers believe that spending money on others gives their life meaning and earns them love and respect (Klontz and Klontz 2009).

Interventions Little evidence is available on the treatment of financial enabling; however, it may be treated similar to other problematic financial behaviors and other types of enabling. Klontz and Klontz (2009) advised that if someone realizes that they are a financial enabler, the first thing they should do is acknowledge their behavior does more harm than good. Sometimes gently saying "no" is the only way to break the cycle of dependence. The enabler should also remind him/herself that it is not about being cheap or uncaring; it is actually what is best for the dependent. Klontz et al. (2012) also suggested that teaching parents ways to respond to their children when they ask for money is a good way to begin the process early so that children do not become financially dependent adults (Klontz et al. 2012). Due to the relational nature of financial enabling, especially between parent and child, a systems theory approach may potentially be useful in the treatment of financial enabling.

Financial Dependence

> Financial dependence is "the reliance on others for nonwork income that creates fear or anxiety of being cutoff, feelings of anger or resentment related to the nonwork income and stifling of one's motivation, passion, and/or drive to succeed" (Klontz et al. 2012).

Financial dependence is defined as the "reliance on others for nonwork income that creates fear or anxiety of being cutoff, feelings of anger or resentment related to the nonwork income, and a stifling of one's motivation, passion, and/or drive to succeed" (Klontz et al. 2012, p. 21). Individuals with lower levels of education and low income who are not married are the most likely to identify with financial dependence (Klontz et al. 2012). Financial dependence can be seen as related to dependent personality disorder (DPD; Klontz et al. 2008b). Bornstein (2012) referred to dependent behavior as interpersonal dependency, which is the tendency to rely on others for nurturing, guidance, protection, and support even when the ability to do so for oneself is possible. Human beings are all born dependent on others for their very existence and the longer one lives, the greater the likelihood that they will once again be dependent on others for activities of daily living (Bornstein 2012). As a personality trait, interpersonal dependency has been actively studied over the past few decades (Bornstein 2012). Some have categorized dependency into functional (physical) dependency and economic dependency (relying on someone else for financial support) (Rusbult and Van Lange 2003). Dependency differences can predict various aspects of social behavior and also have implications on health, psychological disorders, and the challenges of aging (Bornstein 2012). While DPD is not specific to financial dependence, it shares many of the same attributes.

Diagnostic Criteria In their creation of a financial dependence scale, Klontz et al. (2012) included the following items: (a) I feel like the money I get comes with

strings attached, (b) I often feel resentment or anger related to the money I receive, (c) a significant portion of my income comes from money I do nothing to earn (e.g., trust fund, compensation payments), (d) I have significant fear or anxiety that I will be cut off from my nonwork income, and (e) the nonwork income I receive seems to stifle my motivation, passion, creativity, and/or drive to succeed. The DSM-5™ includes eight criteria for DPD: (a) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others, (b) needs others to assume responsibility for most major areas of his or her life, (c) has difficulty expressing disagreement with others because of fear of loss of support or approval, (d) has difficulty initiating projects or doing things on his or her own, (e) goes to excessive lengths to obtain nurturance and support from others, (f) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself, (g) urgently seeks another relationship as a source of care and support when a close relationship ends, and (h) is unrealistically preoccupied with fears of being left to take care of himself or herself (APA 2013).

In addition to the financial dependence subscale of the KMBI mentioned above (Klontz et al. 2012), self-report scales including the Interpersonal Dependency Inventory (IDI) and the Sociotropy-Autonomy Scale (SAS) could be used to assess dependency needs. The Rorschach Oral Dependency (ROD) test measures implicit dependency strivings with little or no awareness on the part of the patient (Bornstein 2012). Scores on self-reported dependency tests reveal how respondents view themselves, the extent to which they feel their dependency strivings are due to dispositional causes, and biases that affect their self-presentation (Bornstein 2012).

Psychological Symptoms Miller (2003) described a dependent personality as a "pattern of submissive and clingy behavior stemming from an excessive need to be taken care of" (p. 421). Miller further asserted that dependents need people and fear only their loss of support. He suggested that dependents look to others for guidance and direction and can be diligent followers. The perception of dependents is that they are immature, needy, clingy, insecure, and weak. College students with high levels of dependency are associated with homesickness, social rejection, and roommate conflict. These issues can remain later in life, causing conflicts at work and the undermining of professional relationships (Miller 2003).

According to Klontz and Klontz (2009), individuals who suffer from financial dependence "live in a childlike world where the normal rules of finance are irrelevant. They have no real sense of how money works in the everyday world, nor do they feel they need to know" (p. 195). Research suggests that financial dependents are significantly more likely to believe that their self-worth is defined by their net worth and that more money brings more happiness (Klontz and Britt 2012). Financial dependency has been shown to lead to increases in child–parent conflict (Aquilino and Supple 2001). In some cases, financial dependence can be life-threatening. For example, in one study, 46 % of domestic violence victims reported that a lack of money was a significant factor in their decision to return to an abusive relationship (Anderson et al. 2003).

Financial Symptoms Financial consequences of financial dependency can be that the well-being of the family (Maas 1990) or a specific family member (Schneider 2000) suffers as a result of trying to financially support a dependent for longer. Financial dependence can add to family tension due to the economic scarcity caused by the dependency. Financial dependence is associated with lower education and lower income, but higher socioeconomic status in childhood (Klontz et al. 2012).

Etiology and Prevalence One thing that contributes to dependent personality orientation is overprotective and authoritarian parenting (Bornstein 2012). Bornstein suggested that these parenting styles tend to foster dependency by creating a helpless or vulnerable self-concept in the child. Overprotectiveness teaches children that they are fragile and ineffectual, and without a powerful caregiver would be unprepared to survive in the dangerous world. Authoritarian parenting can instill the belief that the way to succeed in life is to comply with the demands and expectations of others (Bornstein 2012). Another factor that contributes to dependency is culture. Cultures that are sociocentric (that value interpersonal traits) foster dependency by tolerating it in adults (Bornstein 2012). Gender role socialization also plays a role in dependency. Men tend to be less open about dependency needs and by late childhood have significant differences in self-reported dependency than their female counterparts. Studies reveal that women tend to be diagnosed with DPD at higher rates than men (Bornstein 2012). Infants that are easily startled and are difficult to soothe have a greater likelihood that they will develop a dependent personality later in life (Bornstein 2012). This may be due to an easily startled child revealing a predisposition to dependency because they are unable to soothe themselves without external support, or because the inability to calm the easily startled child might elicit overprotective parenting that instills in the child a fragile and ineffectual belief system (Bornstein 2012). Early-onset separation anxiety carries a greater likelihood that dependency will develop later in life (Silove et al. 2011). Dependent adolescents have high rates of peer group dependency, which makes them susceptible to negative peer influences. Dependent adolescents, like dependent children, experience high rates of loneliness and peer rejection, which also increases the chances that they will experience substance abuse problems and depression (Pritchard and Yalch 2009). In young adulthood, dependents can develop attachments to substitute caregivers or other figures of authority like professors, supervisors, or friends. Older dependents sometimes express dependency needs directly or by increased cognitive impairment that compels others to assume care (Bornstein 2012).

Interventions Clients with dependency issues in many cases seek treatment for the adverse effects of their dependent behavior on friendships, relationships with romantic partners, and relationships with parents, siblings, children, or coworkers and supervisors at work (Kantor 1992; Paris 1998). Bornstein (2012) outlined several strategies to enhance the adaptive features of dependency. First, helping clients express dependency needs while gaining reassurance and strengthening close relationships is a key strategy. Another tactic is to help clients distinguish between unhealthy dependencies (e.g., avoiding responsibility) and more healthy dependencies (e.g., seeking help to acquire a new skill). An additional technique that can

be useful is therapist modeling, where the therapist can model healthy dependent behavior including self-disclosure. The therapist might self-disclose how they were able to gain skill and confidence by working with a more skilled experienced mentor (Bornstein 2012).

Clinicians treating dependency issues need to be able to distinguish between dependency and passivity. Passive patients are not necessarily dependent and if a patient is dependent they will not always be passive. Dependent patients can become quite active when supportive relationships are threatened (Bornstein 2012). Dependent patients can also exhibit destructive behavior like suicidal ideation, domestic violence, and child abuse. Effective therapy requires identifying a dependent's self-presentation strategies in different relationships and settings and their preferred methods of self-presentation when others are ineffective (Bornstein 2012).

Some clients present with multiple dependencies like someone who is both functionally and financially dependent. In those cases, where psychological difficulties are present in addition to functional or financial dependency, multimodal treatment with other mental health professionals may be indicated (Bornstein 2012). Dependents are skilled at reading interpersonal cues and meeting the needs of others. As such, they tend to surround themselves with others who support their pathology. A systems focused approach is useful in identifying areas of the social network that foster unhealthy behavior (Bornstein 2012).

Financial Enmeshment

Financial enmeshment is when parents use money to manipulate a child to satisfy an adult need.

Financially enmeshed parents become so entangled in the lives of their children that maintaining leadership in the household is compromised (Klontz et al. 2012). Enmeshed parents lack boundaries, and in cases of financial enmeshment, they cross the financial boundary with their children by involving them in adult financial issues and decisions. Parents sharing financial information with an age-inappropriate child, which causes anxiety and stress, can be considered financial enmeshment (Klontz et al. 2012). Financial enmeshment was originally coined financial incest by Klontz et al. (2008b) to describe when parents use money to manipulate a child or to satisfy an adult need. While not physically abusive, it is psychologically abusive and can be damaging to the child. An example might be when a parent discusses their financial woes with a child as a way to cope with the anxiety and stress associated with the financial problems.

Diagnostic Criteria In their development of the KMBI, Klontz et al. (2012) developed a financial enmeshment scale. Scale items include examples of the

inappropriate crossing of parent–child boundaries around money: (a) I feel better after I talk to my children (under 18) about my financial stress; (b) I talk to my children (under 18) about my financial stress; and (c) I ask my children (under 18) to pass on financial messages to other adults.

Psychological Symptoms The enmeshed parent often looks like a loving parent and the child can be seen as well adjusted, which underscores the need for thorough assessment of the child's vulnerabilities. Clinical examination and psychological testing can expose aspects of the parent–child relationship that might cause concern (Friedlander and Walters 2010). Strained relational dynamics between parent and child may also occur as a result of enmeshment. Financial enmeshment is associated with money status beliefs and a host of other money disorders, including CBD, GD, HD, financial dependence, financial enabling, and financial denial (Klontz and Britt 2012). This suggests that parents who suffer from other money disorders are more likely to also share inappropriate financial information with their minor children.

Financial Symptoms Children of enmeshed parents are forced to take on an adult role in handling finances that can have long-term painful effects. A common financial effect for enmeshed children is difficulty meeting their own needs because of the caretaker role they have taken. It is common for caretakers to assume financial responsibility for the families for the rest of their lives. In addition, enmeshed children develop a feeling of inadequacy because they eventually realize that they will never be able to do enough and therefore will never be enough (Klontz and Klontz 2009). Adults who have experienced financial enmeshment are more likely to perpetrate the same behavior with their own children (Klontz and Klontz 2009). Research shows that higher net worth men are more likely to engage in financial enmeshment behaviors (Klontz et al. 2012).

Etiology and Prevalence No data exist on the prevalence of financial enmeshment. In cases of enmeshment, the psychological boundaries between the parent and the child have not been adequately defined and established, but the child often has developmentally inappropriate difficulty separating from the parent (Friedlander and Walters 2010). The child may develop clinginess to the parent, difficulty attending school, and difficulty functioning in an age appropriate manner. Quite often, the child is aware of the enmeshed parents' neediness and assumes the protective role for the parent. In some cases, the child actually takes on the caretaking role for the parent (Friedlander and Walters 2010). The parent and child are usually not aware of the problematic nature of their relationship and usually believe that they have an excellent relationship. Maladaptive behaviors and emotional dysfunction come from problematic thought patterns caused by a combination of genetic predisposition and early environmental influences (Beck et al. 1990). Financial enmeshment occurs when a parent cannot adequately distinguish between their needs and the needs of their child (Klontz and Klontz 2009). Financial enmeshment is often unconscious and triggered when a parent has unfinished business, such as their own blurred parent–child boundaries in their life or lack of a satisfying connection to their partner (Klontz and Klontz 2009).

Interventions In an enmeshed relationship not specific to money, therapy should be considered primarily to address the needs and dependencies that are at the root of the enmeshment. Psychotherapeutic therapies are typically challenging and take considerable time. These therapies are often supplemented by strategic coaching, education, and redirection of the parent's neediness to other more appropriate sources (Friedlander and Walters 2010). The child's individual therapy should protect the child and help the child separate emotionally from the enmeshed parent. Therapy should also attempt to remedy the problem of separation and the sense of responsibility for the parent that the child feels. Individual therapy is supplemented with family therapy involving joint meetings where issues of enmeshment are addressed between parent and child. The enmeshed parent is able to learn that they do not need the child to need them, and the child can disengage from the role of caretaker (Friedlander and Walters 2010). Typically, a reason that enmeshed behavior occurs is due to a lack of an adequate support system. Klontz and Klontz (2009) recommended taking all of the frustration, anxiety, worries, and financial stress to a therapist to avoid involving the children in unresolved issues. If appropriate, the parent should discuss with the child that the parent is changing that behavior, and ask the child to let the parent know if they begin to engage in enmeshed behavior again. It is also important for the parent to confide in someone that he or she is changing their behavior so that he/she can be accountable to someone else (Klontz and Klontz 2009).

As with the other relationally focused money disorders (e.g., financial enabling and financial dependency), a systems therapy approach can be useful in treatment. Specifically, Bowen Family Therapy incorporates specific interventions to reduce anxiety and to be able to distinguish between thinking and feeling in order to create differentiation of self or independence of self from others (Nichols and Schwartz 2001). Bowen believed if a person can differentiate thoughts and feelings, then a person could change the functioning of the system or relationships within the system. As a result, the child or parent can break away from the enmeshed relationship and create a highly functioning relationship. Bowen Family Therapy is insight oriented and requires an awareness of the whole family through the use of a genogram or family diagrams that represent family members and relational patterns among members. Other interventions include detriangulation, which is the process of removing oneself from triangulation or the "detouring conflict between two people by involving a third person, stabilizing the relationship between the original pair" (Nichols and Schwartz 2001, p. 530).

Financial Infidelity

> Financial infidelity is secrecy and dishonesty over money.

Financial infidelity is secrecy and dishonesty over money. It can become problematic when couples deliberately keep secrets about their finances or spending from

their partner (Klontz and Klontz 2009). This type of secrecy can erode the foundation of any relationship. When a partner lies about money, the other partner begins to think about other things they may have hidden. In a survey commissioned by ForbesWoman/NEFE, one in three Americans admitted to lying to their spouses about money (Goudreau 2011a). According to a Creditcards.com poll, about 6 million US consumers have hidden financial accounts from their significant others (Prater 2012). Couples would rather talk about sex or infidelity rather than talk about how to handle the family finances (Atwood 2012). Many people grew up in households where no one talked about money, so there is no education on what role money plays in a family unit. Since money is taboo in families, people become adults with irrational beliefs, anxiety, and no idea how to handle money (Atwood 2012). As people enter into relationships, the anxieties begin to emerge.

Diagnostic Criteria Financial infidelity includes any purposeful financial deceit between two or more individuals wherein, there is a stated or unstated belief in mutual honest communication around financial matters. As such, it can involve hiding or lying about spending, costs, giving, borrowing, investing, receiving, the existence of bank, brokerage, or retirement accounts, the balances of accounts and credit cards, credit histories, credit scores, etc.

Psychological Symptoms Some individuals seek to acquire money and material possessions as a way to: (a) compensate for the lack of money in childhood, (b) to repair a self-image, which has been shattered, or (c) to validate oneself (Madanes 1994). Differences in gender and money exist, which can be a factor in acts of financial infidelity. Men tend to see the world as competitive with winners and losers. Women tend to see the world more as collaborative and democratic (Atwood 2012). These differing views about the world can lead to problems between the genders about money. These differences can lead to acts of financial infidelity in an effort to avoid discomfort or conflict in the relationship. According to Atwood (2012), in relationships, men want to merge the money, but keep control over it whereas women want to keep some of it separate. Money is often thought of as synonymous with love, and gifts are seen as a symbol of affection. Klontz and Britt (2012) found financial infidelity, as measured by an affirmative statement to the following item, “I hide my spending from my partner/family,” to predict CBD and financial enabling behaviors.

Financial Symptoms Hiding existing credit cards, checking accounts or savings accounts can be as troublesome for relationships as romantic affairs. Infidelity with money can not only damage trust but also wreak havoc on the other partner’s name and credit history (Prater 2012). According to the ForbesWoman/NEFE poll (Prater 2012), 67 % of those couples experiencing financial infidelity indicated that the deception caused an argument, while 42 % said it caused a problem with trust in the relationship. The most damaging results came by way of separation and/or divorce with 11 % of respondents indicating that the deception resulted in a separation, and 16 % of respondents stating it led to divorce. Whether a cause of financial problems or a consequence, financial infidelity has been found to be associated with lower levels of income (Klontz and Britt 2012).

Etiology and Prevalence Individuals create secret accounts that are hidden from their significant other for a number of reasons (Buckner 2012): (a) they are having an affair and a hidden account is useful to hide gifts, hotel room, dinner expenses, etc.; (b) they don't trust their partner's spending habits and are looking to protect themselves; (c) they want to avoid conflict by being able to make a purchase without permission; (d) they want a way out if there is skepticism about the relationship lasting; and (e) they have insecurity about the relationship and fear that their partner will leave. Klontz and Klontz (2009) also identified financial infidelity in couples where one partner is a financial hoarder, underspender, or financially bullies the other partner.

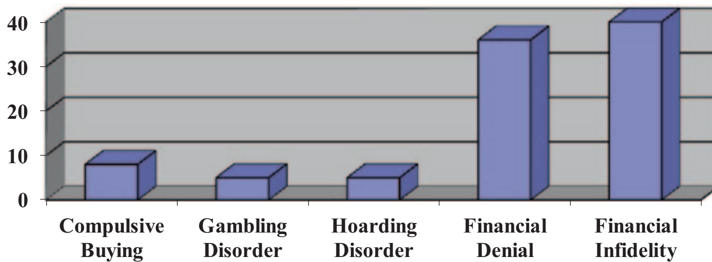
If an individual is not willing to share his or her money with their partner, it may be because they were deprived of the necessities or the lack of resources as a child (Atwood 2012). In coupled relationships, when money or spending is seen as a substitute for love or affection, partners can feel rejected or unloved when their loved one is unwilling to share. Forward (2002) pointed out that if a spouse or significant other is withholding money, it is also likely that they are withholding feelings as well. Money can be used to punish the significant other for the lack of affection. This type of misuse of money can stem from observing parents who used money as a manipulation tool toward their spouse (Smith 1992).

Financial infidelity can be the result of trust issues that occurred in childhood. In some cases, it comes from poor communication skills where partners are deceitful in order to avoid anger, disapproval, or lecturing (Klontz and Klontz 2009). It can also arise from a history of adulthood betrayal or to avoid conflict.

In a *Money* magazine nationwide survey, 71 % of those polled admitted having a money secret, 44 % said that under certain circumstances it was okay to keep financial secrets from their spouse, and 40 % of married respondents admitted to lying about the amount that they spent on something (Medintz et al. 2005). Sixteen percent of married respondents admitted that they bought something that they did not want their spouse to find out about, 43 % cited the reason for deceiving their spouse was to avoid conflict, and 45 % lied because they did not want to deal with their spouse's anger, disappointment, or lecturing (Medintz et al. 2005). An OppenheimerFunds, Inc. survey showed similar results where 26 % of women surveyed said they hid cash from their spouse and 24 % of men admitted the same (Credit Union Times 2005). Credit cards have been shown to be the most likely to be hidden with about two-thirds of those who concealed financial accounts reporting they hid credit cards (Prater 2012). About 45 % of those surveyed reported that they hid savings accounts, 38 % hid checking accounts, and 72 % of women admitted having secret savings compared to only 26 % of men (Prater 2012).

Interventions Klontz and Klontz (2009) developed a four-step process for addressing financial infidelity, using the acronym SAFE. SAFE refers to: (a) *speak* the truth— establish financial safety in the relationship and talk openly about money, (b) *agree* to a plan—establish agreed upon strategies of spending and saving, agree on the amount each can spend without consulting the other, (c) *follow* the agreement—set a trial period and then meet to consider if the plan is working with both

partners; (d) have an *emergency* response plan for when difficulties that cannot be resolved occur. This plan might include enlisting help from a financial therapist, mental health clinician, or financial planner.



Ethical Considerations

Who can diagnose the disorders presented in this chapter? Who can treat them? Is special training required? Mental health clinicians who have received the necessary training and have obtained the appropriate credentials are the only professionals who can diagnose and treat mental health disorders identified in the DSM-5™ (APA 2013). Many of the money disorders described in this chapter are directly associated with DSM-5™ disorders. However, several are indirectly related or not recognized as mental disorders, making diagnosing a gray area. For example, a financial planner trained in financial therapy could certainly identify when financial enabling is occurring and can help structure interventions for the individual and/or family. However, a financial planner who is not also a trained mental health provider should not attempt to diagnose or treat HD, GD, or CBD. It would also be unethical for a mental health provider to treat a DSM-5™ -related money disorder (e.g., HD, GD, CBD) while simultaneously managing the client's assets, selling financial products, receiving commissions or referral fees, or engaging in any other type of business or personal relationship with the client, as this would be seen as a multiple relationship and would be a serious breach of professional ethics in the mental health.

Any professional who has received money disorder training can identify symptoms of a money disorder. However, screening for symptoms and diagnosing a client with a disorder are two different endeavors and require different levels of expertise. In an effort to not muddy the water, official diagnosis of any money disorder is better to be left to clinicians who are trained and licensed to diagnose mental illness. However, best practices could also include: (a) financial professionals screening for potential money disorders and making appropriate referrals; (b) mental health professionals with expertise in personal financial planning providing treatment (in the

absence of a multiple relationship); or (c) mental health clinicians working closely with financial professionals to identify symptoms, deliver treatment, and evaluate progress.

Future Directions

Financial therapists should be aware of the psychological, emotional, relational, and financial symptoms of the money disorders outlined in this chapter. Several money disorders have recently been recognized as mental illnesses by the mainstream mental health community, including HD and GD, and others are being considered for inclusion (e.g., compulsive buying disorder). This encourages research and treatment efforts, and it is hoped that this trend towards recognizing money-related disorders continues. Financial planners frequently come into contact with money disorders and their consequences, and are asked to intervene using standard financial planning methods. Proper referrals and treatment can be administered as a result of recognizing salient characteristics, and financial planners are in a key position to be first responders. Although limited literature and research exists on many money disorders described, these problematic behaviors can negatively impact not only the individual but family, friends, and society at large. As such, it is hoped that research efforts continue to define, describe, and develop interventions for these often debilitating money disorders.

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Chapter 5
Assessment in Financial Therapy

Ronald A. Sages, Timothy S. Griesdorn, Clinton G. Gudmunson and Kristy L. Archuleta

Introduction

Financial therapy as a discipline is in the embryonic stage, striving to combine best practices and theories found in multiple stand-alone fields: marriage and family therapy, psychology, and personal finance (Grable et al. 2010). Financial practitioners have long observed that problematic client financial attitudes and behaviors are a function of more than just a lack of financial acuity; however, they have been at a loss as to how to provide meaningful guidance to troubled clients. Likewise, mental health practitioners have observed financial related problems in working with individuals, couples, and families, but have not had adequate skills or tools to effectively work with their clients. The emerging field of financial therapy bridges the gap that exists in practice and provides meaningful solutions to both financial and mental health professionals.

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> Assessment becomes even more important in evolving disciplines, such as financial therapy in order to evaluate the effect of therapies upon clients and to establish the field of financial therapy as a profession. (Grable et al. 2010)

In the field of social science research, it is essential to assess the efficacy of interventions and measurement techniques to advance knowledge and refine approaches for the benefit of clients. Assessment becomes even more important in evolving disciplines, such as financial therapy, in order to evaluate the effect of therapies upon clients and to establish the field of financial therapy as a profession (Grable et al. 2010). Grable et al.'s (2010) book, *Financial Planning and Counseling Scales,* was the first of its kind in the financial planning, financial counseling, and financial therapy arenas to provide a resource where established measures could be easily accessed by researchers, practitioners, and students. As a follow-up to Grable et al.'s work, this chapter adds new and updated instruments that can be useful in financial therapy. In this chapter, six established and evolving assessment instruments are presented as tools to collect important information from clients to identify areas of strengths and weaknesses and to gauge or track client progress. The measures in this chapter represent a combination of financial well-being and financial beliefs and behavior assessments. Some of these measures have been successfully applied to research in allied fields, while others are evolving as the practice of financial therapy develops. In both cases, it is common for social science researchers to confirm that targeted assessment measures have a solid track record for the intended situational use before employing them (Rossi et al. 2004).

Assessment in Practice

At the outset of a client–practitioner relationship, assessment processes are routinely employed to assist the practitioner in gaining subjective or objective information. For example, when a client initially presents for psychotherapy, the therapist will devote substantial time to becoming acquainted with the client. These initial sessions will typically entail some form of assessment on the part of the therapist in an effort to pinpoint client needs as well as client beliefs and thought processes that contribute to client emotional distress and presumed destructive behaviors (Grant et al. 2008). Through the use of assessment tools, a therapist can identify specific treatment options and strategies to assist in the reduction of distress and harmful beliefs as a means of ensuring that interventions employed are suitably tailored to client needs. The same can be true for financial planners; however, assessment has typically only encompassed gathering personal financial information that would be useful in identifying assets, debt, income, and expenses. Gathering financial,

emotional, and behavioral information are important to a financial therapist who is working with the client using an integrated approach.

In addition to the initial presenting concerns a client may bring to the practitioner, assessment techniques may also assist a financial therapist in uncovering additional considerations that may otherwise be masked by the presenting problem. For example, various money scripts formed early in life, may work to inhibit financial well-being at a subconscious level (Klontz and Klontz 2009). As such, a client may not even be aware of, or be able to provide insight into the money beliefs that they hold. Assessment instruments, like the Klontz Money Script Inventory (Klontz et al. 2011), may be helpful in the identification of belief and behavioral patterns that may prove to be detrimental, but are not initially evident to the therapist or client.

Assessment techniques need to be broad and varied, depending upon the clientele being treated. For example, it is becoming clear that financial anxiety among college students is associated, in part, with student loan debt (Archuleta et al. 2013; Sages et al. 2013). Conversely, individuals who are approaching the traditional age of retirement may find that savings over the work life cycle, and/or investment returns due to an ultra-conservative risk profile, may be inadequate to sustain a comfortable post-retirement life style (Yuh et al. 1998). Furthermore, research has demonstrated there are myriad approaches to financial management based on gender (Noone et. al. 2010) and cultural differences (Yao et al. 2005). Therefore, assessment techniques need to be specific to an array of both financial needs and demographic characteristics, which will enable the financial therapist to understand the etiology of client behaviors.

> To establish sound assessment instruments, three measurement properties of concern must be addressed, including reliability, validity, and sensitivity. (Rossi et al. 2004)

Throughout the treatment process, periodic assessments are also beneficial. According to Lambert (2013), minimizing client deterioration and maximizing client benefits "…involves routinely measuring, regularly monitoring, and tracking client treatment response with standardized scales throughout the course of treatment while providing clinicians (and clients) with this information" (p. 45). This is the essence of assessment, and the ultimate degree of success in treating clients' hinges on the tools that the financial therapist possesses to measure, monitor, and track therapy outcomes. As Lambert (2012) noted, mental health therapist optimism surrounding treatment of clients has been found to be a factor inhibiting an objective assessment of client progress. Under these circumstances, therapists may fail to recognize when clients are failing to achieve positive outcomes because they believe the treatment will work, thereby leading to client deterioration. These findings apply to financial therapists, because bias and attitude of the practitioner can negatively impact treatment success.

While measurement techniques are commonly employed to assess client needs and monitor client progress throughout treatment, assessment also plays a useful role in the training and education of future financial therapists as a means of bridging the gap between research and practice (Hershenberg et al. 2012). In this regard, there are varying academic approaches across a limited number of institutions for educating and training future financial therapists. The Financial Therapy Association (FTA) consists of financial planners, financial counselors, mental health clinicians, academic researchers, and students. One of the primary objectives of the FTA is to help researchers and practitioners collaborate. One aspect of this collaboration invites scholars to conduct research on existing professional practices to begin to understand what works and what doesn't work, so that approaches can be replicated, modified, and taught to a new generation of financial therapists. Academic institutions, like the University of Georgia and Kansas State University, are engaged in multidisciplinary research to study models of financial therapy. In addition, these institutions engage with practitioners across the country to study modalities and techniques. These two institutions, specifically, offer courses in their curriculum to address many of the relevant issues of financial therapy, and Kansas State University is the first to offer a dedicated curriculum to financial therapy, offering a graduate certificate in financial therapy.

Reliability, Validity, and Sensitivity in Assessment

Conducting assessment is important, as previously discussed, and utilizing sound assessment instruments is vital to accurately and effectively establish baselines and benchmarks to help clients identify underlying issues and recognize when they have reached their goals. To establish sound assessment instruments, three measurement properties of concern must be addressed: reliability, validity, and sensitivity (Rossi et al. 2004). Reliability is commonly defined as a measure of consistency of outcome, whereby the instrument is used repeatedly to ensure it is measuring the same thing (Babbie 2010). In the field of financial therapy, reliability of measurement is particularly important as client assessments may include the evaluation of psychological factors. Accurate diagnosis of a client's presenting problem assists the financial therapist in the design of appropriate treatment protocols. Thus, assessment techniques that have been employed in previous research and have a proven track record in measuring psychological constructs have been found to be the most reliable (Babbie 2010).

Validity of measurements is a more challenging concept to demonstrate, although the definition of the concept is fairly straightforward (Rossi et al. 2004). Validity of a measurement technique is commonly regarded as the extent to which the measure actually "reflects the real meaning of the concept under consideration" (Babbie 2010, p. 153). When undertaking an assessment in social science research,

acceptance of a measure as being a representative portrayal of a concept by constituents and researchers alike is essential to being respected as a valid measurement technique.

Sensitivity as a concept in assessment refers to a measurement's ability to detect noticeable differences that are attributable to the treatment being prescribed. Measurement results, however, can sometimes be associated with factors that are not part of a treatment protocol, which may mask the true effects and benefits of the measure. In addition, it is possible that some assessment measures may be designed for certain limited purposes, such as for diagnostic purposes, and that their use for more precise detection would be inappropriate. Many psychological and personality measures fall into this category, confining their use to situations that are narrowly defined (Rossi et al. 2004). Under these circumstances, a social science researcher may administer a pre- and post-treatment survey as a tool to identify the sensitivity of the measure.

Since many of the assessment instruments reviewed in this chapter are of recent design, financial therapy practitioners and social science researchers may wish to routinely survey the literature to gain further insight into the situations to which the measures have been applied and their resulting outcomes. Where available, the measurement properties of each of the instruments are provided. With regard to reliability, psychological measures are deemed suitable if Cronbach's alpha is above 0.70, with a coefficient of 0.80 or higher being good, and a coefficient above 0.90 being excellent (Saad et al. 1999). The creation and initial interpretation of assessment measures is usually the domain of social science researchers until they have become widely employed and accepted in the practitioner community. Notwithstanding, practitioners will frequently collaborate with, and call upon researchers to assist in the interpretation of assessments completed by financial therapy clients. For a more in-depth discussion on utilizing measurement in practice and understanding when a measurement is sound, interested readers are referred to Webb (2010) and Roszkowski and Spreat (2010).

Financial Assets and Liabilities

Relevance for Financial Therapists

A review of financial assets and liabilities will enable financial counselors and therapists to assess potential financial stress the client may be facing. In addition, this information can be a good indication of social, economic status and financial resources and constraints of the client, and suggest certain courses of action. For example, clients with a large negative net worth may want to consider bankruptcy.

Balance sheet		
Item	Definition	Examples
Financial assets		
Liquid assets (monetary assets)	Assets that can be quickly accessed and turned into cash	Checking, savings, money market, cash-on-hand, Certificates of Deposit, etc.
Investment assets	Assets that are being held in anticipation of future appreciation	Retirement accumulations, securities, rental properties, mutual funds, 529 College Saving Plans, pensions, etc.
Material assets	Use assets. Things of value that client may have in the home or use regularly	Home, autos, RVs, clothing, electronics, furniture, jewelry, collectibles, tools, etc.
Total assets	Value of everything you own	Liquid assets + Investment assets + Material assets
Liabilities		
Current liabilities	Debts that will be paid off within a year	Credit cards, bills due, overdue payments, doctor bills, utilities, title loans, etc.
Long-term liabilities	Debts that are scheduled to take more than a year to repay	Auto loans, mortgages, student loans, home equity loans, other consumer loans.
Total liabilities	Total of everything owed to others	Current + Long-term liabilities
Net worth	Amount remaining after all assets are used to pay all liabilities	Total assets – total liabilities

Source(s): Altfest 2007; Grable et al. 2013

Income and Expenses

Relevance for Financial Therapists

Appropriate categorization of income and expenses will enable financial counselors and therapists to identify financial values and patterns of financial behavior. An income and expense statement can also be helpful for gathering data to perform client ratio analyses that may then be compared against accepted benchmarks to ascertain client's financial health and practices.

Income and expense statement (monthly and annually)		
Item	Definition	Examples
Income		
Gross income (nominal income, pre-tax income)	Total household income before taxes	Wages, salaries, interest, dividends, rents, winnings, royalties, subsidies, gifts, social security, pensions, annuities
Net income (disposable income, after-tax income, take-home pay)	Amount of income remaining after taxes and deductions	Paycheck, direct deposit statement, etc.
Expenses		
Savings	Money set aside for future spending	Retirement, emergency, college, down payments, etc.
Net expenses (consumption expenses)		
Housing expenses	Payments required to live in a property	Loan principle, interest, property taxes, Home Owner's insurance, mortgage insurance, association fees (PITI), etc.
Utilities	Payments required for utility services	Gas, electricity, sewer, water, garbage, cable, phone, internet, etc.
Transportation expenses	Payments related to transportation	Auto loans, insurance, gasoline, parking, registrations, repairs, etc.
Food	Payments for food consumed	Groceries, eating out, school lunches, snacks, etc.
Child care	Payments for supervision of children	Child care/day care, baby-sitting, child support, etc.
Medical/Health care	Cost of medical and dental care	Insurance, doctor, dentist, eye care, prescriptions, hospital, etc.
Debt payments	Consumer debt payments	Student loans, credit cards, other short-term loans, etc.
Contributions and gifts	Payments for charity and gifts to others	Church, birthdays, anniversaries, holidays, etc.
Clothing, personal and other	Payments for clothing and personal expenses	Clothing, diapers, shoes, dry cleaning, hair care, cosmetics, entertainment, vacations, personal expenses, subscriptions, bank fees, life insurance, all other expenses, etc.

Notes for items: Below are some commonly recommended percentages useful as guidelines for consideration when looking at spending by category. The ranges allow for some variation, but the total should not exceed 100 %. If a person spends at the maximum end of the range in one category, they will need to curtail spending in other categories to stay below 100 % of net income
Housing (including utilities): 30–35 %
Food: 18–25 %
Transportation: 11–15 %
Medical: 6–8 %
Debt payments: 10–15 %
Contributions and gifts: 2–10 %
Clothing, personal and other: 11–15 %
Source(s): Altfest 2007; Grable et al. 2013

Financial Ratios

Relevance for Financial Therapists

Financial ratio analysis is an efficient way to assess objective client financial conditions after obtaining accurate reports of financial assets/liabilities and income/expenses. Financial planners, financial counselors, and financial educators regularly use financial ratios for summarizing financial information and to aid in financial decision-making. Financial ratios are designed to address specific financial questions, such as “How long could my client live on existing savings?” or “How much of my client’s income is used to pay debt?” The typical *ratio* is constructed from two numbers, one representing a financial resource, and the other a financial demand. Although a single financial ratio calculation represents only a snapshot in time, through periodic reassessments over time, financial ratios serve as excellent barometers of objective financial progress.

Individual/Family financial ratios (Greninger et al. 1996)

Ratio name	Ratio	Benchmark	Use
Overall financial status			
1. Solvency ratio =	$\frac{\text{total assets}}{\text{total liabilities}}$	>100 %	Shows if the household could pay off all their debts
2. Expense ratio =	$\frac{\text{net expenses}}{\text{net income}}$	<100 %	Shows the proportion of take-home income that is consumed by monthly expenses
Liquidity			
3. Liquidity ratio =	$\frac{\text{liquid assets}}{\text{annual expenses/12}}$	>300 %	Shows the “emergency fund” capacity of assets on hand, each 100 % representing one month’s coverage Note: If an accurate income and expense statement is not available the denominator can be based on net income
Savings and investments			
4. Savings ratio =	$\frac{\text{savings}}{\text{gross income}}$	≥10 %	The percentage of income is being saved for the future
Asset allocation			
5. Capital accumulation ratio =	$\frac{\text{investment assets}}{\text{net worth}}$	≥ 25 %	Used as a benchmark for retirement readiness adequacy and financial well-being for households. What percentage of net worth is held outside of housing equity

(continued)

Ratio name	Ratio	Benchmark	Use
Debt payments and housing			
6. Debt payment ratio =	$\frac{\text{total debt payments}}{\text{net income}}$	≤36%	Back-end test benchmark is for a conventional loan with higher limits permitted from FHA, VA, and USDA mortgage loans
7. Consumer debt payment ratio =	$\frac{\text{consumer debt payments}}{\text{net income}}$	≤10% safe ≤15% reduced flexibility ≥20% danger point	Amount of consumer debt payments as a percentage of take-home pay. Shows the extent to which a household is using credit
8. Housing expense ratio =	$\frac{\text{housing expenses} + \text{utilities}}{\text{net income}}$	≤30–35%	Some prefer to measure with net income in denominator. Renters may have a lower benchmark

Notes about individual ratios: 1. The solvency ratio is based on the information from the balance sheet. A solvency ratio below 100% indicates insolvency, meaning that a person's total assets would not presently be sufficient to pay off all debts. Low solvency ratios can be common in early adulthood in an accumulation phase, especially when student loan debt is high. The solvency ratio should decline with age as long-standing debts are paid down and equity in assets grows. This ratio is one of the strongest predictors of bankruptcy

2. The expense ratio is based on information from the monthly income and expense statement. An expense ratio above 100% indicates that spending exceeded regular income, an unsustainable practice that threatens long-term financial sustainability. An expense ratio less than 100% is ideal and indicates the ability to save money. Net expenses refer to total spending prior to any saving activity. Net expenses should not include additional money contributed to savings or investments unless part of a "forced" contribution plan, such as to a retirement fund, in which case they may be included as a net expense to generate a more conservative estimate of the ratio

3. The liquidity ratio is based on information from the balance sheet and income and expense statement. The ratio is commonly referred to as an "emergency fund" and reflects the capacity to respond to a short-term financial crisis stemming from events such as illness, job loss, or major unexpected expense without going into debt. The standard recommendation is to have 3–6 months' worth of living expenses held in reserve, thus a minimum ratio of 300%. Instances where there is low job stability or job security, a history of poor health, a regular income that mainly supports spending only for necessities, or a social or family situation where it is difficult to rely on others in hard times, the ratio should be closer to 600%. For many families a concerted effort may be required to build up such reserves and in some instances it is better to pay off high-interest debts once the ratio attains 300%. This ratio is another strong predictor of bankruptcy. Those who have a higher liquidity ratio are more prepared to endure a financial crisis such as a temporary job loss

4. The savings ratio is an indication of how much money a family is setting aside for future spending needs and goals. Many planners recommend this to be 10% during initial career stages and gradually increase the amount to 15% or more during peak earning years. If income is going to increase substantially in the near future, it may be reasonable for those families to have a very low savings ratio initially and then increase the savings ratio as income increases. Behavioral economists recommend increasing the savings percentage with each increase in pay. The ratio is representative of all saving, not just retirement or other saving needs

5. The capital accumulation ratio is what proportion of net worth is held in investment assets. This is particularly important for retirement readiness as investment assets will likely be used to supplement Social Security and employer pensions. Many households start with home equity as their primary source of net worth and then add investment assets as savings vehicle for future

Klontz Money Script Inventory

Relevance to Financial Therapists

In the field of psychology, a script is an attitudinal stance that a person takes towards a topic, which then typically manifests itself in a particular pattern of behavior. Money scripts, therefore, are attitudes that a person holds towards money, and the ways in which these beliefs manifest themselves with respect to the use of money and activities associated with money and other tangible resources. Klontz and Klontz (2009) suggested that money scripts are "(a) developed in childhood, (b) often passed down from generation to generation in family systems, (c) typically unconscious, (d) contextually bound, and (e) a factor that drives much of one's financial behaviors" (p. 2). The identification of unhealthy, self-destructive, or non-prosperous money scripts can be an important task in the financial therapy process and may be addressed both through social–psychological interventions and financial counseling.

Klontz et al. (2011) developed a taxonomy of the most common money scripts and linked money scripts to demographic characteristics of financial therapy clients. Klontz and Britt (2012) went further and showed how these money script patterns

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goals. Therefore, this ratio can increase with age and needs to be interpreted carefully with respect to where the client is in the lifecycle. The ratio is useful for younger households to determine if they are saving in other areas outside of personal or use assets which are a predictor of future retirement adequacy

6. Debt payment ratio is a measure of how much of the total household income is going towards debt repayment. Even though financial lending institutions indicate the maximum ratio to qualify for a loan needs to be 36 % or less, higher levels of debt payment ratios can create significant economic stress. The condition of "house poor" is a common term for people who utilize much of their net income to make housing payments, leaving little discretionary income. This ratio must be interpreted with caution in high cost of living areas and in situations where incomes are low. All debt payments are included in the ratio including, mortgage, credit cards, auto loans, and student loans. Some planners recommend including lease or rent payments in this ratio for those families who don't have a mortgage to better measure economic stress of renters

7. Consumer debt payment ratio removes the effect of the mortgage from the debt of the household. This ratio is a good indication of other financial obligations outside of housing. Common examples include student loans, auto loans, and credit cards. High consumer debt ratios could indicate higher levels of economic stress, and greater potential for money arguments. It could be used as a measure of economic self-control as consumer debt is often discretionary in nature. Practitioners recommend consumer debt be limited to less than 10 % of net income when possible, with amounts over 20 % a strong indication of financial distress

8. Housing expense ratio is the percentage of net income that goes to the payment of housing and utility costs. This ratio varies among high cost of living areas in the country and needs to be used with caution. In general, households who keep utility and housing expenses to less than 35 % of take-home pay experience less economic stress. These expenses tend to be the largest household expense as a percentage of income; therefore, how they are managed is likely to have a large impact on the overall economic well-being of the householdSource(s): DeVaney 1994; Greninger et al. 1996; Griffith 1985; Harness et al. 2008; Lytton et al. 1991; Prather 1990

could predict disordered money behaviors. Financial therapists familiar with money scripts and that understand their associated financial correlates and behaviors can use the Klontz Money Script Inventory (KMSI) to assess and intervene on dysfunctional financial beliefs.

Measure

The KMSI emerged directly from work with financial therapy clients, as well as a reexamination of a large number of money attitude scales, including power-prestige, retention-time, distrust, anxiety (Yamauchi and Templer 1982), obsession, power, retention, security, inadequacy, and effort/ability (Furnham 1984). Tang's (1992) money ethics; money is good, money is evil, money represents achievement, money is a sign of respect, budgeting is important, and money is power, were also considered. Measures of these overlapping beliefs and attitudes were condensed into 72 items and administered to 422 financial counseling clients. Exploratory factor analysis resulted in four money script patterns as show in the table below. The response set for these items was a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Note that not all items were retained. Reliability scores for each subscale are reported using Cronbach's alpha (α).

The Klontz Money Script Inventory (KMSI) (Klontz et al. 2011)
1. Money Avoidance (α=0.84)
I do not deserve a lot of money when others have less than me
Rich people are greedy
It is not okay to have more than you need
People get rich by taking advantage of others
I do not deserve money
Good people should not care about money
It is hard to be rich and be a good person
Most rich people do not deserve their money
There is virtue in living with less money
The less money you have, the better life is
Money corrupts people
Being rich means you no longer fit in with old friends and family
The rich take their money for granted
You cannot be rich and trust what people want from you
It is hard to accept financial gifts from others
2. Money Worship (α=0.80)
Things would get better if I had more money
More money will make you happier
There will never be enough money
It is hard to be poor and happy
You can never have enough money
Money is power
I will never be able to afford the things I really want in life
Money would solve all my problems

(continued)

Money buys freedom
If you have money, someone will try to take it away from you
You cannot trust people around money
3. Money Status (α=0.77)
Most poor people do not deserve to have money
You can have love or money, but not both
I will not buy something unless it is new (e.g., car, house)
Poor people are lazy
Money is what gives life meaning
Your self-worth equals your net worth
If something is not considered the "best," it is not worth buying
People are only as successful as the amount of money they earn
It is okay to keep secrets from your partner around money
As long as you live a good life you will always have enough money
Rich people have no reason to be unhappy
If you are good, your financial needs will be taken care of
If someone asked me how much I earned, I would probably tell them I earn more than I actually do
4. Money Vigilance (*α*=0.70)
You should not tell others how much money you have or make
It is wrong to ask others how much money they have or make
Money should be saved not spent
It is important to save for a rainy day
People should work for their money and not be given financial handouts
If someone asked me how much I earned, I would probably tell them I earn less than I actually do
You should always look for the best deal before buying something, even if it takes more time
If you cannot pay cash for something, you should not buy it
It is not polite to talk about money
I would be a nervous wreck if I did not have money saved for an emergency
It is extravagant to spend money on oneself
I would be embarrassed to tell someone how much money I make

Notes about Items:See Chapter 3 for a more in-depth discussion about money scripts
Source(s): Klontz and Britt 2012; Klontz et al. 2011; Klontz and Klontz 2009

Klontz Money Behavior Inventory

Relevance to Financial Therapists

Money disorders represent pathological, compulsive, and severe relational problems associated with money and objects. Money disorders can interfere with everyday living, can result in financial ruin, and can interfere with the close personal relationships a person needs to thrive. Klontz et al. (2012) investigated eight money behavior disorders including compulsive buying, pathological gambling, compulsive

hoarding, workaholism, financial enabling, financial dependence, financial denial, and financial and management, using a sample of 422 individuals. Typically, in order to be considered a disorder, the money behavior will be extreme and debilitating. Financial therapy clients who experience disordered money behaviors may go to great lengths to hide these behaviors. Strategies for hiding a disordered money behavior may include limiting the behavior to a low-key location that is private, such as hoarding in one's own home, gambling in another city, shopping online, or by colluding with others in whom they confide. Thus, financial therapists may not become directly aware of a money disorder, but instead learn about such behaviors from clients' family or friends. Financial therapists with training in family therapy can use these interpersonal connections in their systems-based training to reach out indirectly to those who experience money disordered behaviors.

Measure

Klontz et al. (2012) verified the existence of eight disordered money behavioral patterns among their participants. These included an 11-item compulsive buying scale, a 7-item pathological gambling scale, an 8-item compulsive hoarding scale, a 10-item workaholism scale, a 5-item financial dependency scale, a 6-item financial enabling scale, a 3-item financial denial scale, and a 3-item financial enabling scale. Each of these scales exhibited high factor loadings and good inter-item reliability. Reliability for each subscale is reported below.

Klontz Money Behavior Inventory (KMBI) (Klontz et al. 2012)
1. Compulsive buying (α=0.92)
My spending feels out of control
I obsess about shopping
I buy more things than I need or can afford
I feel irresistible urges to shop
I shop to forget about my problems and make myself feel better
I feel guilt and/or shame after making purchases
I often return items because I feel bad about buying them
I have tried to reduce my spending but have had trouble doing so
I hide my spending from my partner/family
I feel anxious or panicky if I am unable to shop
Shopping interferes with my work or relationships
2. Pathological gambling (α=0.95)
I have trouble controlling my gambling
I gamble to make relieve stress or make myself feel better
I have to gamble with more and more money to keep it exciting
I have committed an illegal act to get money for gambling
I have borrowed money for gambling or have gambled on credit
My gambling interferes with other aspects of my life (e.g., work, education, relationships). I have hid my gambling from people close to me
3. Compulsive hoarding (α=0.91)

(continued)

I have trouble throwing things away, even if they aren't worth much
My living space is cluttered with things I don't use
Throwing something away makes me feel like I am losing a part of myself
I feel emotionally attached to my possessions
My possessions give me a sense of safety and security
I have trouble using my living space because of clutter
I feel irresponsible if I get rid of an item
I hide my need to hold on to items from others
4. Workaholism (α=0.87)
I often feel an irresistible drive to work
My family complains about how much I work
I feel guilty when I take time off of work
I feel a need to constantly stay busy
I often miss important family events because I am working
I have trouble falling or staying asleep because I am thinking about work
I have made promises to myself or others to work less but have had trouble keeping them
It is hard for me to enjoy time off of work
People close to me complain that I am so focused on my "to-do" lists that I ignore them or brush aside their needs or concerns
I have trouble saying "no" when asked to work extra hours or take on extra projects
5. Financial dependence (α=0.79)
I feel like the money I get comes with strings attached
I often feel resentment or anger related to the money I receive
A significant portion of my income comes from money I do nothing to earn (e.g., trust fund, compensation payments)
I have significant fear or anxiety that I will be cut off from my non-work income
The non-work income I receive seems to stifle my motivation, passion, creativity, and/or drive to succeed
6. Financial enabling
I give money to others even though I can't afford it
I have trouble saying "no" to requests for money from family or friends
I sacrifice my financial well-being for the sake of others
People take advantage of me around money
I lend money without making clear arrangements for repayment
I often find myself feeling resentment or anger after giving money to others
7. Financial denial (α=0.84)
I avoid thinking about money
I try to forget about my financial situation
I avoid opening/looking at my bank statements
8. Financial enmeshment (α=0.81)
I feel better after I talk to my children (under 18) about my financial stress
I talk to my children (under 18) about my financial stress
I ask my children (under 18) to pass on financial messages to other adults

Notes about Items: See Chapter 4 for an in-depth discussion of money disorders
Source: Klontz et al. 2012

Financial Anxiety Scale

Relevance to Financial Therapists

Anxiety has been defined as a psychosocial syndrome in which individuals have an unhealthy attitude toward managing their own personal finances effectively (Burchell 2003; Shapiro and Burchell 2012). Shapiro and Burchell (2012) noted that financial anxiety can be associated with low financial literacy and an inability to manage money. When people have no ability to handle money, anxiety can be displayed. As a psychological aspect of financial well-being, high financial anxiety can impede an individual's ability to make good financial decisions, leading to poor financial outcomes and even higher financial anxiety. Although research is limited in the area of financial anxiety (Archuleta et al. 2013; Sages et al. 2013; Shapiro and Burchell 2012), it is possible that financial anxiety could become severe enough that it leads to psychosomatic symptoms, which are physical symptoms such as nausea, heart palpitations, or headaches caused by psychological distress. Financial therapists should be aware of the severity of a client's financial anxiety and refer to an anxiety specialist when symptoms are extreme.

Measure

Archuleta et al. (2013) developed the Financial Anxiety Scale (FAS) to measure an individual's financial anxiety. The seven-item scale is measured on a 7-point Likert-type scale, ranging from 1 (never) to 7 (always). Total scores can range from 7 to 49 with higher scores indicating increased anxiety. The FAS had excellent reliability ($\alpha = 0.94$). The FAS cannot currently be used as a diagnostic tool as it does not provide cut-off scores to establish the severity of one's financial anxiety.

Financial Anxiety Scale (FAS) (Archuleta et al. 2013)	
1	I feel anxious about my financial situation
2	I have difficulty sleeping because of my financial situation
3	I have difficulty concentrating on my school/or work because of my financial situation
4	I am irritable because of my financial situation
5	I have difficulty controlling worrying about my financial situation
6	My muscles feel tense because of worries about my financial situation
7	I feel fatigued because I worry about my financial situation

Notes about items: Items were adapted from the Generalized Anxiety Disorder criteria set forth by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders-IV-TR (DSM-IV-TR) (2000) and applied to a person's financial situation
Source(s): Archuleta et al. 2013

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Chapter 6
Seven Steps to Culturally Responsive Financial Therapy

Pamela Hays, Bradley T. Klontz and Randy Kemnitz

Introduction

In the USA, financial planning has been a profession and service of the dominant European American culture. Over 80% of the 378,000 personal financial planners in the USA are White (U.S. Bureau of Labor Statistics 2012), and approximately 80% of households who use comprehensive financial planning services are White (Elmerick et al. 2002). The homogeneity of the profession contrasts with the US population of which people of Asian, Latino, African, and Native American heritage comprise over one third. This suggests that non-Whites in the USA are underserved by the financial planning profession and racial and ethnic minorities are underrepresented as financial planning practitioners. The U.S. Census Bureau estimates that in 2024, the White population will peak and begin to decrease, as ethnic minority populations continue to grow, and in 2043, the USA will become a dominant-minority nation for the first time (U.S. Census Bureau 2012).

These future population and related cultural shifts point to the strong need for multicultural competence among financial planners. Recognizing this need, in 2007, the Financial Planning Association (FPA) established a Diversity Task Force charged with helping financial planners gain competence in the areas of diversity and multiculturalism. The Task Force subsequently drafted a Diversity Statement, adopted by the FPA in 2009 that emphasizes the importance of financial planners providing competent, ethical advice to multicultural communities (Salmen 2009).

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This statement includes the specific recommendation that complementary financial planning be provided to underserved individuals via FPA "Financial Planning Days" (Turner 2010).

One challenge in providing culturally responsive services involves the enormous diversity of cultural beliefs, values, experiences, and norms that can affect the financial planning process. Using a broad definition of culture favored by three major helping professions (the American Psychological Association, the American Counseling Association, and the National Association of Social Work), these influences include those related to ethnicity, race, gender, age, nationality, language, religion, sexual orientation, socioeconomic status (SES), and disability status.

Obviously, such a broad definition precludes the possibility of any one financial planner understanding every possible cultural influence that exists. However, it *is* possible to obtain a *general* understanding of the cultural influences relevant to a particular case that then facilitates a deeper understanding of each client's *unique* cultural experiences and beliefs. But obtaining this level of competence is not a one-time project; it involves an ongoing process of self-education and skill acquisition. The following seven steps adapted from the work of Hays (2009, 2013) and Klontz (2013) offer an overview of this process, with specific suggestions for success in a multicultural world.

> …the more you understand the cultural influences on you, the more aware you will become of biases that can affect your work without your awareness.

Step 1: Know Your Culture

Understanding the influence of culture on one's clients begins with an understanding of cultural influences on oneself. Why? Because the more you understand the cultural influences on *you,* the more aware you will become of biases that can affect your work without your awareness.

Bias is best thought of as a tendency to think, act, and feel in a particular way. Your particular biases grow out of your unique experiences, including family and cultural socialization, combined with the human tendency to create categories and make generalizations, which in turn contribute to particular worldviews. We all have biases, but recognizing your own can be difficult if you belong to a dominant group because your values and beliefs are so widely held and strongly reinforced; it is sort of like asking a fish to describe water when it has never been out of it. In contrast, if you belong to a minority cultural group, you are continuously made aware of your difference by the surrounding dominant group.

One of the ways cultural bias can affect the financial planning process is in participants' differing value priorities. Take the example of a European American woman who grew up in a small Midwestern community that valued thriftiness and saving for a rainy day, and her husband, who grew up in South America where inflation was so constant that the wisest approach to money was to buy something

immediately so that at least one would have something to sell. Because their White American financial advisor was unaware of the ways in which his own dominant cultural context influenced him to agree with the wife, he completely dismissed the husband's view as unreasonable. As a result, the husband felt disrespected and refused to be involved.

In multicultural contexts, differences in priorities may occur with regard to a number of values. For example, the dominant culture highly values personal independence, whereas many Latino families place a higher value on *inter*dependence and shared financial responsibility among family members (Falicov 2001). Similarly, in personal and professional interactions, the dominant culture highly values assertiveness, verbal facility, and rationality, whereas many American Indian and Alaska Native cultures place greater value on subtle communication, listening skills, and an accepting, spiritual orientation to life's challenges (Hays 2006).

Although recognizing dominant cultural influences on oneself can be difficult, recognizing one's own privilege is usually even more challenging.

To facilitate learning about your own culture, it can help to start with an acronym that summarizes nine key cultural influences that need ADDRESSING: age and generational influences, developmental and acquired disabilities, religion and spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender (Hays 2008). Using the ADDRESSING acronym, try identifying the areas in which you belong to a dominant and/or minority group. Then begin the self-exploration process with questions such as, "How have my age and generational experiences, religious or secular upbringing, ethnicity (and so on) affected my beliefs about money, work, recreation, family responsibilities, planning for the future? How have my experiences or lack of experience with disability contributed to assumptions I may hold about my clients' abilities? How does my gender affect the way I interact with my male and female clients? How have my beliefs about money and financial planning been influenced by my childhood socioeconomic status and current situation?" For a more detailed guide to this self-exploration, see Hays (2013).

Step 2: Recognize Your Privilege

Although recognizing dominant cultural influences on oneself can be difficult, recognizing one's own privilege is usually even more challenging. As someone once said, *Privilege is like oxygen—you don't notice it until you lose it*. In an exploration of her own White privilege, feminist scholar Peggy McIntosh (1988) made a list of 46 privileges she and other White people take for granted. Many of the privileges are considered to be still relevant today They include:

- Whether I use checks, credit cards, or cash, I can count on my skin color not to work against the appearance of financial reliability.
- I can easily buy posters, post-cards, picture books, greeting cards, dolls, toys, and children's magazines featuring people of my race.
- My culture gives me little fear about ignoring the perspectives and powers of people of other races.
- I can arrange my activities so that I will never have to experience feelings of rejection.
- I can arrange to be in the company of people of my race most of the time.
- I can turn on the television and see people of my race widely represented.
- I can arrange to protect my children most of the time from people who might not like them.
- I can remain oblivious of the language and customs of persons of color without feeling any penalty for such oblivion.
- I can be pretty sure that if I ask to talk to "the person in charge," I will be facing a person of my race.

…dominant group members are more likely to underestimate the impact of minority group status on life's challenges

McIntosh (1988) argued that dominant group status confers privileges that are unearned and unjustified, but very real. Her point applies to all of the ADDRESSING domains, as each domain has a dominant group and one or more minority groups associated with it. In the USA, with regard to age and generational influences, dominant groups include young and middle-aged adults (i.e., vs. minority groups of children and elders); with regard to developmental and acquired disabilities, the dominant group consists of able-bodied people; religion and spiritual orientation, people of Christian or secular heritage; ethnic and racial identity, European Americans; socioeconomic status, the middle and upper class; sexual orientation, heterosexuals; indigenous heritage, European Americans; national origin, Americans who were born and grew up in the USA; and gender, men and non-transgendered people (Hays 2008). For all of these dominant groups, a system that privileges dominant members and disadvantages minority group members is held in place by layers of personal and societal denial (Helms 1992).

Because dominant group status allows one to view the world as a relatively safe place where creativity, hard work, and effort all pay off, it is easier for dominant group members to tune out or simply not notice their privileges. As a result, dominant group members are more likely to underestimate the impact of minority group status on life's challenges, for example, attending college, finding a job, buying a house, or finding a school that is supportive of one's children. This lack of awareness has direct implications for financial planners who do not perceive such challenges in the lives of their clients.

To recognize the privileges you hold as a result of your identity, try this exercise. Write the ADDRESSING acronym vertically on the left side of a page, and then to the right of each influence, briefly describe the dominant and/or minority influences on you. Next, put a star next to those influences for which you are a member of the dominant culture. Below is an example of Jessica,[1] a White, middle-aged, middle-class, able-bodied financial planner who identifies as lesbian and Christian:

* **A**ge and generational influences: middle-aged
* **D**evelopmental and acquired **D**isabilities: able-bodied
* **R**eligion and spiritual orientation: Christian
* **E**thnic and racial identity: White
* **S**ocioeconomic status: middle-class

Sexual orientation: lesbian

* **I**ndigenous heritage: no
* **N**ational origin: U.S.A.

Gender: female

Jessica's constellation of privileges—in every area except sexual orientation and gender—is unique to her, as yours will be unique to you. Whatever your constellation, the point of this exercise is to draw your attention to the areas in which you hold privilege (i.e., the starred areas) because these are the areas in which you are most likely to lack insider information regarding minority cultures. This lack of information works against your understanding of and relationship with clients, and for this reason, your starred areas of privilege are a good place to focus your learning about other cultures.

Step 3: Learn About Your Client's Cultures

If you anticipate working with individuals from different racial, ethnic, religious, or cultural groups, it is important to understand a variety of cultural beliefs, customs, and norms—especially regarding money and finances. While research on the intersection of financial behaviors and culture is sparse, some gender and cultural differences have been documented. For example, Newcomb and Rabow (1999) found gender differences in childrearing practices regarding money. Specifically, parents of boys emphasized grades, working, saving, and money more than parents of girls. In addition, boys were introduced to family bills earlier and received less financial support. Among adults, the same study found that men reported a stronger desire to earn more and avoid financial dependence; they also reported having more financial knowledge and working more hours. In contrast, women held more negative views of self and others regarding money and reported a greater fear of finances. And compared to women of lower SES, women of higher SES reported

[1] All examples with names are composites that do not represent any one individual.

lower parental expectations regarding grades, working, and saving; a lesser belief in gender equality; and a greater desire for financial *dependence* rather than independence. Given these findings, it is not surprising women have been found to be less likely to plan for retirement, less likely to participate in major financial decisions (Lusardi and Mitchell 2011), and to demonstrate more negative credit card behaviors than men (Mottola 2013).

However—and this is a very big "however"—when researchers considered cultural influences, the findings were quite different. For example, in a small sample of brother–sister pairs, Rabow and Rodriguez (1993) found that Latino boys and girls were raised to hold similar financial beliefs and behaviors. The researchers hypothesized that this gender equality could be related to the poverty of participants, specifically, that the Latino parents wanted to equip both boys and girls with the attitudes and tools to break free from poverty.

Falicov (2001) noted that Latino households are commonly "embedded in a complex extended network of families and friends" with financial responsibilities often shared within and outside of the nuclear family (p. 324). She described how financial support and responsibilities often affect members:

> Money is a fundamental "glue" that holds the Latino family together and maintains bonds for life. It allows families to reinforce bonds and keep the elders, grown children, and other relatives closer to home. Gifts, favors, and loans are viewed as part of life and not perceived as individual weaknesses. The exchange of gifts, favors, or loans applies to all of the extended family and kin, a manifestation of solidarity and unity. Communication styles express and reflect the need to preserve harmony and connection in large groups and are also manifested in communications about money. (p. 317)

In addition to the support that such a social network provides, associated obligations—for example, the care of older family members—have important implications for financial planning. In a sample of 3,622 couples with surviving parents, Shuey and Hardy (2003) found that Latino Americans were significantly more likely than Whites to provide financial assistance and dedicate time to taking care of their aging parents. This difference was true even when controlling for income, parents' need for assistance, parental proximity, and the presence of other caregivers. In the same study, African Americans were also significantly more likely than Whites to provide financial assistance and dedicate time to caring for their aging parents (Shuey and Hardy 2003).

Despite such commitments, the National Institute on Retirement Security found that 69 % of Latino and 62 % of African American working-age households did not own assets in a retirement account, compared to 37 % of White households (Rhee 2013). Latinos were significantly less willing than Whites and African Americans to take investment risks, and African Americans were significantly less investment risk tolerant than Whites (Yao et al. 2005).

Norms among members of other minority groups related to the ADDRESSING influences (i.e., in addition to ethnicity and race) may vary significantly from the dominant culture in ways that are relevant to financial planning. For example, on average, men have higher incomes than women, a fact that works in favor of gay male couples and against lesbian couples. Male and female same-sex couples still do not have the same rights as heterosexual couples regarding inheritance, health

insurance, and other marriage-based privileges. People with disabilities may be limited physically or by discriminatory social attitudes in the work they can do, and are often forced to pay higher prices for necessary special services (e.g., for a restaurant, housing, or hotel that is accessible; for personal care providers; for food and vet bills for service animals). Some religious groups may hold beliefs that require the payment of tithes and limit income-earning potentials. For example, beliefs may prohibit members from working on holy days, or against women working outside the home or in particular settings. These are only a few examples of cultural differences that can affect financial options and planning.

Step 4: Demonstrate Respect for Culturally Related Strengths

Respect is a highly valued concept in many cultures, including Asian, Alaska Native, American Indian, African American, Latino, and Middle Eastern cultures. But culturally respectful behaviors differ widely across cultures. For example, shaking hands is fine in many cultures, but among many Arab Muslim people, upon meeting an unrelated man and woman it is generally not done. Among many Native people and even among some older European Americans, repeated questioning is considered intrusive and disrespectful (Weisman et al. 2005). And among many Latino people, the high value placed on warm, personal relationships means that substantial small talk and some self-disclosure is essential to a good working relationship (Organista 2006).

> An important demonstration of respect is recognition of a client's culturally related strengths and supports.

Because there is so much variation between and within cultures, the more you know about different cultures' customs, the more hypotheses you will have about what is going wrong when you sense some tension with a client. Keeping in mind the ADDRESSING influences, it can help to ask yourself, "Could the discomfort I am sensing right now be due to some unintentionally disrespectful behavior on my part related to one of the ADDRESSING influences (e.g., addressing an older African American client by first name without asking how they would like to be addressed; seeing a client with a disability in an office that is not fully accessible; making assumptions about an immigrant client's access to resources and information?" (Hays 2008).

An important demonstration of respect is recognition of a client's culturally related strengths and supports. Because the dominant culture views minority cultures as somehow less than or deficient, recognizing the strengths and supports in a client's *culture* is especially empowering. Examples include a client's religious faith,

musical and artistic abilities and appreciation, bilingual skills, culturally related knowledge and practical living skills, culture-specific beliefs, the importance of extended families, traditional holidays and celebrations, culture-specific community supports, and culturally related political and social action groups.

A strong commitment to family is one such strength that is relevant to financial decisions. For example, if a client experiences a sudden liquidity event such as an inheritance, lottery win, or substantial raise, there may be a desire and even obligation to gift a substantial proportion of the funds to family or friends. In tailoring interventions with such clients, it is important to incorporate this cultural value into a plan; ignoring or arguing against it may be perceived as being disrespectful or unaware. A better approach is to help the client develop a plan that allows them to both exercise this value and maintain his or her own financial security.

Step 5: Distinguish between Internal and External Parts of a Problem

It is important to distinguish between internal contributions to a problem (i.e., beliefs that work against a client's long range goals) and those components that are primarily external (i.e., in the environment or due to one's behavior). Internal contributions to a financial problem include cognitive distortions ("I'll be in debt forever, so why bother trying to save?"), dysfunctional money scripts ("If I just work harder, I'll succeed. Poor people are poor because they don't work hard enough"), or a lack of financial literacy. External contributions include behaviors not necessarily related to culture (e.g., personal debt due to compulsive buying) and environmental factors stemming from racism, sexism, heterosexism, classism, ageism, and other oppressive ideologies and practices that negatively affect minority groups.

Distinguishing between the primarily internal versus primarily external parts of a problem is helpful because it offers direction regarding the most effective and efficient solution. For an external, changeable part, the most straightforward solution will usually involve taking some action or changing a behavior. For the internal cognitive part, the best approach is usually changing one's thinking. Changing one's thinking is also a helpful approach when the environmental part is unchangeable, or the desired behavior change is too difficult.

For example, with regard to people who have disabilities, Mona et al. (2006) described the importance of recognizing internal self-defeating thoughts that an individual may engage in, along with the very real environmental obstacles. The latter include able-bodied others' dismissive, fearful, and hostile attitudes, and physical blocks such as inaccessible buildings, restrooms, transportation, workplaces, and communication systems. An empowering approach to financial planning includes validating that many of these environmental obstacles are beyond the person's power

to change, helping her to take action when something is changeable via action, and facilitating more realistically positive thinking that leads her towards her goals.

This facilitation of more realistically positive thinking involves providing information that counters the negatively skewed thinking and assumptions that people engage in when stressed. For example, to counter the belief "Planning is pointless because I don't have enough money and never will," it can help to listen to the client's concerns and then emphasize their strengths and supports, explore possible options, make realistic suggestions, and provide educational information. For self-help books that both advisors and clients can use regarding the how-tos of changing self-defeating thoughts, see Klontz and Klontz (2009) and Hays (2014).

At the same time, it is important to note that focusing solely or too quickly on cognitive contributions to financial problems can invalidate real-life roadblocks associated with minority group status, and limit the financial advisor's understanding of the situation and available interventions.

Step 6: Validate Oppressive Experiences

Membership in a minority group brings with it oppressive experiences. Regarding ethnic minorities, Sue et al. (2007) described these often daily slights as "microaggressions." Sometimes, microaggressions are intentional on the part of a dominant group member who wants to assert their position in relation to a minority member, but often they are unintentional. Unintentional examples include the following: (a) a taxi driver passes a Black person for a White person and (b) a White person mistakes a person of color for a service worker and makes comments, such as: "There's only one race, the human race," "You are a credit to your race," or "When I see you, I don't see color."

Many microaggressions are embedded in dominant cultural practices. For example, national and local US holidays are Christian (not Muslim, Jewish, Hindu, or Buddhist); stairs and other inaccessible architecture are built with able-bodied people as a priority (e.g., with ramps as add-ons despite the fact that able-bodied people can use ramps as easily as stairs); educational materials for children highlight Euro-American successes, events, and people; and movies and television shows include one person of color in a group to make them "culturally diverse."

In a typical example of a microaggression, the dominant member says something or uses a word that he does not realize is offensive, and the minority member is faced with the dilemma of saying nothing and feeling uncomfortable versus saying something, then being accused of being overly sensitive or paranoid. In either case, the minority member is left feeling confused, angry, or hurt and the dominant member remains oblivious to the offense.

Membership in a minority group brings with it oppressive experiences.

When a minority member asks about or notes a microaggression, it is common for a dominant group member to question or counter the minority member's experience or reaction, in part because dominant members do not want to believe that racism, heterosexism, ageism, and other forms of oppression exist. However, challenging a person's self-reported experience of oppression invalidates his or her experience and often leads to disconnection between the parties, as in the following example.

John (who was White) and Joe (who was Filipino/African American) moved to a small town. During an initial meeting with one of the local financial planners, a White heterosexual woman named Karen who held the CFP® designation, John and Joe told her they had felt "dissed" a couple of times when they were together and thought it was because they were gay. Karen appeared uncomfortable and responded, "Oh, no that can't be it—people here are really friendly. You probably just took what they said the wrong way. Are you sure they were aiming their comment at you?" Karen was surprised the next week when John called and said they had decided to go with another CFP® and thanked her without further explanation.

Although Karen was well-intentioned, her comment denied that heterosexism, and by implication possibly other forms of oppression, were present in her town. A more validating approach would have been a thoughtful pause and something like "I am really sorry that happened to you. I know there are still some people who hold those kind of attitudes, but I hope you will find there are many people here who do not."

Although in this case, the microaggression led John and Joe to completely disconnect from Karen, it is important to note that often minority group members work hard to stay connected despite the hurt or irritation they feel. Because microaggressions are so pervasive, minority members are often better at getting over or letting go of these negative experiences than are dominant group members. As a person of color once told one of the authors, "You have to choose your battles; if you get upset every time something like that happens, you will be upset all the time."

Step 7: Do Not Challenge Core Cultural Beliefs

With some clients, much of the financial planner's work involves changing clients' self-defeating beliefs about money to more empowering thoughts. However, if the beliefs are central (i.e., core) to a client's culture, such attempts will usually backfire, unless the client wants such change. For example, trying to change a client's core cultural belief regarding the obligation to care for one's aging parents is akin to helping the individual break a social contract. A better approach is simply to accept such beliefs and focus on the client's goals.

> The world is now a multicultural one, and successful financial planning practice requires services that are responsive to all clients, not just those of dominant cultural identities.

> …trying to change a client's core cultural belief… is akin to helping the individual break a social contract. A better approach is simply to accept such beliefs and focus on the client's goals

Religious beliefs are one example of core cultural beliefs that can significantly affect the financial planning process. Walter and Emanuele (2012) found that people who report that they regularly attend religious services donate 50 % more time and 8.5 % more money than those who do not claim to be religious. A commitment to religious contributions may come from a sense of duty, a desire to express thanksgiving and joy, or to promote social justice and charity, or because the individual believes it is a wise investment (Marks et al. 2009). Whatever the reason, failure to accept such values can result in a lost client (Marks et al. 2009).

For example, Klontz (2013) told the story of a 27-year-old White financial advisor who was sought out by a prospective new client—a Protestant, African American woman in her early 50s. In their initial meeting, the woman disclosed that she was donating 10 % of her income to the church. The advisor recommended that she delay her donation and invest the 10 % because this would allow her to better fund her retirement account and quadruple the amount of money she would eventually give to the church. The client politely refused his recommendation, citing a strong religious conviction to give the first 10 % of her income to the church. Not surprisingly, due to his lack of understanding regarding her values, and failure to take the time to do so, the client chose to not work with this advisor.

Future Directions

The world is a multicultural one, and successful financial therapy practice requires services that are responsive to all clients, not just those of dominant cultural identities. Financial therapists of dominant identities will need to work extra hard to recognize the ways in which their own culture and privilege cut them off from valuable information regarding minority cultures. But the rewards of such work include a greater sense of confidence in what one does, more effective services, and a much wider range of clients.

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Part II
Financial Therapy Research-Based Models

Chapter 7
Experiential Financial Therapy

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Introduction

When compared to other therapy approaches, such as cognitive-behavioral therapies, relatively little research exists on the psychotherapeutic effectiveness of experiential therapies (Greenberg et al. 1994). Even so, experiential therapies have been shown to be effective with a variety of presenting problems in a range of settings (see Kipper and Gilandi 1978; Carpenter and Sandberg 1985; Kellerman 1987; Arn et al. 1989; Stallone 1993; Ragsdale et al. 1996; Rezaeian et al. 1997; Greenberg and Malcolm 2002; Watson and Bedard 2006; Klontz et al. 2005, 2007, 2008a). However, a major limitation in the experiential therapy literature is related to absence of detailed operationalization of the approaches being studied (Klontz 1999). One challenge is that there are many types of approaches to therapy that fall within what is commonly referred to as experiential therapy. To varying degrees, they all are linked to a humanistic-existential theory of humanity and use direct experience as the major avenue to psychotherapeutic change (Mahrer 1983).

> Experiential financial therapy (EFT) has a strong emotional component and offers clients the opportunity to increase awareness of their feelings and sensations.

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The model of experiential therapy described herein is grounded in the theory and techniques of psychodrama and primarily employs the use of role-playing techniques. Other key components include: art therapy, music therapy, family sculpting, and gestalt techniques integrated into an approach with philosophical underpinnings in existential-humanistic psychology, developmental theory, and models of family therapy (Klontz 1999). Experiential financial therapy (EFT) has a strong emotional component and offers clients the opportunity to increase awareness of their feelings and sensations. This is achieved through techniques, including mindfulness exercises (Klontz et al. 2008a) such as mindful eating, diaphragmatic breathing, walking meditation, etc. An important purpose in this form of experiential therapy is to "reenact the emotional climate of the family of origin and/or other past and present significant relationships in a person's life. In re-experiencing these events and relationships, one is able to release the emotions that may have been blocked and repressed" (Wegscheider-Cruse et al. 1990, p. 69). A major goal of this approach includes the resolution of unfinished business by working through unexpressed emotions surrounding past relationships and events so that one is better able to live fully in the present (Wegscheider-Cruse et al. 1990). This form of experiential therapy, utilizing psychodrama, has been used for more than 40 years, made popular by the noted treatment center Onsite Workshops, Inc., in Cumberland Furnace, Tennessee. Studies have shown that participants report immediate and lasting significant reductions in a range of psychological symptoms, enhancements in psychological well-being, and reductions in problem behaviors, following experiential therapy in one of Onsite's week-long intensive experiential therapy workshops (Klontz et al. 1999, 2005, 2007, 2008a).

EFT integrates experiential therapy theory and techniques with financial planning concepts in the treatment of money disorders (Klontz et al. 2004, 2006, 2008a; Klontz and Klontz 2009). This model of experiential therapy was first applied to the treatment of disordered money behaviors at Onsite's Healing Money Issues program. The first program, led by Ted Klontz, Ph.D.; Richard Kahler, M.S., CFP®; and Brad Klontz, Psy.D., CFP®, ran in 2003. The treatment approach integrated experiential therapy and personal finance into a 6-day program, utilizing financial education and experiential therapy to treat money disorders and related psychological problems, and received national attention (Klontz et al. 2004, 2006; Zaslow 2003). In a clinical trial, Klontz et al. (2008a) assessed treatment outcomes in 33 participants in Onsite's Healing Money Issues program. Following EFT, participants showed significant reductions in psychological distress, anxiety, and worries about finance-related issues and improved financial health. These improvements were stable at a 3-month follow-up. This chapter will present in more detail the EFT model, including its theoretical underpinnings, therapeutic techniques, and ethical considerations. A case study, illustrating the model's application and outcomes on a client, will be presented.

Theoretical Considerations

The EFT approach discussed herein is grounded in the theory and techniques of psychodrama (Klontz 1999; Klontz et al. 2008a). It conceptualizes many problematic money behaviors as being the result of deeply ingrained money scripts developed

in response to past experiences, which were often traumatic (Klontz and Klontz 2009). The following section explores theoretical considerations of EFT, including financial flashpoints, unfinished business and the malleability of memory, and developmental and reconstructional aspects of EFT.

Financial Flashpoints

Klontz and Klontz (2009) defined financial flashpoints as "an early life event (or series of events) associated with money that are so emotionally powerful, they leave an imprint that lasts into adulthood" (p. 8). They argued that an underlying cause of disordered money behaviors is that of unresolved trauma related to these types of events. This trauma could be directly experienced by the individual, witnessed in another, experienced by one's parents, grandparents, or cultural group, or be the result of severe neglect. It could be financial in nature, such as growing up in poverty, exposure to an extended period of deprivation like that experienced by millions during the Great Depression, or experiencing a significant financial loss. A significant financial gain, accompanied by social stress or family disruption, could also be experienced as traumatic. The trauma could also be nonfinancial, with posttraumatic symptoms negatively impacting one's relationship with money. In an effort to avoid future trauma and/or cope with psychological distress related to the trauma, cognitive and behavioral adaptations are made. In cases of posttraumatic stress, these cognitive and behavioral adaptations can outlive their usefulness and interfere with one's ability to function in the present (Chemtob et al. 1988). There is some support for the emergence of symptoms of posttraumatic stress, for example, in financial planners during the 2008 economic crisis, which may have had a lasting, potentially detrimental impact on their investing behaviors (Klontz and Britt 2012a).

With the exceptions of pathological gambling and hoarding, little research has been done to explore the etiology of disordered money behaviors. With regards to pathological gambling, research has shown that exposure to childhood and lifetime trauma, such as child abuse, child neglect, being the victim of a physical attack, and witnessing someone badly hurt or killed, have been significantly associated with pathological gambling (Scherrer et al. 2007). The severity of traumatic events has been associated with an earlier onset to gambling and increased severity of gambling problems (Blaszczynski and Nower 2002; Petry and Steinberg 2005). Overall, gambling is thought to be a way of coping with a history of trauma and abuse (Leiseur and Blume 1991). Studies have shown that from 23 to 82 % of pathological gamblers admit to a history of sexual or physical trauma (Taber et al. 1987; Specker et al. 1996; Ciarrocchi and Richardson 1989).

Researchers have also explored relationships between traumatic life events and compulsive hoarding behavior. Compulsive hoarding involves the failure to discard a large number of possessions resulting in problematic clutter, emotional distress, and functional impairment (Frost and Hartl 1996). Building off of previous anecdotal accounts, Hartl et al. (2005) found past traumatic experiences co-occurred with compulsive hoarding, though their investigation did not explore whether traumatic

events preceded hoarding. Another study found no differences in experiences of trauma between hoarders and nonhoarders (Lochner et al. 2005); however, the authors were later criticized for using ambiguous methods in assessing trauma and limiting traumatic events to childhood (Cromer et al. 2007). Similar to some smaller studies, Cromer et al. (2007) found that individuals who were classified as hoarders were significantly more likely to have reported at least one traumatic life experience during their lifetime. Furthermore, they found that hoarders who had experienced traumatic life experiences displayed greater severity of hoarding symptoms when compared to other hoarders not exposed to trauma (Cromer et al. 2007). In addition, Cromer et al. (2007) found the relationship between trauma and hoarding to be robust, meaning that the relationship was persistent even using a number of different variations of key variables. A later study by Landau et al. (2011) also found that hoarders experienced a significantly greater number of traumatic events even after controlling for variables, such as age, gender, education, depression, and obsessive–compulsive symptoms.

Some studies have found differences in the timing of traumatic experiences based on the age of onset of compulsive hoarding. Individuals with later ages of onset were more likely to report a traumatic experience directly before the onset of symptoms (Grisham et al. 2005, 2006). Other studies have found that early onset is far more common than late onset, with the average respondent reporting onset between age 11 and 15 and less than 4 % reporting onset after the age of 40 (Tolin et al. 2010). Specific types of trauma also appear to play a role in the development of hoarding behavior. One study found that traumatic events, such as the death of a loved one, physical or sexual abuse, and injury or illness, were infrequently reported prior to onset of hoarding behavior, while possession-related events such as the loss of possessions, threat of eviction, or hoarding behaviors of family members were much more commonly associated with hoarding onset (Tolin et al. 2010). Material deprivation, such as low socioeconomic status, did not provide compelling evidence of a relationship with hoarding behavior (Landau et al. 2011; Tolin et al. 2010). Consistent with the theory presented by Klontz and Klontz (2009), the literature on pathological gambling and compulsive hoarding both indicate that trauma plays a key role in the development of these disordered money behaviors. While EFT targets the resolution of unfinished business related to financial and nonfinancial traumatic events in the treatment of money disorders, more research needs to be done to explore the role of trauma in the etiology and maintenance of disordered money behaviors.

Unfinished Business and Malleability of Memory

EFT offers clients the opportunity to work through unfinished business related to past relationships and events. By doing so, they are able to more fully experience their present lives. Corey (1991) defined unfinished business as “unexpressed feelings…associated with distinct memories and fantasies” (p. 234). He stated that

"because the feelings are not fully experienced in awareness, they linger in the background and are carried into present life in ways that interfere with effective contact with oneself and others. Unfinished business persists until the individual faces and deals with the unexpressed feelings" (p. 234). There is agreement across theoretical orientations that unresolved feelings such as anger and sadness often lead to anxiety, depression, and interpersonal difficulties (Paivio and Greenberg 1995). The symptoms and complications that result from an inability to successfully free oneself from the past may also include: delusional thinking, emotional repression, compulsive behaviors, chronic low self-worth, relationship problems, and, if left untreated, medical problems (Wegscheider-Cruse et al. 1990). There is some support for the effectiveness of experiential therapy techniques in helping clients resolve unfinished business (Paivio and Greenberg 1995).

EFT offers clients the opportunity to work through unfinished business related to past relationships and events.

When emotions related to past relationships and events are unresolved, clients will often display a failure to discriminate between relationships and stimuli of the past and those of the present. As such, they are unable to freely experience present relationships and face present-day financial realities and, therefore, are unable to live authentically. The process of EFT enables clients to develop a more complex set of descriptors for two similar stimuli which were previously not discriminated. By doing so, clients are better able to relate to their present financial lives in a manner consistent with present experience and without the negative effects of unfinished business related to the past.

Through the use of psychodrama's role-playing techniques, EFT enables clients to work through areas of unfinished business. It allows them to address the foundational aspects of symptom etiology and maintenance. Clients are given the opportunity to fully express their feelings and thoughts related to core relationships and events, which when unexpressed, may have adversely affected past and present levels of functioning. The resolution of unfinished business through experiential therapy techniques has been found to significantly reduce a client's psychological distress and help change a client's targeted complaints (Paivio and Greenberg 1995). One of experiential therapy's primary aims is to provide clients with the opportunity to work through the particular unresolved issues that are underlying many of their complications (Wegscheider-Cruse et al. 1990).

The resolution of unfinished business through experiential therapy techniques has been found to significantly reduce a client's psychological distress and help change a client's targeted complaints (Paivio and Greenberg 1995).

Loftus (1979) has demonstrated through numerous clinical trials that human memory is malleable. In research associated with eyewitness testimony, Loftus found that new information presented after an event occurred can be incorporated into the original memory of the event. As such, new information can supplement the original memory and transform an individual's entire recollection of the event. At the extreme, even implausible information can be integrated into an individual's recollection of an event, provided it does not stand in sharp contrast to previously remembered details (Loftus 1979).

The implications of the findings reported by Loftus and colleagues with regard to the misinformation effect and the power of suggestion are clear in terms of cautioning professionals to question individuals in a nondirective manner (Garry and Loftus 1994). Professionals must take care not to put forth suggestions, since the introduction of new information can lead to the formulations of false memories. However, these findings can also help explain how unfinished business can achieve resolution. In EFT, a goal is to alter the cognitive and emotional impact that the memory has had on the individual. According to Rossi (1993), "memory is always a constructive process whereby we actually synthesize a new subjective experience every time we recall a past event" (p. 91). In EFT, the synthesis of a new subjective experience can be achieved through the full expression of emotions surrounding an event and, where appropriate, facilitating a shift in an individual's perception of the event through the addition of new information and insights. Such new information may take the form of a new understanding of the perspectives of others (perhaps through utilizing a role-reversal technique) or in a reframing of the meaning of the event with regard to the individual's life history and/or direction.

Experiential therapy offers powerful techniques that can be used to facilitate the process of working through unfinished business in this manner. Through the warm-up stage, the painful memory can be accessed. During the action stage, unresolved feelings associated with the memory can be expressed and new feelings and thoughts can be introduced into the here-and-now experience of the memory. In the integration stage, clients can gain a new perspective of the event and the memory can be stored in an alternative form. It is unlikely that the critical details of the event will be altered. However, the intensity of associated emotions will likely diminish, as will the power of maladaptive thought patterns that have been generated by the original experience.

Developmental Theory and Reconstructional Aspects of EFT

Much of EFT's focus is on resolving unfinished business related to past relationships and events. EFT looks at the etiology of psychological problems from a developmental framework and sees the resolution of these difficulties as lying within this same framework. Erikson (1963) made the assertion that humankind progresses through eight stages of development in which certain developmental tasks are addressed. These critical steps are turning points and "moments of decision between progress and regression, integration and retardation" (Erikson 1963, p. 270). In this

model, each critical element is systematically related to all others and depends on the proper development of previous stages. Therefore, when an individual's development is impacted by a tumultuous family of origin or significant trauma, stage-specific psychosocial development may be arrested. Kinder (1999) presented a developmental model to help explain problem financial behaviors. He hypothesized that on their way to money maturity, individuals must transition through seven developmental stages, including: the childhood stages of (a) innocence and (b) pain; the adult stages of (c) knowledge, (d) understanding, and (e) vigor; and the awakening stages of (f) vision and (g) aloha.

According to Erikson (1963), when a person does not successfully meet the challenges of a stage of development, therapy can be effective in helping meet the needs of a particular stage. Within this perspective, EFT can be used to re-parent adults who did not successfully maneuver through the appropriate stages of development, thus meeting them at the level of growth at which they were stunted. EFT can be used in a regressive, reconstructional manner to help patients rework missed developmental stages. The therapeutic process provides clients with the opportunity to revisit these earlier developmental periods and draw from them the life-affirming messages they need to enhance their present lives (Illsley-Clarke and Dawson 1989). For example, after working with a client on anger or grief associated with an emotionally or physically unavailable parent though a role-play in a group therapy session, the EFT therapist might prescribe a "reconstructive experience." Following this example, the client may be offered the opportunity to receive nurturing from the parental role-player. If the client agrees, this might be done through either touch, spoken words, or writing, and he or she can receive those needed stage-appropriate messages and affirmations which may have never been offered. According to Dayton (1994), through experiential therapy and psychodrama, clients can experience and practice the dynamics of a given stage in a safe therapeutic environment, thus reworking, reintegrating, and successfully meeting the needs of developmental challenges. These techniques assist with EFT's goal of shame reduction, which helps clients separate themselves from their problematic thinking and behaving around money (Klontz et al. 2008a).

EFT's core strategy is psychodrama, which classically is provided in a group therapy context.

EFT: Principles and Strategies

EFT can be delivered in group or individual therapy settings. However, its core strategy is psychodrama, which classically is provided in a group therapy context. The following section reviews some of the principles and strategies of EFT, including group therapy, classical psychodrama, and an emphasis on identifying and transforming problematic or limiting money scripts.

Group Therapy

EFT's primary mode of intervention is that of group therapy. While EFT can also be provided in individual therapy settings, group therapy offers a powerful medium through which therapy can be delivered. The group has been shown to be a powerful entity for facilitating emotional and cognitive change in its members (Yalom 1995). It can be a counteracting influence on the avoidance and denial often associated with the emotional repression of painful material. It is very difficult for cognitive blocking of such material to persist while an individual responds emotionally to the work and healing of other group members (Wegscheider-Cruse et al. 1990). The process of engaging in group psychotherapy also exposes the client to curative factors that are much more difficult to achieve in individual psychotherapy. Yalom (1995) identified 11 primary therapeutic factors associated with group therapy. These include the instillation of hope, universality, imparting information, altruism, corrective recapitulation of primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

Psychodrama

EFT utilizes the theory and techniques of psychodrama—an action-oriented group psychotherapy originally developed by J. L. Moreno in 1921 (Moreno 1991). Psychodrama provides a framework from which growth and change are understood, while its techniques provide the process by which growth and change are facilitated. Classical psychodrama consists of five basic elements and three phases (Holmes 1991). The basic elements include: (a) the protagonist—the person who is the focus of the psychodrama; (b) the director—the facilitator of the psychodrama; (c) the auxiliary egos—members of the group who play the roles of significant individuals in the protagonist's life; (d) the audience—group members not directly involved in the psychodrama, but who remain actively involved in the process; and (e) the stage—the space in the room where the psychodrama takes place.

The phases of the psychodrama process include: (a) the warm-up phase—used to stimulate creativity and spontaneity of group members, increase trust, and help members focus on personal issues on which they would like to work; (b) the enactment phase—the time when the protagonist explores issues highlighted during the warm-up phase; and (c) the sharing phase—the final stage of the process in which group members share their thoughts and feelings with the protagonist, the auxiliary egos de-role, and the group members share links of commonality with the protagonist and his or her work. EFT utilizes psychodrama's five basic elements and three phases as its core treatment component.

Psychodrama has been credited as being the first systematic approach to psychotherapy that made use of role-playing (Kipper 1986), which has become a popular technique across psychotherapies. In psychodrama, role-players, or auxiliary egos,

are used to represent significant individuals or components in the protagonist's past, present, or future. For example, in EFT, role-players could represent individuals such as one's father or mother, inanimate objects, such as one's house or money, more abstract concepts, such as one's work or retirement, or disowned "parts" of the client's psyche such as their sadness or anger. With the help of the director, the protagonist is asked to interact with the auxiliary egos. This often takes place in a reconstructed scene, such as the family dinner table, which may be related to the client's therapeutic goals. It is the process of addressing the unresolved emotions and cognitions related to these individuals and events which allows for catharsis and the resolution of unfinished business.

Money Scripts

As a component of EFT, clients are assisted in identifying and altering problematic money scripts. *Money scripts* are the unconscious beliefs that every person has developed concerning money and life (Klontz et al. 2008b). Chapter 3 provides an in-depth analysis of four categories of money scripts. What follows is a brief description of money scripts as they relate to EFT. Generally, money scripts are formed during childhood from either direct or indirect messages about money from a child's parents, other significant people in their lives, their circumstances, or society as a whole (Klontz et al. 2008b). Some money scripts can be developed at such a deep level that they become entirely part of an individual's world view or *schema*. A money script is referred to as a script, because like great actors, people learn their scripts to the point that they do not need to consciously think about them (Klontz et al. 2008b). People simply go through life and react to their money scripts, often without giving them any thought. Unfortunately, money scripts often are highly emotionally charged, which can make them difficult to change. Due to their unconscious nature, individuals must also dedicate time to identifying their existing money scripts and correcting them.

Money scripts are oftentimes partial truths (Klontz et al. 2008b). An individual will internalize a money script based on a context in which that script was true. For instance, imagine that a young child watches their parents routinely get harassed by their wealthy landlord. This child may develop the money script that "rich people are bad" or that "rich people only care about money." In the context in which this money script was developed, this may be entirely true. If a child saw a rich individual treating their parents very badly over the rent, they may develop the belief that rich people only care about money. The error in this thinking, however, is that it will not hold true in all circumstances. The child who once saw the rich landlord bully their parents may walk through the streets and immediately feel anger or disgust towards anyone who appears wealthy, but just because somebody appears wealthy does not mean that he or she is a bad person or that they only care about money. This improper belief may be having adverse effects on an individual's social life, professional life, or many other areas. They may unconsciously feel as though

they cannot accumulate wealth, because to do so would make them a bad person, so they are doing everything they can to ensure they can spend all of their money, are chronic under-earners, or are overly generous.

Money scripts can also be deeply rooted in trauma. Early experiences around money can be painful and even traumatic (Klontz and Klontz 2009). When it comes to changing these money scripts, most people will not be able to change unless they are motivated to do so. New information may be beneficial in helping to break away from a money script, but oftentimes the emotional bond to the money script will be far stronger than a logical argument (Klontz and Klontz 2009). This is particularly true if an individual is suffering posttraumatic stress from a past occurrence. People tend to respond to posttraumatic stress in one of two ways, either experiencing hyperarousal around the topic or feeling haunted by the trauma (Klontz et al. 2008b). Another way that some people will respond to a traumatic experience is to take a 180° turn in the other direction. This can often be a harmful action, because just as the original money script is likely inaccurate, the complete opposite is probably inaccurate too.

Money scripts can also be generational (Klontz and Klontz 2009). Depending on when and where an individual grew up, these factors can play into forming unconscious beliefs about life and money. An individual who grew up during the Great Depression may think much differently about the importance of keeping stock of food and housing supplies on hand. This concept may make no sense to a younger individual who has never lived in a world of true shortage. There is no way to determine which person is right or wrong. Both will be right or wrong in different situations, because money scripts are contextual (Klontz and Klontz 2009).

Money scripts can also be changed. It certainly does not mean that changing a money script is an easy process. It may take many hours of concentrated therapy with a professional therapist and considerable time in personal reflection, but by being willing to change and identifying the misconceptions one holds around money, individuals can begin to get themselves on a healthier path financially. As part of the warm-up phase, EFT utilizes techniques to help clients identify their money scripts. These techniques can include Money Scripts Brainstorming (Klontz et al. 2008b), the Money Atom (Klontz et al. 2008b; Klontz and Klontz 2009), the Money Egg (Klontz et al. 2008b; Klontz and Klontz 2009), Financial Family Tree (Klontz and Klontz 2009), What Do You Believe sentence completion (Klontz et al. 2008b), or the Klontz-Money Script Inventory (KMSI) (Klontz et al. 2011; Klontz and Britt 2012b). Several of these interventions are described more fully in Chapter 3.

Case Study

Background Information

Diane is a 65-year-old, divorced Caucasian female, born into an ultra-wealthy family. She has a doctorate in literary arts and works as an unpaid professor at a prestigious university. Diane's now deceased father made a fortune in the

entertainment business and became a philanthropist, a part of the diplomatic corps, serving until his death as a confidante and advisor to several US presidents. He was the founder of a number of significant national and international cultural institutions. Diane's mother was her father's second wife. Diane is the youngest of 12 children, all of whom were primarily raised by their nannies and were not permitted to eat with their parents until age 8. They all attended private schools and hold advanced degrees. However, none are employed and all currently live off the trust funds set up by their father. Diane's father set up a multimillion-dollar family foundation. They meet twice a year for a couple of days. The children did not get along before father died, and now they have to be with each other if they want any of their "causes" to be allocated any monies. Diane is an intelligent, compassionate, considerate, and generous soul who is a recovering alcoholic and drug addict, currently being treated for depression with medication. She was self-referred for financial therapy. While she has worked with a number of therapists over the years, she has never done any work related to her relationship with money.

Presenting Issue

Diane was told by her family office representative that she needed to reduce spending by about 50% to avoid the risk of running out of money. She accepted that analysis and reported that she was spending too much money and needed help. When she came for therapy, Diane was feeling a significant amount of anxiety and fear about running out of money. She also reported feeling socially isolated. Her income and expense statement supported the concern that she was spending about twice as much as she was earning. Her expenditures exceeded US$8.5 million per year while her income had been holding steady at US$4.2 million per year for the past several years.

Case Conceptualization

In looking over Diane's expenditures, nearly half was being spent on children, friends, employees, and acquaintances in ways that subsidized their lifestyles. As such, she was engaging in financial enabling and overspending. She appeared to be using money as a way of connecting with people who had far less and thus being important in their lives. In terms of totally supporting her adult children's lifestyle, she seemed to be trying to make up for her sense that she had not appropriately parented them when they were younger, and that she was very emotionally enmeshed with them.

Intervention

The initial intervention tool was to go over with Diane, item by item, how much she was spending. Working in collaboration with an independent financial planner, her spending was broken into monthly averages. Throughout the process, Diane kept saying, “I can’t believe these numbers,” and then would check with her advisors, come back to the table, and say, “well, I guess so.” She asked for recommendations regarding areas she could cut, so a 50 % reduction in each item line was suggested and the therapist listened to her arguments about why she could or could not make the cut. Diane ran into a lot of powerful emotions as she thought through each line item.

Each of the expenditures was written down on a separate index card and Diane was asked to prioritize each item. Again, she ran into a lot of emotions as she talked about some of the items and it was obvious that more intensive therapy was going to be needed to help Diane come to terms with her situation and make sustainable changes. As such, the therapist recommended that Diane attend an intensive 5.5-day financial experiential therapy workshop to address the emotional side of her money issues that were keeping her stuck in her self-destructive spending pattern. At the workshop, Diane participated in a number of exercises including some that helped her look back at the history of her relationship with money (The Money Egg), and what money scripts were generated by those experiences, for example, money scripts regarding how money works, how it relates to her, her relationship with it, her responsibilities, how she feels about herself as a person, and money’s intersection with her relationships with family and friends. One of the more powerful memories Diane recalled was her dad telling her “Women should not worry about making money, but to make sure that they did good things with it.” The EFT group therapy experience gave her an opportunity to look at some of those most powerful moments in her history with money, things that she did not have the chance to say, and feelings that she did not have the chance to process as a child. She was, in role-playing exercises, able to make amends to her children for the neglect she is certain they felt as a result of their being raised by nannies, as she had been. Diane left the program reporting that she felt a lot of relief and with plans to make amends to her children and let them know that, over time, she would be reducing the amount of support she would be giving them. She was also going to focus on being a better mom, by becoming a better listener. She left the program with a renewed commitment to live within her means.

Treatment entailed a 3-day initial intervention followed by 16 weekly phone calls leading up to her attending the 5.5-day EFT workshop. This was followed by once per month check-in calls, where each line item in her budget was reviewed and she reported on what she has done or is ready (or not) to bring to the table to look at. Meetings are ongoing, including in-person, day-long visits once every 3 months.

Outcomes

Diane has been able to reduce her spending by approximately US$300,000 per month. She has several actions pending, such as selling her share of a private jet service and selling her primary residence (two things that she said, initially, that she just could not even consider doing). She has made a number of trips in the coach section of planes (she had never done that before) and has resigned from several nonprofit boards, all of which required travel and related costs at her own expense and expected major donations from their board members. She has informed her children that they will continue to receive support, but over time, the amount will gradually be decreased until they are entirely self-supporting. She has reduced a number of personal services, such as personal trainers coming to her home, eating out, purchasing a custom wardrobe, consolidating art collections which had large storage fees, and reducing a number of other significant costs.

If Diane can keep the vision of needing to reduce her spending by about half of what it was when therapy started, she will be financially solvent and will not run out of money. A complicating factor is that, from time to time, her family office representative will tell her, for example, that her investments produced US$ 800,000 last month (US$ 400,000/month is her spending goal). When that happens, she suddenly cancels financial therapy appointments because it seems that the pressure is off. Unless she continues to stop "mothering" her children as if they are 8 years old, she will remain emotionally enmeshed and will not be able to maintain financial boundaries and her commitment to help them become self-sufficient.

Some of the important differences that exist within group therapy include: (a) less control over the content and direction of a therapy session, (b) increased potential for adverse experiences, (c) increased potential for stress that might come from confrontation or criticism from other group members, and (d) the possibility of a client growing dependent on the group (Koocher and Keith-Spiegel 1998).

Ethical Considerations

While research on experiential therapy has shown many potential applications across a wide range of disorders (Greenberg et al. 1994), the powerful nature of the approach also carries important ethical considerations. EFT in a group setting only heightens these ethical concerns. Some key areas of consideration include differences between group psychotherapy and individual psychotherapy, therapist competence in the use of experiential techniques, leader power issues, and aftercare (Klontz 2004). Many of the factors which make group therapy such a powerful tool are the same ones that make group therapy a high ethical risk (Lakin 1994).

Previous surveys have shown that many therapists are dissatisfied with the ethical standards that exist for group psychotherapy (Roback et al. 1992). Some of the important differences that exist within group therapy include: (a) less control over the content and direction of a therapy session, (b) increased potential for adverse experiences, (c) increased potential for stress that might come from confrontation or criticism from other group members, and (d) the possibility of a client growing dependent on the group (Koocher and Keith-Spiegel 1998).

Given the reduced control a therapist has in a group setting, the therapist must constantly evaluate the trade-off between group interest and individual interest when conducting a group session (Moreno 1991). In doing so, the therapist will need to regulate the pace and intensity of the conversation, which can be difficult during emotionally charged conversations (Glass 1998). Confidentiality is another area which needs to be addressed with group members. Because nonprofessionals within the group will be held to lower standards of confidentiality, the American Psychological Association's (APA's) Ethical Standard 10.03 advises therapists to "describe at the onset the roles and responsibilities of all parties and the limitations of confidentiality" (p. 1072). Association for Specialists in Group Work (ASGW) Best Practices Guideline A.7.d also advises the clinician to explain that unless a specific state statute indicates otherwise, legal privilege will not apply to the group discussions (Rapin and Keel 1998). Lakin (1994) also pointed out that social pressure can encourage individuals to conform and accept outcomes, which would have been rejected outside of the group. While this social pressure can be beneficial, it can also cause harm and therapists should watch out for this (Klontz 2004).

Therapists must also be conscious of their own qualifications to use experiential techniques. APA's Ethical Standards 2.01 and 2.06 require that therapists only provide services within their areas of competency. The ASGW recommends that therapists acquire at least an additional 60 h of supervised specialty training in addition to 20 h of core training prior to independently practicing group therapy (Wilson et al. 2000). Some researchers have recommended that psychodrama should be used very carefully when working with severely disturbed populations, if it is used at all (Corey 1990). The therapist's competence is essential in making a judgment call of when a particular type of therapy is appropriate (Klontz 2004).

Power issues are another important consideration for therapists. Clients should never feel forced or coerced into participating if they are not comfortable. Greenberg et al. (1994) identified therapist intrusiveness or pressure as one of the biggest factors which could hinder effectiveness of experiential techniques. Therapists also should not use psychodrama to fill egotistical needs or rush clients due to the therapist's impatience (Corey 1990). A clinician should respect a client's natural movements both toward and away from growth. A therapist should also encourage this same type of attitude for the group as a whole. One way therapists can help prevent unintentional coercion is to give group members as much freedom as feasible when setting up an exercise, while still providing the appropriate guidance (Klontz 2004). It is also essential for a therapist to have a clear understanding of their own psychological issues, so that they can be careful not to push a client in the event that the therapist begins to react to an experiential exercise (Klontz 2004). This relates to the APA's Ethical Standard 2.06 (a) which states, "Psychologists refrain from initiating

an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner" (p. 5).

Aftercare is another ethical area which should be given consideration. Clients may have divulged a lot of information and gone through intense cathartic work. This could leave them feeling open and vulnerable. While a group environment may be a supportive and loving place, it may be beneficial for a therapist to help clients mentally prepare to transition back into environments outside of group therapy (Klontz 2004). It is often recommended that therapists suggest clients consider limiting how openly they discuss their group experience with people outside of the group. Corey and Corey (2002) also suggested clients should be encouraged to refrain from saying everything to another individual that they might have expressed during role-play. The group can assist members in still expressing what needs to be said, but doing it in a way that is most likely to be successful (Klontz 2004). It may also be beneficial for the therapist to suggest some ways in which people that enjoy the feelings of support and care can encounter those same feelings in their life outside of the group (Klontz 2004).

It is ill-advised for a non-mental health-trained financial therapist to perform psychotherapy for money disorders and/or attempt to help clients resolve unfinished emotional business related to past relationships and events. However, financial planners could use experiential teaching methods with clients, as well as the money script exercises described above.

Future Directions

Experiential Financial Therapy (EFT) is one of the few financial therapy approaches with empirical evidence supporting its effectiveness. Even so, much more research on this financial therapy modality is needed. Ideally, future research will include randomized clinical trials with treatment and control groups. Additionally, it would be beneficial to conduct dismantling studies to examine the effectiveness of specific EFT techniques to determine their utility. For example, it would be beneficial to examine if outcomes differ if EFT is delivered in long-term weekly hourly sessions versus short-term intensive programs and the therapeutic utility of specific interventions (e.g., money script exercises). EFT would also benefit from efforts to adapt group therapy interventions to individual therapy applications. It is not always feasible to offer group therapy. Examining the effectiveness of the individual techniques outlined in this chapter is warranted to guide financial therapists' work with EFT. In the meantime, readers can utilize the approach described in this chapter to impact client behavior, which has been shown to be associated with client reports of positive, lasting effects across psychological and financial domains.

> Experiential financial therapy (EFT) is one of the few financial therapy approaches with empirical evidence supporting its effectiveness.

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Chapter 8
Solution-Focused Financial Therapy

Kristy L. Archuleta, John E. Grable and Emily Burr

Introduction

Traditionally, financial therapists begin the process of discovery and analysis by focusing on their client's past behavior. Nearly always, this involves digging into previous negative behaviors that have, in turn, led to the current issues, questions, and concerns facing the client. Through either training or preference, financial therapists have tended to place primary attention on a client's history and how the client developed financial problems and negative behavior rather than promote and build on a client's positive characteristics to develop solutions to financial issues. Recently, researchers have started to question the assumption that the central mechanism to help financially troubled clients begins with a review of negative past behavior. The notion that solution-focused therapy (SFT)—an evidenced-based therapeutic technique—can be applied within the personal finance domain as an alternative to current planning and counseling methodologies is the focus of this chapter.

Solution Focused Therapy helps clients to focus on future goals.

SFT is a theoretically informed approach traditionally used by mental health practitioners to help clients appreciate and utilize their personal, interpersonal, and en-

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vironmental skills, strengths, and assets to focus on future-oriented goals and tasks (de Shazer et al. 2007). The ultimate goal of SFT is to resolve a client's presenting condition by helping the client think or do something different to increase life satisfaction (Nichols & Schwartz 2001). SFT techniques are known to be adaptable to different presenting issues and situations within traditional psychotherapy domains (Lethem 2002). Given the historical use of SFT, and the clinical evidence regarding the method's effectiveness, it seems reasonable to hypothesize that SFT might be an effective tool for practitioners who are helping their clients work through money confusions, maladies, and opportunities. The solution-focused financial therapy (SFFT) model was developed by integrating SFT principles and techniques and general financial counseling practices (e.g., expense tracking, developing a budget). This chapter describes the history of SFT, the core principles, assumptions, and techniques associated with SFT, how the model was created, and how SFFT can be applied to a financial therapy case situation.

> Solution Focused Therapy is a theoretically informed approach traditionally used by mental health practitioners to help clients appreciate and utilize their personal, interpersonal, and environmental skills, strengths, and assets to focus on future oriented goals and tasks (de Shazer et al. 2007).

SFT: A Brief Review

Historical Background

SFT has been described as a therapeutic approach that helps clients work towards their ideal future by building on their strengths and resources (Lethem 2002). It is a brief, future-oriented therapeutic approach that focuses on openness, collaboration, goals, strengths, positivity, and solutions (de Shazer et al. 2007). SFT was developed in the mid-1980s by Insoo Kim Berg, Steve de Shazer, and colleagues at the Brief Family Therapy Center in Milwaukee, WI (Nichols 2010). de Shazer's work stemmed from Bateson's research on communication and Milton Erickson's "pragmatic ideas about how to influence change" (Nichols 2010, p. 320). Erickson believed every person had the ability and strengths to make change, but they need guidance in being reminded of that fact (Cade 2007; O'Hanlon and Weiner-Davis 1989). SFT was developed as a family systems theoretical approach, which takes into account not just the individual (i.e., subsystem of a larger system) but also the influences of larger systems like family, friends, community, and the environment. In short, the family systems theory assumes the sum is greater than its parts. Stated from a family systems perspective, it is important to look at all of the influencing aspects of the system rather than only at the individual system.

> Solution focused therapy has been used in a variety of fields, including marriage and family therapy, business, social work, policy evaluation, education, health care, criminal justice, child welfare, domestic violence, to name just a few.

Since its development, SFT has been used in a variety of fields, including business, social work, policy evaluation, education, health care, criminal justice, child welfare, domestic violence, medicine, and substance abuse, to name just a few. According to Murray and Murray (2004), an "important benefit of adopting a solution oriented approach is that the theory is adaptable to diverse populations" (p. 356). For example, solution-focused premarital counseling allows a couple to be the specialist in their own lives. The method allows the counselor to create a space and a framework where the couple's background and culture can be at the forefront of premarital discussions (Murray and Murray 2004).

> SFT has been shown to create positive outcomes in a shorter period of time and create autonomy in clients as compared with other therapeutic approaches (Bannick 2007).

SFT has been shown to create positive outcomes in a shorter period of time and create autonomy in clients as compared with other therapeutic approaches (Bannink 2007). Gingerich and Eisengart (2000) reported their outcome review for SFT research. They reported positive support for its use. More recently, Corcoran and Pillai (2009) analyzed experimental and quasi-experimental studies, comparing SFT with alternative treatments or no treatment for a number of presenting issues (e.g., parent–child conflict, marital problems, crisis hotline callers, and teens with school problems). In 50% of the studies included in Corcoran and Pillai's review, SFT was found to show improvement over the alternative treatments or no-treatment groups. Additionally, Corcoran and Pillai stated that SFT is cost-effective because the services can be provided in a short time frame. They concluded that although SFT appeared to be equivocal, additional research with diverse groups needs to be conducted to establish its effectiveness.

Assumptions and Principles

SFT ascribes to a practical set of assumptions and principles, making its applicability to diverse settings both adaptable and reasonable. de Shazer et al. (2007) defined the major assumptions of SFT as believing:

a. “If it’s not broken, don’t fix it” (p. 1)
b. “If it works, do more of it” (p. 2)
c. “If it’s not working, do something different” (p. 2)
d. “Small steps can lead to big changes” (p. 2)
e. “No problems happen all the time; there are always exceptions that can be utilized” (p. 3)

The SFT approach focuses on clients’ strengths and assumes that clients want to make change and possess the ability to change.

The SFT approach focuses on clients’ strengths and assumes that clients want to make change and possess the ability to change. SFT is not interested in how a particular “problem” came to be, but rather in developing solutions that work to deal with the outcomes associated with a problem. One way solution-focused therapists help clients develop effective solutions is by looking for, and helping clients search for, solutions that have worked in the past when similar problems have arisen. This is a fundamental difference between typical financial counseling and planning methodologies. Essentially, the SFT approach asks clients to search their history not for problem examples, but rather examples of how past problems were dealt with. When patterns of success are uncovered, these “solutions” are explored in greater detail. When clients are doing well, SFT assumes that what clients have done or are doing will continue to work into the future. The therapeutic recommendation is for the client to continue doing more of the same. In other words, when clients are behaving or thinking in a way that is productive and positive, then clients should utilize the strengths associated with these attitudes and behaviors by doing more of those things that are working well.

Change is difficult. Because change is hard, SFT encourages clients to go slow and make small changes. When clients are encouraged to make small changes, the likelihood that those changes will be implemented increases. When clients see that the changes they are making are also working, the working assumption, with SFT, is that clients will be encouraged to make more small changes, which, collectively and over time, will result in larger and more substantial changes. In addition, when clients see small changes working, they may be inclined to implement further changes in the future.

Sometimes, clients are not able to make meaningful progress towards their goals. A lack of progress may be due to unproductive thoughts, behaviors, or emotions that lead to poor outcomes. Sometimes, lack of progress is due to resource availability. A key assumption within SFT is that if clients fail to alter their behavior they will continue to obtain the same result. Simply increasing access to or use of resources, for example, will only temporarily change a client’s situation. SFT is designed to create long-term behavioral change that is not linked directly to the acquisition of new resources as the primary determinant of later goal achievement. SFT therapists spend

a great deal of time helping clients self-reflect and evaluate the behaviors that are standing in the way of behavior change and goal achievement. Clients are continually asked to look for alternatives to current behavior and to implement techniques that lead to objective completion. Oftentimes, clients get caught in a rut of focusing on a problem. In fact, traditional financial counseling and planning data gathering and analysis techniques promote this type of thinking. The result is that many clients have difficulty recognizing alternatives. SFT assumes that problems do not happen all of the time. Every client has moments of satisfaction and peace. Within the context of SFT, clients are encouraged to seek out times in their life when a particular problem was not present. When clients recognize a time when a problem has not occurred, clients can then identify what they were doing differently at that time or moment and how the environment around them was also different. Once these differences have been identified, clients can work to recreate the experience.

This concept is deceptively simple. It is quite easy for clients to think of times in the past when they faced a problem. A typical management technique asks clients to make a list of their strengths, weakness, opportunities, and threats. This is called a SWOT analysis. The typical SWOT analysis results in a very long list of weaknesses and threats. Getting clients to think of past positive behaviors and situations and opportunities for the future is more difficult. SFT encourages clients to focus intently on good things that happened in the past and then to locate, via memory and discussion, what was happening at the time that made the situation positive. For example, a client who is experiencing a lack of food in the household might recall a time, say 5 or 10 years previously, when a similar situation occurred. The positive aspect from this memory is that the client was able to surmount the obstacle. The client may have volunteered at a food bank and learned that their situation was not as bad as that faced by others in the community. Additionally, they may have gained access to additional resources that helped meet their own shortages. Reflecting on the past, the client is able to identify strategies that they could employ again to overcome the current challenge. SFT helps the client grasp the fundamental truth that they do have skills, abilities, and talents that have served them well in the past. Focusing on replicating the positive, rather than dwelling on the negatives, helps many clients move forward towards goal achievement.

Techniques and Interventions

The key techniques associated with SFT include: (a) recognizing and affirming pre-session change, (b) discussing past attempts, (c) asking the miracle question, (d) developing goals, (e) asking scaling questions, (f) complimenting clients, (h) taking a curious, unassuming stance as the therapist, and (i) developing a collaborative therapeutic relationship. Many times just the step of making the first appointment can help create change for the client; this is referred to as pre-session change (de Shazer et al. 2007). At the beginning of the initial session, the client is asked about any changes, including small changes that have occurred since mak-

ing the appointment. Identifying pre-session change, even if the change seems to be minor, can lead to increasing the client's belief that change can happen (Lethem 2002). Past attempts to solve or change the problem are also discussed early on in the therapy process. It is important for the therapist to understand what the client has tried, what has worked in the past, and what has not worked. Then, the small things that have worked can be expanded upon to help create solutions (de Shazer et al. 2007). This is a collaborative process driven by the client. In other words, the SFT therapist is tasked with encouraging the client to do more of what works; however, the actual choice of what works is generally client driven.

A client's response to the miracle question can help lead to the development of short-, intermediate-, and long-term goals.

The Miracle Question As part of SFT techniques, therapists avoid using directive or interpretative communication and opt for using questions as the primary source of communication (de Shazer et al. 2007). It would be very unusual for an SFT therapist to make a checklist of things to do or for the therapist to describe a particular course of action. Instead, the therapist focuses efforts of questioning, interpretation, encouragement, and providing information about resources that the client may not understand. At the heart of SFT is one influential procedure: the miracle question. This question is designed to help a client paint a picture of what life would be like if an unexpected "miracle" happened during the night that solved all of the client's problems. The miracle question leads to follow-up questions that help the client and therapist understand what differences the miracle would make in the client's life. Additionally, answers to the miracle question provide a guide to how important people (e.g., parents, friends, significant others, children) in the client's life would notice changes in the client (Thomas and Nelson 2007).

A client's response to the miracle question can help lead to the development of short-, intermediate-, and long-term goals. Within SFT, goals must be important to the client. This simply means that goals must be shaped in such a manner that the client is continually focused on the changes he or she wants to make now and in the future. Client goals should be "concrete, achievable, and measurable" (Thomas and Nelson 2007, p. 18). By continually refocusing on client goals, rather than past or current problems, clients can maintain a higher degree of motivation. Quite simply, rather than focusing on problems that seem insurmountable, clients who use SFT principles seem to exhibit a higher level of motivation to achieve goals.

Scaling Questions The use of scaling questions is one of the most popular SFT techniques because it can be used in a variety of ways. A scaling question is an approach used to establish the relevancy of goals and to gauge progress towards goals through the client's eyes or from the client's perspective (Thomas and Nelson 2007). For example, a client may be asked, "On a scale from 0 to 10, where 0 is that you are not managing your money at all and 10 being that you are managing

your money very well, how would you rate the job you are doing managing your money?" In general, these types of queries help clients and therapists to visualize the client's progression towards one or multiple goals (Thomas and Nelson 2007). Scaling questions can also be used as follow-up inquiry to the miracle question. For example, a therapist may ask "On a scale from 0 to 10, where 0 indicates the anxiety you were feeling when you made the first appointment to meet with me and 10 indicates how you will feel if the miracle occurred, how would you rate your anxiety right now?" When these questions are used, the scale typically ranges from 0 to 10, with higher numbers indicating more success in the area being scaled. Some therapists prefer to use a scale that ranges from 1 to 10. In the end, the choice is a therapist's preference.

Scaling is a beneficial way to track progress towards goals where an increase in numbering should be highlighted and explored as to what brought upon the improvement (Lethem 2002). When a client responds with a lower number on the scale, regression should also be explored; however, it is very important to keep in mind the client's positive attributes. For instance, a therapist may ask a client how they would rate their progress in terms of developing a budget, using a scale from 0 to 10 where 0 indicates that the client is not working on a budget and 10 indicates the client has developed a budget and is successfully using it. In a previous meeting, the client may have reported budget use as 5, but during the next meeting the client may report 3. This gives the therapist an opportunity to help the client discover why the client has regressed. One way to do this is to ask questions like, "Why did you move down on the scale?" or "What kept you from moving up on the scale this week?" Caution should be used when exploring regression. The way these two example questions have been framed may highlight past negative behaviors and attitudes, which runs counter to a solution-focused approach. Clinical studies have shown that asking the following type of question is both effective and solution oriented: "If you are a 3 on the scale, what kept you from being, say, 1 or 2 on the scale?" If clients report the lowest number on a scale, like 0 or 1, then focus should be turned to what the client can do to make slight movement up on the scale. An example question could be, "What could you do to move up a half a point on the scale?" Rather than turning the client's attention to negative events, these types of questions force the client to acknowledge that their situation could be worse or to utilize their strengths to make a little progress. Additionally, the client's answer, by definition, will include positive aspects of behavior. It is this very behavior that holds the promise of a "solution."

Complimenting Clients Compliments can and should be used when highlighting client progress. A compliment can also be used to provide encouragement when a client faces a difficult task or assignment. Compliments should be meaningful, appropriate to the situation, and sincere and can be used at any stage of therapy. It is important to conceptualize a compliment within SFT. A therapist would not necessarily say, "You have nice shoes." Instead, the therapist might say, "Wow! It is pretty incredible that you were able to complete a big task at work even though you were feeling very anxious." This gives the therapist a chance to further explore,

with the client, how the task was completed while feeling anxious and exactly what the client was doing differently that helped them achieve a particular task.

> Compliments should be meaningful, appropriate to the situation, and sincere and can be used at any stage of therapy.

Compliments can also be used when clients appear to regress. If a client who responds they are at a 3 on the scale rather than a 5, the therapist can explore how the client managed to keep from being a 1 or a 2 on the scale. That is, the therapist should attempt to reframe a defeat into a positive takeaway. One way to do this is to compliment a client for basically "hanging in there" in the face of adversity. Once the client notices ways they have refrained from being a 1 on the scale, the therapist can compliment the client on the skills and abilities that kept them from being even lower on the scale. Compliments should always "help to punctuate what the client is doing that is working" (de Shazer et al. 2007, p. 5).

Curiosity An important aspect of SFT is the curious, unassuming, and collaborative stance the therapist takes with a client. Curiosity of the therapist helps show they are interested in learning more about the client (Thomas and Nelson 2007). The unassuming therapist does not judge nor try to hypothesize about underlying issues or what could be happening with the client (de Shazer et al. 2007). This stance helps to create an atmosphere of genuine interest in the client, as well as positivity and support with compliments and encouragement. The notion that "getting people to talk positively will help them think positively and ultimately to act positively" is part of the role a counselor plays with a client (Nichols 2010, p. 323).

It is worth noting that for many financial therapists the notion of honest curiosity is the most difficult aspect of SFT. Nearly all financial service professionals have been trained to gather relevant client data, analyze the data, and create recommendations that can be implemented. This methodology assumes that the adviser, more often than not, knows the solution to any given problem or question. Those who follow an SFT approach dismiss the idea that the financial therapist always (or almost always) knows the correct path for a client. Of course, the adviser may have ideas or product solutions in mind for a client, but within an SFT framework these become suggestions rather than recommendations. Curiosity instead allows clients to formulate solutions that are unique and proven to work for a particular client. Often, the client and adviser arrive at a similar solution; however, the likelihood of client implementation is enhanced because the solution is almost always perceived as being originated by the client. Clients are more likely to implement a solution when it is their idea.

> Clients are more likely to implement a solution when it is their idea.

Collaboration A solution-focused financial therapist must be collaborative, refrain from explicitly being the expert, and utilize a client-centered approach. This requires that the financial therapist believe the client is an expert in and on his or her own life, attitudes, and behaviors. The financial therapist serves as a guide, rather than a person whose job it is to tell the client what should be done (de Shazer et al. 2007). Although the solution-focused approach does view the client as the expert, education and tools that can benefit the client are *never* withheld when needed. The client-centered approach helps the financial therapist adapt to the client's individual situation, wants, and needs rather than utilizing a "one size fits all" plan or product approach (Nichols 2010). Tuning into the client's needs and wants allows the financial therapist to listen and understand the client's problem and then move towards working on solutions together. Part of being able to "tune into" the client involves actively listening and understanding the client's unique voice as a mechanism to facilitate building a strong client–therapist relationship. This aspect of SFT is often referred to as "joining" in the mental health fields.

Applying SFT to Financial Therapy

The adaptability of SFT within the context of financial therapy was tested by a team of researchers at Kansas State University (KSU). This team developed an approach called SFFT that integrates SFT principles and techniques and financial counseling techniques (Archuleta et al. 2013a). A manual, *Solution Focused Financial Therapy (SFFT) Training Manual* (Archuleta et al. 2013b), was developed to train practitioners in the approach and provide consistency of implementation of SFFT techniques. The manual was based on the *Solution Focused Therapy Treatment Manual for Working with Individuals* (Trepper et al. 2010). The manual approach was designed to be implemented by a practitioner over the course of three phases, with the entire process consisting of 3–5 sessions, depending on the client's situation. The approach, as outlined in the manual, allows for time and flexibility based on the needs of individual clients.

On average, clients reported that their clinical distress and depressive symptoms decreased, while their financial well-being, financial behaviors, and financial knowledge improved.

Eight college students, ranging in ages from 18 to 34 years, volunteered to participate as clients in a clinic-based study. Clients were engaged in the process for 3–5 sessions, depending on the client's needs. Presenting problems ranged from wanting to learn more about investments to finding enough money to pay bills. Clients were given a pretest, a posttest at the end of the final session, and a follow-up evaluation after 3 months. On average, clients reported that their clinical distress

and depressive symptoms decreased, while their financial well-being, financial behaviors, and financial knowledge improved. Because of the small sample size used in the pilot study, statistical significance cannot be determined. More research is needed to validate the use of SFFT with diverse samples (Archuleta et al. 2013a). The following discussion provides an outline of the SFFT approach.

Phase One

The first phase of SFFT encompasses the client engagement meeting (first session), which is used to build rapport with the client, establish goals, identify possible solutions, and encourage client identification of personal strengths. During this phase, SFT techniques include: (a) joining, (b) discussing historical accounts of solutions, (c) defining pre-session change, (d) use of the miracle question, (f) scaling, (g) goal setting, and (h) complimenting. Joining is another term for building a trusting relationship with client. Joining can take many forms (i), but often the process of joining begins with the practitioner learning about the client and what has prompted the client's help-seeking behavior. The practitioner usually begins the session by introducing himself/herself by stating, "Thank you for coming in today. You don't know me, so I appreciate you seeing me today." Here, the practitioner often introduces the use of observation (if applicable) to the client. Other questions that may be asked to facilitate joining include, "What brings you in today?" "What do you hope to accomplish in our meeting today?" and "What should I know about you that will be useful in our work together?" Another useful question that can be asked is "So, how will we know if today's meeting is a successful one?" Joining is an ongoing and continuing task throughout the session as the practitioner continues with a curious stance, described earlier, and using reflective listening skills.

Once the process of joining has been started, the practitioner can move towards assessing historical accounts of solutions, in which past attempts to solve similar situations are reviewed. The practitioner may ask, "Is there anything that you have done in the past that might be useful for you now?" Other questions that can be used include, "Have you experienced a similar problem in the past?" and "Is there anything else I need to know that has been helpful to you in the past so that I can best help you now?" These questions allow the client to reflect on how they can use past solutions to remedy the current problem or issue without focusing too intently on the problem itself.

Pre-session change refers to the behavioral or cognitive changes that clients often experience as a result of making the first appointment. Pre-session changes can include slight differences in which clients manage or perceive their circumstances before financial therapy begins. A practitioner may simply ask, "What changes have you noticed since you first called to make an appointment?" The SFFT manual suggests asking a scaling question as a follow-up, such as "If 0 represents where you were when you made the first appointment and 10 represents the successful completion of our work, where would you say you are now?" The scaling question should

then be followed by "What number would mean that you have met your goals?" and "Why are you a (insert client's number) on the scale rather than a (identify a number below the client's stated number)?" Again, the practitioner's role is to urge the client to think about what they have already done to create change by further encouraging the client to continue to make more similar changes as a way to reach the client's goals.

The miracle question is the hallmark of SFT techniques. The miracle question offers a way to help clients formulate goals. The question helps prevent the client from being bogged down by a particular problem or set of problems and instead asks the client to imagine what life would be like without the challenge. The miracle question can be difficult or awkward for solution-focused newcomers. Stith et al. (2012) provide best practices to implement the miracle question. In SFFT, the practitioner will set up the question scenario by using the following description or some variation of this description, which was adapted from de Shazer et al. (2007):

> Let's suppose that after we talk here today you leave and you go do whatever you usually do on a day like this. Then as the day goes by you continue doing whatever you usually do. Then you come home, you have dinner, perhaps watch TV, and do whatever else you would normally do as the evening goes on. Then it gets late, you get tired, and you get into bed. You are comfortable and you eventually drift off to sleep. I don't know if you notice or not, but you've fallen asleep and you are sleeping well. You are not too warm or too cool. In the middle of the night you feel at peace. Somehow something deep inside you shifts a bit. I'm not sure if it is wisdom or confidence, or what, but something shifts. A miracle has happened. It is not just any miracle. It's a miracle that changes your financial behavior or attitude that brought you here today go away…just like that. But since the miracle happens while you are sleeping you won't know it happened. [Pause] So, you wake up in the morning. During the night a miracle happened. The problems that brought you here are gone, just like that. You eventually wake up. You are refreshed. You get out of bed and start your routine.

Once the miracle situation is described, the practitioner should then ask: "How will you know that the miracle occurred?" Answers to the miracle question should be framed to move away from *content* (e.g., I had no bills to pay) to *process* or dynamics related to the financial issue(s) (e.g., emotions, thinking, relationships, such as: "I would think about purchases before I make them" or "I would feel relieved"). The practitioner's role is to encourage clients to be as specific as possible in their descriptions by asking questions like "What would if look like if you thought about purchases before you made them?" or "What else would you notice is different?" Answers to the miracle question often point to exact and meaningful solutions that a client can implement to help address their financial concerns immediately. Potential follow-up questions include the following:

- What is the very first thing you notice after you wake up?
- What would you be doing differently with your money?
- How will you know that things are improving?
- How do you discover that things are different?
- What would your family notice about you that was different?
- How do other people in your life notice that something was different about you?
- What other things would be different?

The miracle question can be difficult to ask for those who are new to SFFT. This difficulty arises because the practitioner must trust that the client will "go along with" the exercise. Additionally, to be effective, the practitioner must believe that the exercise will be useful. Interestingly, much of the clinical work suggests that clients, regardless of demographic background or presenting problem, are open to exploring solutions in this manner. Difficulties also sometimes arise because the question must be set up appropriately so that the client can picture a miracle actually occurring in his/her life. The question should not be asked too abruptly. Clients could find it quite odd to be talking about an issue and then be asked to answer the miracle question without an appropriate conversational transition.

When asking the question, timing is of crucial importance. The appropriate pacing is to ask the miracle question so that the session is not rushed (for more detail, see Stith et al. 2012). Stith et al. (2012) offered several useful tips on how to ask the miracle question appropriately. In addition to introducing the exercise at the appropriate time, they suggested (a) framing the miracle question so that the practitioner does not anticipate or prescribe the way the miracle could be or should be identified; (b) asking the question in a slow, deliberate, and dramatic manner; (c) asking follow-up questions; (d) avoiding problem solving if the client brings up a problem during the middle of the miracle question and instead making a note to revisit the issue after the client has finished addressing the miracle; and (e) making the miracle question interactional. The last suggestion refers to having a couple or family come up with a miracle together as way to unify the family, rather than focusing on individual miracles.

Phase One also involves the assignment of financial homework to the client. Financial homework is assigned to each client based on their situation. Examples include accessing credit reports, tracking expenses, and documenting feelings associated with shopping. The SFFT manual suggests asking clients to track expenses over the course of 4 weeks, beginning after the first session. The manual also recommends that clients begin to gather their financial information, starting with accessing their credit reports. The number of weeks between each appointment determines how much homework is reasonable to assign and how many times a particular exercise or assignment is assigned. For example, if client meetings are scheduled 2 weeks apart, then tracking expenses can be assigned at the first and second session so that expenses are tracked for a total of 4 weeks. Financial homework should be reasonable and doable. Assigning too much homework can be overwhelming for clients, and if too much is assigned, then clients are likely to give up. It is important for practitioners to remember that homework is a tool not a graded assignment.

A technique that traditional SFT therapists often employ is observation, where a third person (the observer) views the practitioner working with the client via a live video stream or behind a one-way mirror. Near the end of the session, the practitioner takes a break from the session to meet with the observer. This is, of course, fully disclosed to the client. The observer helps the practitioner look for client strengths as a means to identify ways to compliment the client. The role of the observer can be very important as the observer may notice patterns and dynamics that are not

easily recognized by the practitioner. This is not due to a lack of skill by the practitioner, but rather because the observer is not affected by the interpersonal dynamics in the client–practitioner relationship. SFFT encourages the use of an observer in which the observer is trained in the opposite field from the practitioner, allowing the professional to collaborate in a more holistic manner. Unfortunately, the use of an observer is not always possible. In these cases, alternative collaboration efforts may be implemented. For example, two professionals in opposite fields may meet together with the client. Another possibility is that the professional working with the client consults with a professional from the other field by discussing the case. Regardless of the approach, ethical standards should be followed.

Phase Two

Sessions two through four are similar in format where the counselor asks questions to elicit client's strengths and increase accountability. The purpose of these meetings is to help the client begin taking responsibility for making changes in his/her life, even if minor changes are made. Examples of questions asked during these sessions include:

- What is different about this week than last week?
- What did you do differently?
- How did you manage to do this?
- What would be the signs that you were doing more of the things that are good for you?

Scaling questions can and should also be used to assess commitment to change, confidence to change, and motivation to change. For example, the manual encourages practitioners to ask, "On a scale from 0 to 10, with 0 representing that you are not willing to do anything differently to resolve this situation and 10 being that you are willing do whatever it takes to sort things out, where do you see yourself right now?" A scaling question, such as this, can then be followed up with questions like:

- What number on the scale from 0 to 10 will let you know that you are willing to be committed to the change process?
- How will you know that you are willing to be committed to the change process?
- What about yourself or what will you be doing that indicates that you are committed to the change process?

Then, the financial therapist follows these questions with a review of previously assigned homework. Mandatory homework assignments for the second session include creating a net worth statement. This helps a client value their assets and identify their financial liabilities. For session three, the homework involves identifying income sources and evaluating all debts. Finally, homework for session four involves developing a budget. Of course, these homework assignments are designed for situations in which the presenting problem is remedial in nature. Clients who

present with what would be considered traditional financial planning questions and concerns should be given different homework assignments. For example, someone who is concerned that they are not saving enough for retirement may be asked to obtain information about their retirement plan from current and past employers.

Phase Three

The goal of the third phase is termination or the conclusion of treatment. Session five, or the final session (determined by the client and practitioner), includes: (a) reviewing the client's previously assigned homework; (b) evaluating previously established client goals by conducting scaling questions, in addition to complimenting the client for his/her achievements; and (c) focusing on the progress the client is making and recording what they learned about themselves throughout the process. In addition, the manual encourages practitioners to ask questions to help clients develop a maintenance plan and identify potential setbacks in the future and brainstorm ways to deal with those setbacks.

To implement the SFFT approach, a practitioner should have a strong working knowledge of personal finance topics, tools, techniques, and SFT. The practitioner's financial training will impact the type of financial situation that is best treated with SFFT. For example, a practitioner with a financial counseling background will likely be prepared to work with issues, such as bankruptcy, budgeting, and debt repayment. A practitioner with a financial planning background should be prepared to deal with more complex situations, including portfolio management issues, retirement and estate planning, and family asset transfer concerns. A mental health clinician may also implement this approach, assuming they have a fundamental background in personal finance and are equipped to work with broad financial issues, such as money management, money scripts, or conflicts over money. Due to the differences in skill sets, a practitioner may find it helpful to collaborate with a professional from the opposite field. In other words, a financial professional might find it helpful to collaborate with a mental health practitioner who is proficient in SFT. A mental health clinician may find it equally helpful to work with a financial practitioner who has in-depth expertise on financial topics.

Case Study

This section describes the basic use of the SFFT manual with a traditional financial planning presenting issue. The SFFT approach can also be used with multiple financial issues, whether in a traditional financial counseling, psychotherapy, or coaching setting.

Background Information

Terrance is a 44-year-old married man with two teenage children. Unlike some clients, Terrance's presenting problem is less of a crisis and more of an opportunity. Terrance was recently promoted to a junior vice-president position at the firm. Along with extra responsibilities, his pay was increased dramatically. This means that his wife can now quit her part-time job in order to spend more time with their children before and after school, which is the fulfillment of a long-term family goal.

Presenting Issue

For the first time in his life, Terrance has decided to seek the help of a financial professional. Terrance was skeptical of advisers in the traditional marketplace so he began to search the Internet for other financial help options. He ran across the website of the Financial Therapy Association and found a local provider and made an appointment. It just so happens that the practitioner uses the SFFT approach.

Case Conceptualization

Terrance has worked long hours for many years and his hard work has finally paid off with receiving a job promotion. Terrance's salary increase was more than enough to compensate for the loss of his wife's income when she quit her job. However, the family's expenses have also increased and Terrance has found himself having a difficult time beginning to save for retirement. In addition to retirement, he would like to build up enough in savings so that if he were to lose his job that he and his family would be able to pay their expenses for at least 6 months. He has found himself worrying about his and his wife's financial future; however, he is unsure what he should do about it. The following discussion highlights how the financial therapist and Terrance worked through his retirement questions, using the SFFT approach.

Intervention

The following transcript excerpt is between the SFFT practitioner and Terrance and showcases some of the interventions of SFFT. The case opens right after the financial therapist and Terrance meet and sit down together.

PRACTITIONER: It is so nice to meet you Terrance. Let's get started. We only have a short time together today, so I want to make our meeting as useful and enjoyable as possible. Tell me, when we finish working together how will we both know that today's meeting was useful?

TERRANCE: That is an easy one. I was recently promoted at work. I met with my benefits administrator at work to learn about my retirement options. You see, I finally am making enough money to start planning for retirement. If you can give me some ideas on how to start a retirement plan that would be huge outcome.

PRACTITIONER: Congratulations on your promotion! Your firm must really appreciate your service.

TERRANCE: Yes, I guess they do.

PRACTITIONER: Okay, so you would like to develop a retirement plan, correct?

TERRANCE: That is correct. I love my company. But, here is the problem. I am now making a bit more than $ 200,000 per year, but according to the benefits person I am not saving enough money to even start thinking about a retirement plan.

PRACTITIONER: So, let me make sure that I have this correct. With your promotion you are now making more money and you are still finding it hard to save enough for retirement. Is that about right?

TERRANCE: Exactly; what makes things worse is that a few years ago I was making just a fraction of my current income.

PRACTITIONER: About how much was that?

TERRANCE: It is a bit sad, but I was making about $ 45,000 five years ago.

PRACTITIONER: That is nothing to be sad about. You have more than quadrupled your income in five years. That says a lot about your skills, abilities, and willingness to work hard to make your dreams come true.

TERRANCE: I never thought about it that way. But even so, that doesn't help me get past the fact that I just don't have enough income to even start a retirement plan. I've got to tell you that I am getting kind of depressed about this issue. I am not sure how much more I can work and earn. If $ 200,000 isn't enough to get going on a retirement plan, I just don't know what to do. Maybe I should give up on planning for the future and just live for today.

PRACTITIONER: Help me better understand this issue. Can I ask you what may seem to be a strange question?

TERRANCE: Sure.

PRACTITIONER: Okay. Let's say that on a scale of 0–10, 0 means that developing a retirement plan is totally not important and 10 represents that developing a plan is extremely important to you. How would you score the importance of you and your wife developing a retirement plan?

TERRANCE: I would say about an 8.

PRACTITIONER: An 8! It sounds like developing a retirement plan is very important to you. Now I am going to ask you a follow up question. Why not a 7?

TERRANCE: My wife and I have about 20 years before retirement. If we don't start saving now, we will only have Social Security to live on, and quite frankly that scares me. If I put my score lower it would mean that I am avowing reality. Yes, 8 is about where I am right now.

PRACTITIONER: That really does help. Are you up for answering another strange question?

TERRANCE: I suppose.

At this point, the practitioner described the miracle question situation and asked Terrance to express the miracle that occurred overnight. In this case, Terrance's response was as follows: "The miracle is an easy one. My entire retirement plan would be magically funded and I would have no more worries."

Because it is common for clients to jump to an unrealistic answer like Terrance's response or say they would win the lottery, a practitioner can respond with silence and wait for clients to answer with a more realistic answer or state, "This is a difficult question, so please take your time responding" or "We can only deal with possibilities." Then, help the client focus on process rather than content. In this case, the practitioner responds with the latter statement.

PRACTITIONER: We can only deal with possibilities. As someone who deals with financial issues every day I can tell you that very few people win the lottery or wake up to find their pension fully funded.

TERRANCE: Well, you did ask for a miracle, right?

PRACTITIONER: I did and you said you would have no more worries. How would people who know you well realize that these worries were gone? What would you be doing differently?

TERRANCE: I'm not sure that people except for my wife would know that I had any worries.

PRACTITIONER: How would your wife know that your worries were gone?

TERRANCE: Well, I would probably be sleeping better at night and I would be less tense.

PRACTITIONER: Okay. How else would your wife know that your worries are gone?

TERRANCE: Hmmm. Well, I would probably not be as grumpy or short with her.

PRACTITIONER: Okay. So, if I understand you correctly, you would be getting more sleep, be less tense, and not be as grumpy towards your wife? [Terrance nodded his head to affirm the practitioner's reflection of what he said.] Can I ask you another scaling question?

TERRANCE: Sure.

PRACTITIONER: On a scale from 0 to 10, 0 being the miracle has not occurred and 10 being the miracle has been fulfilled, how much of the miracle has occurred for you?

TERRANCE: That is tough. I guess I would say a 1.

PRACTITIONER: A 1. Really? Why not a 0?

TERRANCE: Well, I have thought about a plan and I am here to get help with making a plan.

PRACTITIONER: Yes. That is true. Those are all good things that have helped you move towards your goal of developing a retirement plan. Now, what kinds of things do you need to do in order to move up one-half point or one point up on that same scale?

TERRANCE: Hmmm…Let me think. [Pause] Well, I guess we could save some money, at least a little. I would like to have enough extra savings that my wife and

I could start funding our retirement plan without sacrificing everything else in our lives.

PRACTITIONER: Okay. What other kinds of things could do to in order to move one-half point or one point up on the scale.

TERRANCE: I could open a savings account to begin an emergency fund. I think if we had a cushion then we could start contributing towards a retirement plan.

PRACTITIONER: Those are all good things that will help you move one-half point or one point up on the scale. Do you think that you could do one of those things between now and the next time we meet?

TERRANCE: Yes, I think I can do that. Opening a savings account would be something I can easily do.

PRACTITIONER: Great! So, you will open a savings account between now and the next time we meet. Now, let's think back to the scale again. What number on the scale would mean that you were in control of your situation?

TERRANCE: I would say an 8.

PRACTITIONER: Okay. Well, what would an 8 look like?

TERRANCE: I would love to go back to the benefits administrator and sit there comfortably and say that I can afford to put aside big dollars for retirement.

At this point, the first session came to an end with the practitioner assigning Terrance homework. One of the homework assignments included opening a savings account for an emergency fund, which was something that Terrance said that he would do between the first and second meetings. The practitioner may assign other homework as well. For example, Terrance might be asked to bring back to the second session specific financial details regarding his family's cash-flow situation and estimates of retirement savings requirements from the benefits administrator. The following narrative captures dialog that occurs during the second session.

PRACTITIONER: I have been wondering if you and your family have always had trouble saving money.

TERRANCE: No; that is the crazy thing about all of this. Do you remember the last time we met? Well, I told you I made about $45,000 per year. That got me thinking when I was driving home how we ever made ends meet back then.

PRACTITIONER: That is the same question I had. Five years was not really that long ago. Were you able to save money when you were making $ 45,000?

TERRANCE: As strange as it sound, yes, we were actually saving more money than now. That makes things today even more frustrating. Where is all the money going?

At this point, the practitioner and Terrance would likely review the cash-flow statement from the homework assignment. The practitioner would use his or her skills to point out that taxes and other withholdings have gone up, as would other expenses, including those associated with the new job. This exploratory exercise opens a unique SFFT opportunity, as illustrated below.

PRACTITIONER: Let's go back five years. You've already indicated that you were saving money, even though you were earning less. What were you doing back then that helped you save money?

TERRANCE: In some ways, that is an easy question to answer. Because we didn't have as much, we simply didn't spend as much.

PRACTITIONER: Can you be more specific?

TERRANCE: For example, we had basic cable television.

PRACTITIONER: What do you have now?

TERRANCE: When I got the promotion I upgraded my television to a 54-inch screen. We now how upgraded cable throughout the house.

Practitioner: That sounds fantastic. What does that cost per month?

TERRANCE: Oh, about $ 200 or so.

PRACTITIONER: This is a tough question to ask, and to answer, so take your time. Thinking back five years compared to today, would you say that you are more or less happy in terms of your television viewing.

TERRANCE: No doubt, today is much better.

PRACTITIONER: Are you $ 150 per month happier? By the way, that is $ 1800 per year.

TERRANCE: When you put it that way, I am not so sure.

PRACTITIONER: What else was different five years ago?

TERRANCE: Well, we certainly did not eat out as much.

PRACTITIONER: What else?

TERRANCE: When I got the promotion, I joined the local club. We didn't have that expense before.

PRACTITIONER: Do you need a club membership for your job?

TERRANCE: Not really; I just though the family deserved a little luxury now that I am making some real money.

PRACTITIONER: Do you remember our first meeting?

TERRANCE: Of course.

PRACTITIONER: During that meeting I asked how we would know if our working together would be a success. Do you remember what you said?

TERRANCE: I think I said something like helping me generate ideas on how to start a retirement plan. Is that right?

PRACTITIONER: You've got it. In fact, you have already solved your question.

TERRANCE: What do you mean?

PRACTITIONER: The last time we met you were stressed about not having enough cash flow to begin funding your retirement plan. I have been sitting here listening to you describe specific ways that you could find anywhere from $ 200 to $ 500 per month in savings.

TERRANCE: I guess you are right.

PRACTITIONER: I am really impressed.

TERRANCE: You are? What do you mean?

PRACTITIONER: What I have been hearing is that five years ago you were making less money, but you were happy. Today you are making a lot more money, but are more stressed. How about taking what you were doing when you were happy and applying the same behavior now?

TERRANCE: Do you mean spend like we did five years ago?

PRACTITIONER: Why not give it a try. If you could be sleeping better, less tense, and be more in control of your financial situation, would you be willing to take some spending cuts now? By the way, you are making enough money that you can splurge once in a while too. You just need to take it easy.

One of the recommendations of this approach is for mental health and financial practitioners to work together.

Outcomes

Depending on the type of practice, Terrance and his adviser might continue to meet to deal with specific ways to cut spending, save money, and allocate retirement savings. The relationship might also blossom into an opportunity to address other financial questions. It is also possible that once Terrance confirms his solution, the relationship could end. Either way, use of the SFFT manual approach, as illustrated here, has achieved the following outcomes: (a) a reduction in Terrance's financial stress level, (b) the identification of specific ways to cut current spending, and (c) the implementation of goal-based behavior.

Ethical Considerations

One of the recommendations of this approach is for mental health and financial practitioners to work together, but it can be used by one professional. It is important to note that financial professionals and mental health professionals often have different ethical codes; however, the fiduciary standard is a benchmark standard when SFFT is used. This means that confidentiality is of upmost importance. Due to health-care privacy laws, mental health practitioners must abide by very strict confidentiality rules. In most cases, waivers to discuss information with another professional will need to be signed by the client.

Future Directions

SFFT is unique within the new field of financial therapy. SFFT is among the first clinically developed and tested financial therapy techniques that have shown evidence of effectiveness for a wide range of financial issues and concerns. SFFT provides financial therapists, psychotherapists, financial planners, and financial counselors with a step-by-step procedure that can be incorporated into nearly any financial therapy practice today.

Future clinical studies are needed to confirm the basic tenets of SFFT. Much of the developmental work in SFFT has been conducted using individuals and families living in the Midwestern USA. Researchers interested in financial therapy topics are encouraged to begin clinical assessments of SFFT with different clinical samples on a multitude of presenting problems. These clinical studies need to be published and disseminated among researchers and practitioners.

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Chapter 9
Cognitive-Behavioral Financial Therapy

George Nabeshima and Bradley T. Klontz

Introduction

Cognition refers to the mental operations people utilize to process information. The result of these mental operations is the formulation of beliefs. In the field of cognitive-behavioral therapy (CBT), treatment is provided for modifying harmful and negative beliefs acquired by individuals that result in self-defeating behavior. Financial beliefs are core components that contribute to financial behavior outcomes and, hence, lessons learned from CBT regarding belief modification to offset negative behavior can provide both helpful and useful information for delivering financial therapy services and conducting financial therapy research. This chapter covers the application of CBT techniques in the area of financial therapy in three parts. First, concepts regarding how beliefs influence behavior from a CBT perspective are examined. Second, CBT techniques utilized to modify undesirable beliefs that cause self-defeating behavior are reviewed. Third, the use of CBT to treat money disorders is investigated.

The Connection Between Beliefs and Behavior

The heart of CBT is the view that unproductive beliefs are the source of self-defeating behavior (Ellis 1987; Chambless and Gillis 1993; Beck 2005; Longmore and Worrell 2007). The ABC framework proposed by Albert Ellis hypothesizes how beliefs are developed. Ellis's framework is reviewed and compared with common psychological theories utilized in financial planning relating beliefs and behavior.

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In financial planning research, beliefs play a central role with influencing individual behavior.

The ABC model consists of three components, with each component represented by the letters A, B, and C (Ellis 1987). The first stage represented by the letter A is called an activating event. An activating event is an experience that an individual undergoes. The next stage represented by the letter B stands for belief. In this stage, a belief is developed from the activating event experience. The last letter C represents consequence. In this stage, the developed belief causes a cognitive, emotional, and behavioral consequence.

It should be noted that people can experience similar activating events but develop a variety of different beliefs and, as a result, create different types of individual consequences for themselves. An example of this in the context of financial planning is retirement saving and stock market volatility. Stock market volatility could potentially cause investment losses in people's retirement accounts. The activating event of market volatility and losses may result in different beliefs and behaviors regarding retirement savings. Some individuals may be unfazed by the volatility and continue to invest believing the investment losses are only temporary and investment markets will rebound. Others may take the experience of investment losses to create a belief that the stock market is a bad place for retirement savings and result in a behavioral change to only save in accumulation vehicles that provide lower fixed returns with no perceived potential for losses, such as time bank deposits. Still others may feel that saving for retirement is a bad idea since their saved money experienced losses. The ABC model does not provide an explanation for why people can create different beliefs from similar activating events. Instead, it only identifies what activating events are responsible for creating the beliefs.

In financial planning research, beliefs play a central role with influencing individual behavior. The theory of planned behavior is a widely used theoretical framework in financial planning research studies (Ozmete and Hira 2011). In this theory, intentions and behaviors are influenced by three belief constructs. These include behavior beliefs influencing attitudes, normative beliefs regarding social norms, and control beliefs involving task difficulty and self-efficacy (Ajzen 1991). Examples of research referencing this theory include studies on credit card use (Rutherford and DeVaney 2009) and individual savings (Rabinovich and Webley 2007). Another belief construct utilized in financial planning research is locus of control. Locus of control refers to people's perceptions regarding their beliefs in whether they control events that affect them (Rotter 1966). People with an internal locus believe they control events and those with an external view believe the events are outside of their control. Studies regarding perceived control have been completed in analyzing money management behavior (Perry and Morris 2005; Davis and Hustvedt 2012). Research in this area has found locus of control beliefs as being related to different types of money management behavior with stronger internal locus of control views corresponding with more desirable financial behavior.

Recent research on money scripts has also supported the link between financial beliefs and financial behaviors. Specific patterns of money beliefs have been associated with lower net worth, lower income, lower socioeconomic status in childhood, and higher revolving credit (Klontz et al. 2011). Klontz and Britt (2012) found that beliefs around money, including money avoidance, money status, and money worship scripts, were significant predictors of disordered money behaviors, including compulsive buying disorder, hoarding, pathological gambling, and others.

CBT has a variety of techniques that are used to address self-defeating thoughts that can be applied in financial planning and financial therapy encounters.

Positive beliefs can lead to productive behavior, and undesirable behavioral consequences can occur when beliefs are dysfunctional. One goal of CBT is to modify dysfunctional beliefs by changing the cognitive thought processes that created these undesirable beliefs (Longmore and Worrell 2007). The techniques used in CBT could yield significant benefits for the financial planning field since it also understands the important role beliefs have with influencing behavior.

Cognitive-Behavioral Techniques

CBT has a variety of techniques that are used to address self-defeating thoughts that can be applied in financial planning and financial therapy encounters. Techniques introduced by early CBT pioneers, such as Aaron Beck and Albert Ellis, were aimed to restructure dysfunctional cognitive distortions (Beck 1970; Ellis 1987; Young and Beck 1980; DeRubeis et al. 2010; Dobson and Dozois 2010; Dryden et al. 2010). These techniques can be used by advisors and financial therapists to help people reassess self-defeating beliefs that hinder or impede positive financial behavior. In other techniques, no attempt is made at changing negative cognitive beliefs, but rather these beliefs are acknowledged as real, and coping strategies are used to deal with them (Hayes et al. 2006; Siev and Chambless 2007; Gaudiano 2008; Hofmann and Asmundson 2008; Singh et al. 2008; Hofmann et al. 2010). These types of techniques can help people experiencing adverse financial conditions, create a mental mindset to cope with their challenging situations, and develop proactive strategies and behaviors to address, resolve, and improve their circumstances. Both types of strategies, restructuring cognitive beliefs and coping strategies, have a potential for use by individuals and their advisors in the financial planning arena.

In laymen's terms, dysfunctional cognitive distortions represent thinking that is generally not true to reality and adversely encourages a behavior that prevents people from succeeding. For example, in a financial context, a dysfunctional cognitive distortion may be a belief by an individual that he or she is too dumb and will not be able to understand the retirement plan offered by their employer and, as a result, not

participate in the retirement plan offered at work and hence not save for retirement. In this case, the dysfunctional thought is the belief of being dumb, and the resulting self-defeating financial behavior is not saving for retirement.

The process to restructured dysfunctional beliefs is generally completed in a series of steps which include (a) identifying irrational beliefs, (b) challenging irrational beliefs, (c) testing the validity of irrational beliefs, (d) creating replacement beliefs, and (e) modifying behavior (Young and Beck 1980; Hofmann and Asmundson 2008; Beck 2011). The overall process is problem focused and generally deals with the present rather than the past. Although a past event may have activated a belief, the focus is not on changing the past, but instead focuses to reinterpret the past event to develop a positive attitude in the present (Ellis 1987; Longmore and Worrell 2007). Also, the process is generally a proactive and collaborative experience with people self-assessing their own thought processes with the help of a therapist.

To identify potential dysfunctional irrational thoughts, a self-monitored record of automatic thoughts, or an automatic thought diary designed as a homework assignment, can be useful to track both good and bad thoughts that a person may encounter throughout the day (Young and Beck 1980). In financial therapy, the automatic thought record has been adapted from CBT for use in identifying, challenging, and changing problematic money scripts, which has been called a money script log (Klontz et al. 2006, 2008; Klontz 2011). In essence, the money script log is a tool to help clients examine their thoughts, feelings, and unconscious thinking patterns around money. Clients are asked to identify specific financial situations, in which they feel some distress, identify the emotion, and then ask themselves, "What money-related thought is going through my head right now?" (Klontz et al. 2008, p. 87). After recording the situation and emotion, clients are asked to identify the automatic money script underlying the emotion. They are then asked to create an alternative, more accurate money script, and identify an adaptive behavioral response. This process could include: (a) challenging oneself to identify alternative truths that would make the money script more accurate, helpful, or functional; (b) considering possibilities that are the opposite of or are in opposition to the money script; (c) considering beliefs that broaden or redefine the money script; or (d) consulting with a financial planner or therapist to help identify alternative, more accurate, beliefs (Klontz et al. 2008).

In financial therapy, the automatic thought record has been adapted from CBT for use in identifying, challenging, and changing problematic money scripts … (Klontz et al. 2006, 2008; Klontz 2011).

The automatic thought record can be used to identify potential schemas. In CBT, schemas are defined as thought patterns that individuals use to organize their experiences (DeRubeis et al. 2010). Schemas can be viewed as the core beliefs people acquire to guide their interpretation of events they experience and their

behavioral reaction to these events. When schemas or core beliefs are dysfunctional, then irrational automatic thought distortions can occur. These irrational thoughts can lead to emotional distress and problematic behaviors (Sheppard and Teasdale 2000). Examples of irrational automatic thought distortions include negative filtering, harmful exaggerations, adverse personalization, and other faulty logic reasoning processes or illogical rules (Weems et al. 2001; DeRubeis et al. 2010; Drapeau 2014).

Negative filtering refers to focusing only on the negative aspects of a situation and discounting the potential positive elements that are related to the same situation. Negative filtering can occur when individuals review their investment statements. An investment account typically contains a number of investments. Some of the investments may have experienced losses while others show gains and positive returns. Negative filtering can occur, if individuals focus only on the losses, and do not properly acknowledge the investments with gains when evaluating the account in its entirety. Such negative filtering could lead to a pattern of self-destructive investment decisions, wherein the individual is predisposed to sell investments at a loss, when the more prudent response might be to hold or even add to the position.

Harmful exaggerations can occur through overgeneralizations, magnifying or minimizing importance, and labeling. Overgeneralizations refer to making conclusions with overextended inferences. For example, a person may have made a poor choice in a particular purchase and, thus, overextend this experience to the rest of their buying decisions and feel that they always make bad purchase decisions. This can also occur when individuals magnify negative elements or experiences and minimize positive aspects, similar to negative filtering discussed previously. Harmful labeling occurs when people apply a global negative label to exaggerate all the negative qualities that the label confers. For example, a person who generally pays his or her bills on time may pay one bill late and label himself or herself as being “bad with money.” The “bad with money” label is an exaggeration based on one event. A series of harmful exaggerations can lead to catastrophic thinking that future outcomes will always be bad. This thought distortion could lead to avoidant behaviors, including ignoring one’s financial reality or excessive risk avoidance.

> …all-or-nothing, anti-money, and anti-rich beliefs … are associated with poor financial outcomes and can lead to a host of self-destructive financial behaviors (Klontz and Britt 2012).

Adverse personalization involves blaming oneself for failure due to events outside of one’s control. This could be due to mitigating factors or due to the actions of others. Adverse personalization can also be characterized with faulty personalized hindsight or unreasonable “should have known” expectations, even if a person behaves the best he or she could have in a given situation. For example, consider the individual who purchases a particular gadget and a month later a new product is announced for sale that is better than the gadget previously purchased. In this

situation, a person may take individual blame for not waiting for the new product release, when in reality he or she could not have reasonably known about the new product being released. If a person can identify incorrect instances of adverse personalization, then blame and fault can be reattributed away from him or her.

Other types of faulty logic and illogical rules include all-or-nothing thinking, mind reading, and fortune telling. All-or-nothing thinking refers to creating dichotomous opposing characterizations of situations, behaviors, or people, rather than characterizing along a more realistic continuum. For example, all-or-nothing, anti-money, and anti-rich beliefs (e.g., “money corrupts people,” “rich people are greedy,” “people get rich by taking advantage of others,” “good people shouldn’t care about money”) are associated with poor financial outcomes and can lead to a host of self-destructive financial behaviors (Klontz and Britt 2012). Mind reading from a CBT perspective refers to believing to know what others are thinking without sufficient supporting evidence. Fortune telling refers to believing to know about the future without adequate information. The downside of mind reading and fortune telling include ignoring alternative possibilities and making unwarranted conclusions.

Once automatic thoughts are inventoried, a number of strategies can be used to test and identify which ones are incorrect, unhelpful, or self-defeating (Young and Beck 1980; Hofmann and Asmundson 2008; Beck 2011). First, it is important to sufficiently define or quantify belief terms. For example, “financial success” needs to be sufficiently understood so that it can be objectively evaluated. How the term is defined can provide a basis for its measurement. For example, with the term “financial success,” it may be determined that the objective of financial success need not be an all-or-nothing reality but, instead, an objective that is experienced along a continuum. Next, evidence supporting a belief and evidence contradicting a belief can be examined. In the case of a dysfunctional money script, an individual can self-assess the validity of the belief through both deductive and inductive reasoning regarding the assumptions of the false belief and provide his or her own rationale for why the belief may not be true. Deductive reasoning looks at absolute factual evidence, and inductive reasoning looks at probable evidence. Representations of inductive reasoning include generalizations, extrapolations, and inferences. For example, a person may think that the worst outcome regarding a financial transaction will occur to him or her, but, the probability of the worst-case scenario is actually quite small. Inductive reasoning would conclude that because the probability is small, the worst-case scenario outcome is unlikely. In addition, a list of pros and cons regarding the particular belief can be created to identify if the belief is helpful or harmful to an individual. Another strategy to identify the validity of a belief is to test it in a real-life situation. For example, a person with limited financial means may think that financial planners only work with wealthy people. To test this assumption, an experiment could be set up by the individual, whereby he or she calls a list of planners and advisors, and asks them if this is a true or an incorrect assumption.

When irrational automatic thoughts are identified as being invalid, alternative replacement beliefs can be created to promote supportive and positive behavior (Ellis 1987; Gaudiano 2008; Beck 2011).

When irrational automatic thoughts are identified as being invalid, alternative replacement beliefs can be created to promote supportive and positive behavior (Ellis 1987; Gaudiano 2008; Beck 2011). Alternative replacement beliefs can be alternative interpretations of the events people experienced. For example, consider a situation in which two acquaintances pass each other on the street and neither greets the other person. A potential invalid automatic thought might be that the lack of greeting is evidence of dislike. An alternative interpretation could be that one or both of the individuals are shy, are mentally preoccupied with other thoughts, or just did not notice each other as they passed. Alternative replacement beliefs can also include alternative perspectives for people's own individual qualities and capabilities. In these situations, people may be able to decrease negative self-talk and redefine themselves in a more positive way that promotes more supportive behavior for success (Verplanken et al. 2007).

In other circumstances, alternative beliefs regarding how to respond to the situations in a more proactive way can be developed. Methods for these types of coping responses include relaxation techniques and mindfulness strategies (Hayes et al. 2006; Siev and Chambless 2007; Hofmann and Asmundson 2008; Singh et al. 2008; Hofmann et al. 2010). Relaxation techniques incorporate strategies that change mental anxiousness and anxiety by changing an individual's physical state. This could be achieved by consciously relaxing tense muscles and by using breathing exercises. Imagery is another relaxation technique whereby people mentally think of a calm or relaxing image or experience to improve their existing moods. In mindfulness strategies, effort is concentrated on decreasing rumination and focusing on solutions. Rumination involves continually thinking about an adverse situation without focusing on strategies to address or improve upon the current situation, obstacles, or setbacks. Diversion strategies to mentally preoccupy and redirect attention away from uncomfortable conditions that cannot be changed can also be considered.

Eventually, it is desirable for positive behavior to take the place of self-defeating behavior after irrational thoughts are replaced by more supportive alternative beliefs (Young and Beck 1980; Ellis 1987). Changing behavior is at times simple. However, sometimes behavior change may put people outside of their comfort zones. In these instances, techniques dealing with the process of change can be incorporated utilizing techniques such as exposure strategies (Tryon 2005). Exposure strategies can be designed as gradual steps or a process of intense emersion. Examples of strategies utilizing gradual steps could involve tasks, such as scheduling activities and breaking down larger tasks into smaller more achievable components (Young and Beck). Furthermore, exposure strategies can use real or imagined stimuli. Imagined stimuli techniques could involve role playing, mental imagination, and acting "as if" (Anderson et al. 2005; Beck 2011). For example, a wealthy money hoarder with significant anxiety around spending may be given the task of indulging in a massage or buying an item that would be normally seen as an anxiety-provoking extravagance. This exposure task could at first be imagined and as anxiety wanes in the face of the imagined stimuli, the experiment could then be real, resulting in an actual behavior trial. Exposure strategies can desensitize anxiety and counter condition uncomfort-

able tasks to develop behavior that is more supportive for improving people's overall quality of life. To measure progress with improving the level of comfort with new behavior, a rating scale from 1 to 10 could be used to evaluate uneasiness. Relaxation techniques would be practiced and applied in imaginary and real scenarios to reduce levels of anxiety. Ideally, the rating scale will show improvement with comfort levels for new behaviors over time after repeated, imagined, and real-exposure trials.

> CBT has been utilized to help individuals with problematic money behaviors, including hoarding disorder, gambling disorder, and compulsive buying disorder.

CBT techniques can be useful for financial planners and financial therapists in counseling and planning engagements. These techniques provide a structured framework for those advising individuals with financial challenges that are the result of dysfunctional belief patterns. Irrational automatic thoughts can be addressed, challenged, and potentially replaced with more supportive beliefs, promoting more positive financial behaviors, through a collaborative and proactive process between the helper and client, via a process of self-assessment and individual change.

The Use of CBT in the Treatment of Money Disorders

CBT has been shown to be effective in improving behaviors of individuals hindered with self-defeating core beliefs (Beck 2005; Longmore and Worrell 2007; Hofmann et al. 2012). In the area of money disorders, CBT has been utilized to help individuals with problematic money behaviors, including hoarding disorder, gambling disorder, and compulsive buying disorder. Each of these disorders can be traced to irrational beliefs, and research has shown that CBT can be an effective intervention for replacing inaccurate thoughts with more supportive beliefs to reduce disordered money behaviors and improve an individual's overall quality of life.

> Dysfunctional and irrational thoughts related to hoarding disorder are the result of core beliefs that people incorrectly associate with items and objects.

Hoarding Disorder

Acquisition of goods makes sense to ensure adequate resources are available when needed and, from an evolutionary perspective, the act of accumulating objects has developed as a basic human instinct. However, when saving behavior

turns extreme and unrelated to any physical utility or purpose, then this type of conduct can create adverse and undesirable consequences (Grisham and Barlow 2005). Hoarding disorder can be described as the accumulation of belongings and the inability to discard possessions that are useless or of limited value to the extent that living spaces are sufficiently cluttered, impairing the functional use of space, and causing distress (Steketee and Frost 2003; Grisham and Barlow 2005).

Dysfunctional and irrational thoughts related to hoarding disorder are the result of core beliefs that people incorrectly associate with items and objects. Steketee and Frost (2003) identified some potential cognitive errors related to compulsive hoarding behavior. Examples of these include the emotional belief that objects provide comfort, the belief that the loss of objects will result in the loss of identity and self, the belief that objects are needed to maintain memory, the belief that accumulation of objects creates more control, and the belief that an obligation or responsibility exists to accumulate possessions for oneself and for others. Klontz and Britt (2012) found money avoidance and money worship beliefs to be predictive of hoarding disorder symptoms. Another aspect of hoarding disorder includes the avoidance of anxiety related to discarding objects and the avoidance of decision making for determining which objects to discard (Steketee and Frost 2003; Grisham and Barlow 2005).

CBT provides the means for individuals to question and challenge dysfunctional thoughts related to hoarding disorder (e.g., Do I have enough time to use all my possessions? Have I used this item recently? Do I need this object to maintain my identity?). Questions can be used to test the validity of irrational thoughts regarding excessive accumulation and provide the basis for cognitive restructuring of thoughts related to hoarding (Grisham and Barlow 2005). Potential behavioral change strategies developed from cognitive therapy include organizing possession based upon a hierarchical list based on value and exposure to the act of discarding less valuable and unneeded items.

Examples regarding the effective use of CBT in treating hoarding disorder have been documented in the research literature. A study by Tolin et al. (2007) followed 14 adults with the hoarding disorder and treated them with 26 CBT sessions over a 7–12-month period. Comparison of pretest and posttest results showed a significant decrease in hoarding behavior. Another study randomly assigned subjects to receive CBT over 12- and 26-session periods or to be waitlisted (Steketee et al. 2010). After the 12-week session, people receiving CBT saw significant improvement with moderate effect sizes in hoarding severity and mood improvement compared to those who were waitlisted. People completing the 26 sessions reported improvements with a large effect size. CBT has also been used with success in treating symptoms of hoarding disorder in group therapy (Gilliam et al. 2011; Muroff et al. 2009). Group CBT provides the added benefit of increasing access to therapy since treatment costs are typically lower in a group setting compared to that of individual therapy sessions.

Gambling Disorder

Gambling disorder is characterized by a lack of impulse control in cases where people risk items of value on games of chance (Petry et al. 2006). Games of chance refer to contests, wherein the odds of the game are determined by probability, and not by a player's skill (Wulfert et al. 2006). Generally, games of chance cannot be controlled by a player and are sometimes confused by a player as games of skill whereby the outcome can be influenced by a player's knowledge and effort. Two core distorted beliefs associated with gambling disorder include the ideas of primary illusory control and secondary illusory control (Toneatto and Gunaratne 2009). Primary illusory control refers to a gambler's belief that he or she is in control of gambling outcomes. Secondary illusory control refers to a gambler's belief that he or she is able to predict gambling outcomes. Klontz and Britt (2012) found that money status beliefs predict gambling disorder behaviors, wherein pathological gamblers cannot separate their net worth from their self-worth, and "may gamble in an attempt to win large sums of money to prove their worth to themselves and others" (p. 40).

Examples of techniques used in CBT to provide alternative and healthier viewpoints regarding gambling include awareness-raising and rational evaluation to create the basis for new beliefs that are more supportive of positive behavior (Toneatto and Gunaratne 2009). A key element of CBT also includes the identification of gambling triggers and coping strategies when triggers are encountered (Petry 2005; Wulfert et al. 2006). Gambling triggers are circumstances that tempt, promote, or fuel the desire to gamble. Examples include being in the presence of other gamblers or, simply, receiving a paycheck and feeling bored. Coping strategies include removing oneself from gambling environments, seeking the help of others, developing diversion activities, and using mindfulness meditation strategies.

Petry et al. (2006) conducted a CBT study for gambling disorder with a large number of participants. In this study, 231 individuals were randomly assigned to one of three categories. These included (a) a Gamblers Anonymous participation category, (b) a Gamblers Anonymous participation category with the use of a CBT workbook, and (c) a combined category of Gamblers Anonymous with eight individual CBT treatment sessions. The findings of this study revealed that those exposed to CBT had reduced gambling behavior over a month, 6-month, and 12-month period after the CBT intervention was provided. This is consistent with other smaller studies that have also shown that CBT works in reducing gambling behavior by people months after receiving treatment (Wulfert et al. 2006; Marceaux and Melville 2011).

Compulsive Buying Disorder

Compulsive buying disorder involves obsessive shopping fueled with high emotion and psychological involvement to acquire goods without contemplation or regard to

financial costs (Kellett and Bolton 2009). In addition to financial costs, compulsive buying disorder can also involve significant time consumption and personal mental involvement. The obsessive nature of compulsive buying disorder is generally an experience involving uncontrollable urges and lack of self-control. It is not uncommon for people's views regarding their self-image to drive their purchase decision. However, in the case of compulsive buying disorder, an overrepresentation of self is made by material purchases and a belief that the purchase of material goods is a prime source of self-worth, social rank, and personal well-being (Kellett and Bolton; Kearney and Stevens 2012).

Dysfunctional beliefs that predict compulsive buying disorder include: (a) the belief that more money and more things will create happiness and give life meaning, (b) the belief that more money and things will improve one's social status, and (c) a conflicting feeling that money is a source of fear, anxiety, and disgust (Klontz and Britt 2012). With compulsive buying disorder, there is an underlying belief that buying objects will create happiness and act as a vehicle for improving one's moods. Although moods can improve during the shopping experience and briefly exist after acquiring a product, the feeling is often short-lived and may be followed by negative feelings of guilt, depression, and lower self-esteem (Hanley and Wilhelm 1992; Kellett and Bolton 2009; Muller et al. 2013). Another potentially faulty belief is that of image spending which reflects the view that the acquisition of a material good will automatically bring oneself closer to one's view of an ideal self (Kearney and Stevens 2012).

Dysfunctional beliefs that predict compulsive buying disorder include: (a) the belief that more money and more things will create happiness and give life meaning; (b) the belief that more money and things will improve one's social status; and (c) a conflicting feeling that money is a source of fear, anxiety, and disgust (Klontz and Britt 2012).

Alternative beliefs regarding the desire for compulsive buying can be developed through CBT. Research regarding the use of CBT for compulsive buying disorder is limited (Mitchell et al. 2006). However, a report by Kellett and Bolton (2009) provided a few examples of questions that can be used to disrupt irrational compulsive buying beliefs. Questions to self-assess the purchase need, purchase motivation, the level of happiness the purchase will bring long term, and how one will feel after the purchase is completed can be asked of oneself to self-assess the legitimacy of buying new items.

Kellet and Bolton (2009) provided a single case study to document the successful application of CBT in treating compulsive buying. After ten sessions, one individual who had described herself as having a lifelong preoccupation with shopping reported herself as no longer dependent on compulsive buying. Two other studies using cognitive behavior therapy to treat compulsive buying also shared positive results. One study exposed 28 subjects to individual CBT treatment (Mitchell et al. 2006) and the

other study compared the effectiveness of group face-to-face cognitive therapy for 22 subjects with telephone-guided self-help therapy that was provided to 20 other participants (Muller et al. 2013). Both studies also had waitlist control groups and reported CBT treatment as being significantly effective when compared to the other groups.

Case Study

Background Information

Tyler is a 55-year-old, divorced, mental health professional who recently transitioned from working for a social service agency to starting his own private psychotherapy practice. Tyler grew up in a small town. His father was a physician, mother a nurse, and his family was considered wealthy in their town. Tyler recalls growing up with a tremendous amount of guilt and shame around his family's socioeconomic status. He felt like he could not fully relate to the other kids, who looked at him as being different. This was devastating for Tyler, who wanted to fit in with his peers. To make matters worse, Tyler's parents employed some of his friends' parents in various professional and household helping roles, which added to his sense of guilt and estrangement. Tyler's feelings about the financial disparities he observed, led to a passion for advocating for economic equality wherever he could. He pursued a career in social work, in part, to try to help and empower economically and otherwise disadvantaged individuals. Tyler came to financial therapy at the encouragement of a financial planner after the development of a rather dismal financial plan. Tyler was inspired to seek a financial plan because he realized he lacked knowledge about how to operate a business. He also realized that he was approaching retirement age and had little saved. While he knew that saving was important, he acknowledged that it seems like he has gone out of his way to not accumulate money. In looking back on his career choices, he consistently chose jobs in which he was overworked and underpaid; letting others determine his worth, and never asking for a raise or seeking opportunities for advancement. He realized he had shunned higher paying careers and professional opportunities, not out of a lack of interest but out of a desire to avoid being considered wealthy.

When used in the treatment of money-related mental disorders, CBT should only be used by qualified mental health professionals.

Case Conceptualization

From a CBT perspective, Tyler's chronic neglect of his financial health is the result of his cognitions, with his current thinking of maintaining his financial avoidance and unwanted feelings. In CBT, three time frames are taken into consideration,

including current thinking, precipitating factors, and developmental events and chronic patterns of interpreting those events (Beck 2011). As such, Tyler's cognitive–behavioral financial therapist assumed that Tyler's current thinking patterns based on his developmental history and interpretation of his history, were the primary causes and solutions to his stated problem of chronic financial self-sabotage.

Interventions

In CBT, there is an emphasis on (a) establishing a strong therapeutic alliance, (b) collaboration between therapist and client, (c) a focus on the present, (d) a focus on problems and goals, (e) a time-limited engagement, (f) structured therapy sessions, and (g) an emphasis on education and relapse prevention (Beck 2011). In general, cognitive-behavioral financial therapy was focused on helping Tyler identify, evaluate, and change his dysfunctional money beliefs to bring about emotional and behavioral changes.

Tyler's financial therapy consisted of approximately 3 months of weekly therapy sessions. The initial focus of therapy was the establishment of a strong therapeutic alliance, wherein the therapist sought to express caring, warmth, empathy, positive regard, and a sense of competence. The therapist's case conceptualization of Tyler's problem was shared with Tyler in the first few sessions, with room for Tyler to accept and/or modify the conceptualization in a collaborative fashion. At the beginning of each session, the therapist shared the agenda of the session, inviting Tyler to add his own agenda items. In addition, an emphasis was placed on homework assignments between sessions, which involved a variety of experiential exercises.

Early in therapy, Tyler was given an early version of the Klontz money script inventory (KMSI) (Klontz et al. 2011) to complete. Tyler was also asked to complete several money script logs between sessions. The money script log asked him to note: (a) money situations that triggered distress or concern; (b) his feeling; (c) his corresponding money script; and (d) an alternative, more accurate money script and/or adaptive behavior (Klontz et al. 2008). With the KMSI, Tyler identified a preponderance of money avoidance and anti-wealth beliefs, including "I don't deserve a lot of money when others have less than me," "there is virtue in living with less money," "being rich means you no longer fit in with old family and friends," and "rich people are greedy." These beliefs were confirmed as Tyler completed his money logs. Entries in the money log were often triggered when Tyler was faced with business decisions, such as whether or not to set up a retirement plan, how much to spend on setting up his office, etc.

With a clear pattern of dysfunctional thinking around money identified and linked to a logical origin in Tyler's developmental history, the cognitive-behavioral financial therapist focused on helping Tyler identify his errors in thinking, which included negative filtering (e.g., discounting the positive behaviors and personalities of many wealthy individuals), magnification (e.g., exaggeration of the preponderance of negative behaviors of wealthier individuals), and all-or-nothing thinking (e.g., having more money than others is bad and classifying people as being either rich or poor without regard to gradation and context).

The therapist then focused on cognitive restructuring of these beliefs, helping Tyler explore the evidence confirming or refuting these cognitions. The therapist helped Tyler develop alternative, more accurate, and more helpful money scripts (e.g., some wealthy individuals do harm, but many have dedicated their lives and their wealth to bettering humanity; it is important for me to take care of myself and my family, etc.). Tyler was also given homework assignments designed to expose him to previously avoided environments and social groups (e.g., expensive restaurants, meetings with successful business leaders in his community), where he was encouraged to observe and collect evidence either confirming or refuting his negative beliefs about wealthier individuals. These experiences were debriefed in therapy.

Tyler was also given a variety of cognitive and behavioral coping strategies to help him deescalate intense affect as he engaged in his homework assignments, including techniques such as thought stopping (e.g., interrupting his negative self-talk by visualizing a STOP sign and "yelling" internally, "STOP"), using a cue card to help him replace dysfunctional thoughts with more accurate money scripts (e.g., he had written several helpful statements on a card he kept in his wallet for reference), and deep diaphragmatic breathing to decrease anxiety.

Outcomes

Tyler came to financial therapy motivated to change his financial course. Rapport was established early in therapy, and Tyler was receptive to the therapist's case conceptualization of the etiology and maintenance of his financial self-sabotage and the therapeutic process. After 3 months of financial therapy, Tyler was able to make a significant shift in his underlying beliefs about money. He began contributing fully to his IRA, which he has sustained for the past 7 years. At last report, his financial planner stated that Tyler's money avoidance and anti-wealth thoughts emerge at times, but Tyler is able to notice them for what they are and replace them with more accurate and helpful beliefs. Five years after the cessation of therapy, Tyler's mother passed away, leaving him a relatively large sum of money. Tyler's financial planner reports that Tyler invested all of the money, which is setting him up for a comfortable retirement. Tyler is reportedly convinced that if he had not participated in financial therapy he would have squandered his inheritance.

Ethical Considerations

CBT concepts and techniques can be applied in a variety of settings. In the financial planning context, planners can help clients identify their money scripts and challenge distorted and inaccurate beliefs about a variety of financial planning topics, including the stock market, the need for insurance, etc. As mentioned above, CBT

is also being used by mental health professionals to treat money disorders, such as gambling disorder, hoarding disorder, and compulsive buying disorder. When used in the treatment of money-related mental disorders, CBT should only be used by qualified mental health professionals.

Future Directions

The premise of CBT is that thoughts affect feelings and behavior, which in turn determines the choices people make, how they live their lives, and their social and emotional outcomes. When an individual's underlying beliefs are dysfunctional, distorted, inaccurate, and/or unhelpful, thoughts can promote self-defeating behavior that may hinder or impede one's ability to achieve success. Research has found that dysfunctional beliefs about money predict disordered money behaviors and are associated with poor financial health. CBT has been shown to be an effective framework for restructuring and creating alternative thoughts that are more supportive for positive behavior. The application of CBT theory and techniques in financial therapy is appropriate and promising to aid clients in challenging and changing self-limiting beliefs and developing beliefs supportive for financial success and achieving financial well-being.

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Chapter 10
Collaborative Relational Model

Martin Seay, Joseph W. Goetz and Jerry Gale

The collaborative relational model of financial therapy is based on the concept of utilizing two complementing professionals, each with core expertise in different areas, to provide in-depth and comprehensive financial therapy to clients.

Introduction

The financial planning and mental health are based upon well-established certifications and licenses, which are predicated on the completion of extensive education and experience requirements. While educational programs are geared toward either financial skills and knowledge, or clinical skills and knowledge, there are few programs that offer an interdisciplinary approach of these two fields. Identifying this trans-disciplinary approach, and with recognition of the benefits of joint counseling, the collaborative relational model of financial therapy is based on the concept of utilizing two complementing professionals, each with core expertise in different areas, to provide in-depth and comprehensive financial therapy to clients. This chapter will introduce the model, provide the foundation of its theoretical framework, and provide an example case study of how it may be used in practice.

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Background

The development of the collaborative relational model of financial therapy began as a grant received in 2007 by Gale and Goetz at the University of Georgia (UGA) to assist low-income populations improve relationship and financial well-being. UGA faculty who taught in the degree programs of family therapy and financial planning collaborated to develop a new approach called *relational financial therapy (RFT)* to assist couples who were experiencing both financial and relationship stress. RFT, as originally conceptualized, is a five-session intervention model involving two service providers (i.e., financial planner and family therapist) working together to address the intersection of a couple's relationship and financial issues. A pre and posttest pilot study, involving 12 couples, indicated statistically significant improvements in couple's financial well-being and pointed to relational benefits as well (Kim et al. 2011). Some of the male participants indicated an initial openness to the concept of *financial therapy* as opposed to *therapy,* indicating the word *financial* may have served as a buffer to the negative stigma associated, at times, with *therapy*. Interestingly, after completing the five sessions, the male participants expressed they were now open to the value of therapy in general.

A pre and posttest pilot study, involving 12 couples, indicated statistically significant improvements in couple's financial well-being, and pointed to relational benefits as well (Kim et al. 2011).

Although not the intent of the study, the students of financial planning and family therapy, who facilitated the five intervention sessions, reported learning new knowledge and skills that would benefit their practice as well as their own lives (Green-Pimentel et al. 2009). The data not only established the effectiveness of a collaborative model in terms of reducing relationship problems and financial stress of couples but also indicated high satisfaction among the student financial planners and therapists in terms of their collaborative counseling experience with someone of complementary expertise. Overall, the findings indicated a potential for professional financial planners and therapists to collaborate to more effectively assist couples who are experiencing both relationship and financial challenges. Kim et al. (2011) and McCoy et al. (2013a) recommended that university-based family therapy, social work, counseling, and psychology programs integrate a course on personal finance into their programs of study. Similarly, a recommendation was made that university-based financial planning programs integrate a course on communication skills and financial therapy interventions into their programs of study.

Because of these potential service benefits to clients and pedagogical benefits to students, following the pilot study, the authors implemented what is believed to be the country's first clinical practicum in financial planning, wherein graduate students studying financial planning worked both independently as well as

collaboratively with graduate students in the family therapy program to implement financial therapy interventions to improve individual's and couple's financial and relational well-being. This clinical-based, experiential learning course attempted to address the need to better prepare financial planning students to effectively work with clients and transition into the professional world of financial planning (Goetz et al. 2005, 2011). The ASPIRE Clinic (www.aspireclinic.com), the service center wherein the practicum took place, provided financial planning services on a pro bono basis to community members and provided students an unparalleled opportunity to develop skills and knowledge based in financial therapy, including an opportunity to conduct self-observations via videotaped sessions with clients as well as ongoing supervision and feedback.[1] This is an example of where a transition is made from financial planning to financial therapy in that clients' emotional and cognitive schemas around money were addressed as an integral component of the financial planning process and development of the planner–client relationship. The initial RFT model utilized an integration of various theoretical models and frameworks, including family systems theory, the transtheoretical model for change, and a modified version of the six-step financial planning process.

This chapter provides a description of the initial model of RFT developed at the UGA as well as a brief description of how that model has evolved to become even more holistic in nature. In addition, various models for professional collaborations in providing financial therapy are provided toward the end of this chapter.

Collaborative Relational Model of Financial Therapy

The initial model of relational financial therapy (later evolving into the collaborative relational model of financial therapy) involved one service provider with financial planning expertise and one service provider with family therapy expertise working together to improve clients' financial and relational well-being. Coming from an ecosystemic perspective (Auerswald 1968), it was assumed that unexpected life events and associated financial stress may adversely affect relationships and the larger family system. Even though previous studies had clearly demonstrated the association between financial stress and relationship quality (see Aniol and Snyder 1997; Dew and Xiao 2013; Gudmunson et al. 2007), few attempts had been made in practice to address both these issues concurrently through professional collaboration (Gale et al. 2009). As such, the initial interdisciplinary, psychoeducational intervention model of RFT involved the two service providers collaborating over five sessions.

This five-session model combined couple/family therapy with financial planning for couples presenting with concomitant relationship and financial distress. Across the five sessions, aspects of the financial planning process and systemic therapy

[1] The ASPIRE clinic also includes nutritional counselors, home design consultants, and law students that each provide services independently as well as collaboratively across disciplines.

were incorporated. The objectives of the intervention model included: (a) helping clients improve couple communication, (b) strengthening relationship stability, (c) decreasing financial distress, (e) increasing financial management skills, (f) creating an economic internal locus of control, and (g) improving financial and overall well-being (Kim et al. 2011). Both psychometrically validated scales as well as other questions assessing relationship strength, communication, and financial wellness were administered before the intervention began, during the intervention, and post intervention for clinical purposes.

A five-session treatment protocol served as a guide for the two service providers, but the service providers organized the sessions in a way that was consistent with the goals of the couple. During the first session, the service providers focused on building a strong working alliance with the clients, described the important interrelatedness of relational and financial distress, and gathered client data, including information about financial communication patterns, family of origin issues around money as well as an historical understanding of their relationship. Across the five sessions, specific financial and relationship exercises were completed based on a values- and goals-based process. This initial five-session model was designed for working with couples near or below the poverty level. Over the past few years, this model has evolved into the collaborative relationship model for financial therapy that is designed for work with individuals, couples, and families across the life span and across varying income levels.

The concept behind the collaborative relational model of financial therapy is quite simple—bring together two professionals in different fields to work together to address the complex intersections of financial and relational issues. While originally limited in scope to financial and family therapy services, over time, the collaborative relational model of financial therapy has expanded based upon the principle that many aspects of well-being may need to be addressed concurrently. Financial problems are often intertwined with other issues, and without addressing the systemic tapestry, solutions based on only one strand are more likely to fail over time. Accordingly, students studying dietetics/nutrition, home design, and law were integrated into the collaborative relational model of financial therapy at the ASPIRE Clinic to address food and health issues, home environment issues, and legal problems/vulnerabilities. This collaborative approach allows professionals with varying specialties to leverage separate expertise to address interwoven problems. This model is based in the perspective that the financial therapy is attending to overall well-being through prevention, education, resiliency, and intervention therapy.

> The concept behind the collaborative relationship model of financial therapy is quite simple—bring together two professionals in their fields to work together to address the complex intersections of financial and relational issues.

Current clients in the ASPIRE Clinic may see only one or many of these service providers depending on their area of need. However, when the need for financial

therapy is indicated, clients typically see a cocounseling team of one financial planning student and one family therapy student. This financial therapy team may also collaborate with a dietetics, home-design, and/or law student, depending on presenting client issues. For example, one client case involving a couple utilized a three-person counseling team (including students from law, financial planning, and family therapy) to address issues associated with potential divorce, bankruptcy, division of assets, credit, foreclosure, and retirement planning. In this particular case, the need for all three areas of expertise is quite obvious, and the collaborative relational model of financial therapy assumes the intervention work would be suboptimal without the synergistic benefits resulting from the three counselors collaborating outside and within sessions to assist the client.

The specific interventions used in client cases depend on the client issues presented and theoretical orientations of the counselors working with the client. However, systems theory and the six-step financial planning process remain at the foundation of the collaborative relational model of financial therapy. Various integrative approaches are used in the implementation of specific interventions. For example, depending on the clients' goals and presenting issues, specific therapeutic interventions based in narrative financial therapy (McCoy et al. 2013b), cognitive-behavioral financial therapy, or feminist financial therapy may be utilized (Goetz and Gale 2014). For example, a psychoeducational and feminist approach is often used when a client presents with financial illiteracy and feelings of disempowerment around money management. Further discussion regarding the theoretical bases of this model is discussed in the next section.

> Systems theory and six-step financial planning process remain at the foundation of the collaborative relational model of financial therapy.

Given the multiple fields included in the model, the collaborative relational model of financial therapy necessitates a comprehensive assessment of clients' overall well-being before financial therapy begins. As such, background information forms are completed, including a holistic initial consultation assessment (HICA) developed by the ASPIRE Clinic staff to identify whether financial therapy is the optimal service model for the client. In this approach, clients may be individuals or couples, and even families, with multiple entry points to receive these services. They may begin with a family therapist, a financial counselor, or a law student and based on client(s)' needs, move to a collaborative approach with the other professional(s) also providing services. At this point, different models of service are possible ranging from (a) a one-time consult from the other professional; (b) parallel services in which the client(s) receive both therapy and financial counseling separately, but coordinated between the service providers; or (c) a collaborative and integrated approach in which the two or more professionals work together with the client(s) (see Goetz and Gale 2014).

> It is important to note that the collaborative relational model of financial therapy requires an investment of time from both professionals to gain an adequate level of rapport, trust, and understanding for each other before counseling begins.

It is important to note that the collaborative relational model of financial therapy requires an investment of time from both professionals to gain an adequate level of rapport, trust, and understanding for each other before counseling begins. As in any cocounseling setting, professionals must be comfortable working together and be able to present a clear and open communication style between themselves and the clients. This is particularly true since each has a unique area of expertise, and will need to be responsive to changing directions that their partner may take. The clients' presenting issues and concerns drive the session; therefore, the counseling team should attend to different issues at different times. This means that the focus can shift from financial concerns to relational concerns in different sequences, and it is important for the treatment team to adjust accordingly, such that the different service providers will take the lead at different times.

It is relevant to note that this model is being used in a university setting where the service providers are supervised graduate students who are not paid. To implement this model in a private setting involves considerations of how to reimburse both providers, the use of insurance, and clear professional standards to avoid potential ethical violations. For example, it may be that the mental health provider is the initial service provider who sets the fees (with or without insurance). The financial service provider could be brought in as a onetime consultant or for more than one session with additional costs for the clients. This could occur in the other direction as well with the financial planner being the initial point of service. Depending on clients' level of income, one could also consider pro bono work. The long-term benefit of pro bono work is that either professional may generate new paying clients from new strategic alliances resulting from the collaborations.

In the private sector, it is important for the professional (a) to meet professionals from other disciplines and (b) to have the knowledge to discern the knowledge, skill, and compatibility of these other professionals. Therapists could attend (and present) at financial planning continuing education events or conferences, and conversely, financial planners could attend regional chapter meetings of family therapists, psychologists, or social workers to begin building a network of professionals.

Theoretical Considerations

The collaborative relational model of financial therapy finds its theoretical basis in the ecosystemic perspective (Auerswald 1968). The ecosystemic perspective combines systems theory with viewing the clients within their social/cultural/historical context. As in an ecological system, all parts are connected and when in a balanced

environment, the whole system is healthy. For example, consider how life events (e.g., health crisis, loss of employment, death of a family member, birth of a child, dementia of a parent, loss of one's home, an adult child leave the home, marriage of an adult child, chronic pain) have consequences on well-being of the whole family. Each of these events can affect not only relationships but also financial decisions, both with long-term effects. To view individuals outside of their ecosystemic context risks addressing only part of the problem. It also leaves out considerations of positive resources and aspects of resilience that may also be a part of their ecosystemic context. When addressing these complex and intersecting aspects, the collaborative team are better able to achieve long-standing success for the client system.

To view individuals outside of their ecosystemic context risks addressing only part of the problem.

Case Study

Background Information

John Ford (24) and Marsha Wayne (25) are a young couple at the beginning of independent life. After working a couple of years after college, John returned to school to receive a master's degree to provide for job improvement. Meanwhile, Marsha, having previously completed a master's degree, is working two jobs in the area of public administration to make ends meet and support John's education costs. John and Marsha have been regularly meeting with a marriage and family therapist to address issues of unbalanced power in their relationship. With John's impending graduation, John and Marsha have decided to get married. As the family therapist conducted premarital counseling sessions, she realized that the source of some of John and Marsha's relationship issues involved financial debt and financial decision making for their future. The therapist realized that to address these financial concerns in a meaningful manner for the couple was outside her scope of knowledge and practice. Therefore, the family therapist asked a financial planner to join the couple and herself in their counseling sessions to provide collaborative relational financial therapy.

Presenting Issue

John and Marsha were facing several challenges as they prepared for his graduation and their marriage. Foremost, from an emotional perspective, significant relational power imbalances were causing stress to both spouses. Marsha showed limited patience with John and was aggressive in displaying her displeasure with any perceived shortcomings or faults. This created constant tension, with Marsha

feeling heightened stress levels and disappointment while John expressed feeling emasculated. During therapy sessions, he would often shut down and said he had no voice. The couple said their imbalance was reinforced by their financial situation. As Marsha currently made significantly more money, John felt he was not contributing enough to have a voice. He noted how he was brought up in a family where the husband was the primary wage earner. This was compounded by John's growing student loan balance, with repayments soon to begin.

Additional stressors for the couple were the significant changes that were on the horizon. With John's imminent graduation, he was openly exploring the job market and it had quickly become evident that employment opportunities, while strong, were likely to require that the couple move to a different location, which would change Marsha's employment and success. Due to his field of study, John expected to receive a well-paying job, which, compounded by Marsha's need to find a new job after the move, would vastly alter their relative financial pictures. There were many complex emotions concerning these decisions, which included both John and Marsha being fearful of change. Hovering over all this change was the stress of planning and paying for their wedding as well as the impending need to combine finances and begin repaying significant student loans, serving to further irritate the tensions in their relationship.

Intervention

After the family therapist asked and received permission from John and Marsha to include a financial planner in their therapy sessions, the family therapist and financial planner met to establish working parameters for their interaction. Having worked together previously, they had built a level of rapport and trust that provided them the basis needed to work together collaboratively to address John and Marsha's concerns. Given this prior investment of time, the family therapist felt comfortable with their working relationship and the financial planner was introduced to John and Marsha. Importantly, the financial planner was not introduced as an extra or tangential service, but rather integrated into the existing dialogue as a content expert to help address the concerns and issues already brought to the table by John and Marsha.

> The therapist played a relatively minor active role in the first session, but was able to gather significant information about the clients and at times help the couple de-escalate their emotional reactivity with one another.

As might be expected, the first collaborative session was mostly focused on the financial planner establishing rapport with John and Marsha and gathering necessary client financial information. While the financial planner was focused on data gathering, the family therapist was able to observe the interaction, focusing on the

discussion and interplay between the couple as they discussed their financial situation and goals. Consequently, the therapist played a relatively minor active role in the first session, but was able to gather significant information about the clients and at times help the couple de-escalate their emotional reactivity with one another. Before and after each session, the family therapist and financial planner spent time debriefing with each other, sharing their insights and observations of the session. This debriefing is critical to maintaining an active working partnership and maximize the benefits of the collaborative synergies. Specifically after the first session, the family therapist was able to frame John and Marsha's communication and financial goals through her understanding of their relationship. This included bringing in aspects of their own family of origin and how their parents communicated about financial decisions as well as cultural expectations they felt about their roles in the relationship. Importantly, this provided the financial planner with new understanding on how to base subsequent financial analyses, and reporting to the clients in a manner that would coincide with the work being done by the family therapist to alleviate relationship distress.

In this case, four collaborative sessions were held. Based on data gathered in the original session, the second session centered on the financial planner sharing the outcomes of his analysis and presenting the financial options available. Given that many of their financial issues centered on how to integrate and share financial responsibilities, the financial planner consulted with the family therapist prior to the session to gain insights in how to best frame and convey recommendations, given her greater understanding of the couple's relationship dynamics. In session, a dialogue between both counselors and the couple was held, with the family therapist often guiding the couple's discussions around the financial matters as presented by the financial planner. While the financial planner was able to bring the financial advice to the table, the family therapist helped to align that advice with the relationship dynamics of the couple.

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The third and fourth sessions centered on implementation of the financial recommendations and discussing client feedback and feelings related to these actions. While the actions recommended were financial in nature, they paralleled and reinforced the relationship changes of the couple. John and Marsha married in-between the third and fourth sessions, serving as a culmination of much of the financial advice as well as serving to address many of the stressors present in their relationship. A relatively large time gap in sessions was held between the third and fourth sessions due to this, allowing the fourth session to be much more retrospective than focused on upcoming changes and actions. Consequently, the family therapist largely ran this session to explore relationship changes felt by the couple.

Outcomes

Over the course of the four sessions, significant improvements were noted in John and Marsha's interaction and relationship. While originally seeking to maintain separate finances and accounts, over the course of the sessions the couple decided to combine the majority of their financial accounts. Through reflection, John was better able to appreciate the financial support provided by Marsha and understand the stress she had been under. Conversely, through looking forward to John's employment and the financial changes it would bring, Marsha was better able to come to peace with her sacrifices in providing this support. These realizations, combined with moving through the stressors and positive emotions associated with getting married, provided for more open and continuous dialogue surrounding financial matters, which then translated to other areas of the relationship. It was typical for the family therapist to encounter hostile conversations in the original premarital counseling sessions, however there were marked changes and enhanced cooperation during the collaborative sessions. After the four sessions, John and Marsha, in consulting with both service providers, decided to discontinue collaborative relational therapy. Having achieved balance in their relationship, they transitioned to a more traditional service whereby they began meeting solely with the financial planner.

Overall, through collaboration with a financial planner, the family therapist was able to provide for improvement and empowerment in financial matters that would have been outside of her area of expertise. As indicated by the ecosystemic perspective, addressing these stressors enabled the therapist to focus attention on John and Marsha's relationship and the effect of each other's behavior. John and Marsha were able to communicate in a healthier manner and improve overall relationship quality. Meanwhile, through insight from the family therapist, the financial planner was better able to understand and incorporate relationship dynamics in framing his recommendations. Through collaboration inside and outside of the counseling room, the family therapist and financial planner were able to achieve improvements in the couple's financial and family lives that may not have been possible otherwise.

Ethical Considerations

Ethical considerations must be taken into account when determining whether to perform collaborative relational financial therapy. It is critical that each professional is clear about the limits of their professional standards, attending to such aspects of dual relationships, confidentiality, competence, use of social media, and fee collection. Before counseling beings, each professional must be willing to invest time to create a working relationship with his or her counterparts. This is essential to create a cohesive working relationship. Furthermore, each professional must have confidence that, given clients' presenting problems, collaborative relational financial

therapy is likely to achieve better results than individual counseling. In many cases, a single professional may more appropriately address the clients' presenting issue.

Future Directions

Given the broad guidelines provided within the collaborative relational model of financial therapy, the modality is likely to continue to evolve and grow over time. What originally began as a model to facilitate family therapists and financial planners to work together to provide cohesive service to clients has already grown to include integration with nutritionists, lawyers, and home environment and design experts. As indicated by the ecosystemic perspective, over time, additional environmental stressors and resources will be identified and integrated within the collaborative relational model of financial therapy.

> It is critical that each professional is clear of the limits of their professional standards.

In the short run, broad expansion of the collaborative relational model of financial therapy may be easier to achieve in the university setting. Many large universities boast programs that train students in many of the services mentioned, often contained within the same college (e.g., colleges of family and consumer sciences or human ecology). Given the benefits of experiential learning, uniting academic programs to create collaborative clinics (or augment existing clinics) benefits the students as well as community members, universities, and the profession. In addition, many law schools already recognize the benefit of service learning and contain clinics providing pro bono legal counseling, an existing entity that may be leveraged to integrate this crucial service. In many cases only reorganization and cooperation among faculty and existing programs is required, creating possibilities for rapid growth.

In addition to the opportunities to expand in a university setting, the services provided by the collaborative relational model of financial therapy can be replicated in the private and nonprofit sectors. For financial planners grounded in comprehensive and holistic financial planning, the concept of relying on and incorporating related service providers is already ingrained into their service model. In some cases, it may be possible to augment and evolve these existing relationships to develop a collaborative service model, and moving toward the holistic characteristics of the collaborative relational model of financial therapy. As a first step, practitioners should seek out likeminded professionals in compatible service areas that recognize the interrelated nature of their services and their impact on consumers overall well-being.

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Chapter 11
Ford Financial Empowerment Model

Megan R. Ford

Introduction

As financial therapy grows, more questions arise from practitioners, professionals, researchers, and academics as to how we can work most effectively with persons experiencing coexisting financial, emotional, relational, and economic stressors. This chapter highlights the Ford Financial Empowerment Model (FFEM).[1] The FFEM integrates financial education and skill building with popular relational therapies that can be utilized with persons presenting financial empowerment issues.

Description of Chapter Topic

What does financial empowerment look like? Perhaps you know someone who demonstrates financial success and confidence. On the other hand, maybe someone else in your life seems the opposite of financially empowered. How might you describe them? Also, what contextual factors are essential to acknowledge during the process of financial therapy? Most importantly, how can financial therapy, and the FFEM specifically, assist those seeking more confidence and knowledge with their finances? This chapter addresses these fundamental questions, along with many more. Discussion and explanation of the model's stages, structure, and theoretical components are outlined, including detailed information on the model's theoretical

[1] The FFEM was originally published in *The Journal of Financial Therapy*. What is presented in this chapter is a revision based on further testing and utilization of the model. Namely, the use of experiential therapy has diminished, whereas the focus is more on cognitive-behavioral and narrative therapies. The stages have also been renamed from the original printing, although the principal remains the same.

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anchor points—cognitive-behavioral and narrative therapy. In addition, an exploration of common themes in the work of financial therapists, including empowerment, confidence, and contextual considerations.

Evidence-based work, just like in the science, medical, and traditional clinical mental health fields, is fundamental to the development and validity of financial therapy.

Theoretical Considerations

A theoretical underpinning is essential to both present and future models of financial therapy (Archuleta and Grable 2010). Since financial therapy is still in its infancy, many theoretically backed, evidence-based models for practice have not yet been created. Evidence-based work, just like in the science, medical, and traditional clinical mental health fields, is fundamental to the development and validity of financial therapy. The evidence-based model of financial empowerment presented in this chapter integrates cognitive-behavioral and narrative therapies with financial education and intervention (Beck 1976; Beck et al. 1987; Ford et al. 2011; Freedman and Combs 1996; White and Epston 1990; Wright et al. 2006). Cognitive-behavioral, narrative, and experiential therapy models are popular models used in the practice of marriage and family therapy, as well as in other psychotherapy fields (Beck 1976; Beck et al. 1987; Freedman and Combs 1996; White and Epston 1990; Wright et al. 2006).

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy, or CBT as it is often referred to, is a popular therapy technique that spans psychology, counseling, therapy, and social work. A commonsense approach, CBT relies upon two fundamental themes: (a) thoughts (or cognitions) have a significant influence on emotion and behavior, and (b) behaviors can affect patterns of thought, as well as emotions (Beck 1976; Beck et al. 1987). CBT focuses on one's thoughts, feelings, and subsequent behaviors and the interplay between them. While this approach can be fairly structured and directive, it also allows space for the client to recognize repeated patterns that are not constructive, in turn gaining important insights (Beck 1976; Beck et al. 1987; Wright et al. 2006). CBT can potentially work well in helping clients of financial therapy, as it can assist them in identifying and changing the patterns that keep them financially disempowered (Ford et al. 2011).

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Narrative Therapy

Our lives and experiences can be viewed as our *stories,* which is a basic tent or premise of narrative therapy. Narrative therapy is positive, collaborative, and focuses on the therapist helping the client to co-construct a more preferred, or empowered, life story (Freedman and Combs 1996; White and Epston 1990). This therapy is easily integrated into financial therapy practice, as we can look at our financial experiences as stories about money (Ford et al. 2011).

With many different theories in psychotherapy to draw from, cognitive-behavioral and narrative theories are utilized for the FFEM's approach to financial therapy for specific reasons. In large part, the theories highlight the collaboration and working relationship between practitioners and their clients—which involves equality, partnership, and alliance. All of these elements are foundational in building empowerment (Ford et al. 2011). When a client of financial therapy feels supported and confident, yet is challenged to be a part of the process of learning and goal making, and not just a spectator, feelings of empowerment can develop (Ford et al. 2011). A client has more ownership and pride in these accomplishments, as they are attributing their growth and success to themselves, rather than another.

Second, the theoretical frameworks incorporated also have a similar end goal of creating new ways of thinking and feeling, yet the process of getting to that goal is different for each. The cognitive-behavioral approach involves the exploration of thinking, feeling, and behaving, with cognitions and behaviors as the main focus (Beck 1976; Beck et al. 1987; Wright et al. 2006). Narrative therapy examines the self-defeating thoughts that can lead to problem-saturated stories and focuses on "re-storying" or "cognitively altering" these self-defeating thoughts in order to form more empowering life stories (Freedman and Combs 1996; White and Epston 1990). Although different, components of cognitive-behavioral and narrative therapies can blend and build upon the other quite naturally (Ford et al. 2011).

Financial therapists consist of practitioners from varying disciplines, some of whom may be more familiar and confident with the specific approaches and therapeutic techniques in the FFEM. While it is not necessary that a practitioner of the FFEM be a licensed mental health professional or a certified financial practitioner, it is strongly recommended that practitioners act ethically, remain within their scope of practice and knowledge, and do significant research on the techniques and concepts the FFEM utilizes. An adequate understanding of the FFEM elements is essential before integrating them into financial therapy practice.

> …when a person feels empowered, they are more likely to take initiative and feel accomplished and successful.

Empowerment in Financial Therapy

With theoretical underpinnings then established, it becomes necessary to address how empowerment is relevant to work in financial therapy, and how it would be defined or conceptualized through the FFEM's theoretical lenses. To empower is to help individuals who feel inadequate in handling a situation to discover the capabilities that reside within them. Blanchard et al. (2001) described the facilitation of empowerment as a process that makes it possible for individuals to recognize and gain complete access to their internal power, security, and influence. Facilitating empowerment makes it possible for individuals to utilize that power and strength when engaging with themselves, others, and society and its various institutions (Blanchard et al. 2001).

The FFEM views the process of facilitating empowerment within financial therapy in similar ways. From a narrative therapy perspective, the belief is that it is possible for clients to rewrite their stories, thereby creating a more adaptive and preferred way of living, and the collaborative therapy process can assist in recognizing or anchoring this (Freedman and Combs 1996; Nichols and Schwartz 2007; White and Epston 1990). Similarly, the FFEM's approach to financial therapy validates the notion that clients are strong and resourceful and have the ability to be powerful, productive, and motivated. Empowering clients involves facilitating a process in which clients can begin to assert themselves and more fully utilize their inherent strengths. Financial empowerment is arguably integral to financial health and well-being. When a client feels confident, motivated, and competent in dealing with important aspects of their financial life, they are becoming financially empowered (Ford et al. 2011). Ford et al. (2011) asserted that when a person feels empowered, they are more likely to take initiative and feel accomplished and successful.

The FFEM views the process of facilitating empowerment within financial therapy in similar ways. Empowering clients involves facilitating a process in which clients can begin to assert themselves and more fully utilize their inherent strengths. To understand the use of empowerment in the FFEM model, looking at it in both a theoretical and cultural context is essential. To grasp the FFEM for financial therapy, it becomes necessary to establish how each theoretical model might view issues related to empowerment, and conversely, disempowerment (Ford et al. 2011).

Empowerment and Cognitive-Behavioral Therapy

Feeling disempowered can manifest itself in many different ways. Through a cognitive-behavioral perspective, a lack of empowerment could be understood as perpetual negative automatic thoughts and schemas, or fundamental ideas about oneself and the world, that cause clients to feel helpless, powerless, and hopeless, which in turn can prompt them to act according to these negative beliefs about themselves and their abilities (Beck 1976; Ford et al. 2011; Wright et al. 2006). Negative patterns of thinking, feeling, and behaving keep clients trapped in a cycle that fuels

disempowerment and hinders feelings of success and confidence. Through the use of cognitive-behavioral techniques, the practitioner can assist the client in identifying and restructuring these negative patterns, giving way to more empowered behavior.

Empowerment and Narrative Therapy

From a narrative therapy perspective, the lack of empowerment may be seen as a negative, inescapable story that clients have constructed about themselves or about the world in which they live. They have internalized the external ideas about power, influence, and worth, making them feel that they, themselves, are disempowered (Ford et al. 2011; Freedman and Combs 1996; White and Epston 1990). Negative narratives about oneself and one's inability to reach his/her full potential can be considered stories of disempowerment that keep clients from entertaining the possibility of a new, more fulfilling story.

> Negative narratives about oneself and one's inability to reach their full potential can be considered stories of disempowerment that keep clients from entertaining the possibility of a new, more fulfilling story.

The Ford Financial Empowerment Model

The FFEM is a four-stage model consisting of (a) preparation, (b) skills development, (c) narrative development, and (d) termination as illustrated in Fig. 11.1. While the preparation stage is essential to creating a foundation for successful financial therapy, moving forward into the other stages can be less structured. The stages in the FFEM were organized in a way that allows for some fluidity and movement back and forth among stages, where practitioners can invite clients to move deeper into the process of change or facilitate change at a more concrete, surface level, whichever suits the client and their unique needs. The FFEM process is like digging, in which the practitioner and client work collaboratively to uncover more insight and establish more substantial and permeating change, as they explore below the surface (Ford et al. 2011; Satir et al. 1991). The process is highly individualized and professionals should use their best judgment, while also generating feedback from clients and collaborating with them about what "their version of success looks like." For instance, it may be that client success, to the degree that it warrants termination from the financial therapy process (stage 4), is achieved just by working through stage 2. Others may view this differently and communicate the desire to explore more deeply how their financial stories and experiences with money are preventing them from reaching financial empowerment (stage 3).

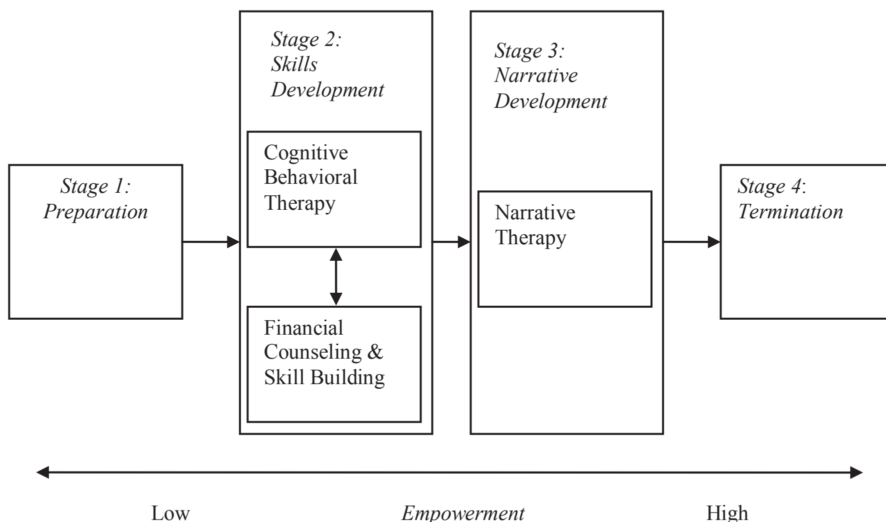

Fig. 11.1 Revised Ford Financial Empowerment Model. (see Ford et al. 2011)

> If process-level considerations are not taken into account, the practitioner may completely miss critical elements of the case, and as a result, be less effective in assisting a client with their unique needs (Ford et al. 2011).

Preparation Stage

The Initial Consultation Prior to entering into the financial therapy process that utilizes the FFEM, the financial therapist engages in an initial consultation session with the client. The model defines "financial therapist" as a mental health practitioner, a financial expert, or a pairing/group of these persons. The initial consultation is intended to achieve several things, including: (a) identifying the presenting issue; (b) assessing red flags, needs, and goals; (c) determining the desire and willingness for change; and (d) determining if the client is a good fit for financial therapy or if outside referrals need to be made (Ford et al. 2011). Once the initial consultation is completed, case conceptualization can begin.

Case conceptualization is a crucial aspect of the FFEM, as it creates the opportunity for the financial therapist to make theoretically-based assumptions about potential underlying issues impacting the client (Ford et al. 2011). The conceptualization of a case is often referred to as "thinking at the process level" by mental health practitioners. Process-level considerations are important considerations, such as culture, gender, power dynamics, education, and relational/family-of-origin issues. If process-level considerations are not taken into account, the practitioner may

completely miss critical elements of the case, and as a result, be less effective in assisting a client with their unique needs (Ford et al. 2011).

Assessments Within both research and practice, it is crucial to be able to evaluate whether therapeutic efforts are having an impact. Just as the FFEM is theoretically informed, it is also important for present and future financial therapy work to be empirically based (Archuleta and Grable 2010). In the preparation stage of the FFEM, several formal assessments from both traditional mental health and financial disciplines are completed by the client, including the Outcome Questionnaire-45.2 (OQ-45.2) and Patient Health Questionnaire (PHQ-9), which are mental health assessments for overall functioning and depression symptoms, and a number of individualized rating scales that measure financial stress, satisfaction, behaviors, and knowledge (Ford et al. 2011; Kroenke et al. 2001; Lambert et al. 2004). To reiterate, only those practitioners with adequate experience in administering mental health and financial assessments should integrate these procedures into their personal financial therapy practices. While the FFEM utilizes the OQ-45.2 and PHQ-9, other assessments that measure basic functioning, along with anxiety and depression symptomatology, could also be effective and achieve similar assessment goals. Other applicable measures include financial satisfaction, objective and subjective financial knowledge, and financial behaviors. See Chapter 5 for additional information on assessments in financial therapy.

Stage 2: Skill Development

Once the preparation stage is completed, stage 2 begins. Stage 2 encompasses the utilization of both cognitive-behavioral and financial counseling and education across approximately four to six sessions (Ford et al. 2011). Depending on the client's background and unique experiences, in addition to the complexity of their current financial issues, this stage may take more or less time. Interventions and techniques from each theoretical perspective are discussed.

CBT Interventions The CBT framework respects clients' views of the problematic situation and offers proactive and concrete interventions to motivate clients. Interventions are aimed at disrupting patterns of avoidance or helplessness and developing coping skills (Wright et al. 2006). Specific interventions related to cognitive-behavioral practices that can be most useful in financial therapy are the introduction of the cognitive-behavioral model, agenda setting, thought records, and homework (Beck 1976; Beck et al. 1987; Wright et al. 2006).

The *cognitive-behavioral model,* an intervention utilized in stage 1, helps clients better conceptualize and understand the interactions between thoughts, feelings, and behaviors (Beck 1976; Beck et al. 1987; Wright et al. 2006). In the FFEM, this intervention is collaborative and visual. The practitioner assists the client in exploring and connecting the elements of their thoughts, feelings, and behaviors, and will draw this out on paper, or on a marker board for the client to see more clearly.

> The ongoing interaction between one's thought process, feelings, and actions may perpetuate a chain-reaction or pattern that can spiral out of control and be disempowering, misinforming one's choices (Ford et al. 2011).

Applied to financial therapy work specifically, how someone perceives a given financial situation, conjures up feelings about the situation, which in turn informs how they act in that financial situation. How people choose to act can then lead to new feelings pertaining to the financial situation. The ongoing interaction between one's thought process, feelings, and actions may perpetuate a chain reaction or pattern that can spiral out of control and be disempowering, misinforming one's choices (Ford et al. 2011). In summary, the cognitive-behavioral model can assist in identifying and understanding patterns of disempowered financial thoughts, feelings, and behaviors that can then inform its restructuring (Beck 1976; Beck et al. 1987; Wright et al. 2006).

Additional interventions and techniques from the cognitive-behavioral framework are also utilized in FFEM model work. *Agenda setting* is a process in which the events and goals for the session are outlined to help guide and organize the therapy session. Agendas mimic a "to-do" type list with items that clients can check off as they complete each task. This intervention provides structure to sessions, and thus helps empower clients by instigating feelings of accomplishment. *Thought records* are designed to help clients understand the interplay between thoughts, feelings, and behaviors and examine its legitimacy (Beck 1976; Wright et al. 2006). These records can be particularly helpful with problem-saturated financial narratives and unhelpful thought patterns, as it offers clients the opportunity to examine the evidence for and against these thoughts. Evidence sometimes begins to prove to clients that their thoughts and patterns are unwarranted or unnecessary. *Homework* can include a variety of things from assigned readings, activities, or research, to important questions for clients to ponder, all of which may help build clients' independence and confidence in their abilities (Wright et al. 2006).

Financial Counseling Interventions During stage 2, the FFEM encourages practitioners to begin financial education and skill building through combining, when appropriate, financial counseling intervention and cognitive-behavioral techniques. Popular financial counseling and educational interventions (e.g., checking credit reports, tracking spending, co-constructing cash flow statement, negotiating wants versus needs, building a spending plan, organizing a debt-repayment plan) can be integrated with CBT interventions because they focus on changing behavior through a deliberate process of restructuring thoughts and actions around money (Ford et al. 2011; Garman and Forgue 2006). Financial education materials, handouts, and budgeting tools connect particularly to the cognitive-behavioral homework intervention, as these are things that clients can often read, explore, or complete outside and in between meetings with the practitioner. Many financial counseling interventions can help clients gain knowledge and understanding of financial issues through the practice of "doing," which can restructure one's thought processes in

how they view their current behavior, ultimately changing the way they manage their finances (Ford et al. 2011). Although the cognitive-behavioral practitioner is often viewed as the expert, it is important that when using the FFEM that they work collaboratively with the client and employ the "expert" role in a psychoeducational frame (Wright et al. 2006). Collaborative work may be most effective with clients who lack empowerment, as it challenges them to be a vital part of the process, but also helps them to feel supported and encouraged (Ford et al. 2011). Collaboration with the financial therapist may also make clients more aware of the exceptional power they hold in the process of change, as clients can begin to witness their part in therapeutic progress.

Popular financial counseling and educational interventions can be integrated with cognitive-behavioral therapy interventions because they focus on changing behavior through a deliberate process of restructuring thoughts and actions around money (Ford et al. 2011; Garman and Forgue 2006).

Stage 3: Narrative Development

To explore financial disempowerment more deeply and create new money stories, the model shifts to stage 3. Stage 3, although focused on the utilization of narrative therapy interventions, still may include elements of both cognitive-behavioral and financial counseling and education. The FFEM allows for transitions between stage 2 and stage 3, as it may be necessary to weave back and forth (Ford et al. 2011). Stage 2 can take four to six sessions, but once again, depending on the client's needs and goals, this stage may take more or less time.

Stage 3 of the FFEM dives deeper into a client's issues with money and assists them in creating a more preferred money story and feeling more empowered (Ford et al. 2011).

Narrative therapy, with its roots in social constructionism, asserts that society, the environment, and those who surround us have a strong influence over our beliefs, attitudes, and behaviors (Freedman and Combs 1996; White and Epston 1990). Narrative therapy's principles of freedom and flexibility of preferred narratives allow clients to construct stories about their lives that are relevant and meaningful to them. Collaboratively constructing a new, preferred story or narrative encourages clients to reexamine their problems and view them in a way in which they are less problematic or no longer pathological (Freedman and Combs 1996). In the same way, stage 3 of the FFEM dives deeper into a client's issues with money and assists them in creating a more preferred money story and feeling more empowered (Ford et al. 2011).

To rebuild the client's money stories, the practitioner and client engage in the process of co-construction, in which they work together to construct a narrative that opens the client up to new ways of being, feeling, and living. In order to form these new stories, helping professionals can use the deconstructive listening interventions from narrative therapy, which may help them to listen to clients in a different, more focused way (Freedman and Combs 1996). The process of deconstructive listening opens up space in the financial therapy process for pieces of clients' narratives that have not yet been storied or rewritten (Freedman and Combs 1996; White and Epston 1990). Through these listening interventions, clients come to understand that their stories around money are important and that they are heard, both of which are empowering. Users of narrative therapy attempt to actively listen for specific things, such as sparkling moments, unique outcomes, and story openings (Freedman and Combs 1996; White and Eptson 1990). Sparkling moments and unique outcomes are events or instances that are exceptional and may not have been originally predicted in the client's problem-saturated narrative. These distinctive moments and outcomes can become story openings, a starting point that the helping professional and client use to begin constructing new stories and preferred experiences.

Thoughtful and well-crafted questions have the potential to open up conversation, challenge clients, and provoke deeper thought. Narrative therapy creates space for story growth and development through the intervention of asking active, open questions. Such questions can be used to generate the preferred experiences and stories of clients by lingering longer and challenging the client to think more deeply (Freedman and Combs 1996; White and Epston 1990). Landscape of action and landscape of meaning questions can further facilitate the depth and breadth of stories. Landscape of action questions facilitate story development through examining the process and details of the narrative, whereas landscape of meaning questions open up conversation around the implications, meanings, motivations, goals, and beliefs within the financial story (White and Epston 1990; Freedman and Combs 1996). The utilization of these questions helps clients explore new stories to a greater depth and provides a richness and detail to the preferred narrative.

Lastly, one of the key narrative interventions is the process of externalization, or helping the client to recognize that the problem they are facing is external to them (Freedman and Combs 1996; White and Epston 1990). In other words, neither the client nor any part of the client is the problem. Externalizing the problem allows the client to see it as separate from their sense of self or identity, making the problem more manageable, and easier to confront or resolve (Freedman and Combs 1996; White and Epston 1990). When we lessen feelings of guilt and shame around money problems, we are likely to experience less avoidance as well (Ford et al. 2011; White and Epston 1990). The regained sense of control around money is extremely empowering and motivating (Ford et al. 2011). Externalization in financial therapy can be not only achieved through conversation but also enhanced through more exploratory and creative techniques, such as art, craft, and drawing activities.

> Termination of financial therapy within the FFEM model may be different case to case, as clients may choose to drop out and not return, initiate termination on their own without practitioner agreement, or the practitioner and client may be in mutual agreement about the ending of the process.

Stage 4: Termination

The completion of financial therapy work in the FFEM involves the process of termination. Termination of services can manifest in numerous ways, but the FFEM aims to have at least one session dedicated to reviewing and discussing the financial therapy process and the client's progress throughout. Despite this intention, termination of financial therapy within the FFEM may be different case to case, as clients may choose to drop out and not return, initiate termination on their own without practitioner agreement, or the practitioner and client may be in mutual agreement about the ending of the process. Several valuable things happen during termination sessions: (a) clients may gain more empowered feelings from looking back and reflecting on their progress, (b) practitioners may have the opportunity to receive valuable feedback on the financial therapy process, and (c) marking the end of the process provides clients an official "finish line." The needs and requests of clients, in addition to their feelings of readiness, should be considered.

Sensing when the client may be ready for termination is an important part of the last stage of the FFEM and financial therapy generally. As the client approaches stage 4, the financial therapist may witness the client taking on a more active role in the process, relying less on the financial therapist, to accomplish tasks and reach goals. Clients may also demonstrate more confidence, more positivity, and more empowered behaviors (e.g., positive, responsible financial behaviors, goal-oriented behaviors, consistency, more future orientation). It is also very possible that clients will verbalize their intentions to become independent of the practitioner and financial therapy process in the near future. When uncertain, the redistribution of assessment instruments that measure the areas of financial stress, satisfaction, and well-being may help the practitioner and client to know when they are possibly ready for termination, or independence from further financial therapy intervention.

Case Study

To demonstrate how the FFEM can be integrated into financial therapy practice, a case study based on actual financial therapy work is included. In order to protect confidentiality of the client, identifying and demographic information have been changed.

Background Information

Dana, a single, Caucasian, 23-year-old female from the Southern United States, had recently returned to school, taking a few classes at a time to finish her degree in graphic design. Dana was employed full-time for less than US$ 20,000 a year, but enjoyed her job and felt that it paid her well. A self-professed money avoider, Dana initiated financial therapy to learn more about money management and gain more confidence with her financial situation. During the initial session, Dana also shared that she had never experienced wealth in any capacity, as she grew up with a divorced, single mother who struggled with chronic mental health issues and who did not manage money well herself. The client noted that she had experienced significantly distressing issues related to her family of origin and had worked through much of it by attending mental health therapy services for several years. Dana was not participating in mental health therapy at the time she initiated financial therapy, but had been referred by her former therapist who mentioned that the financial therapy process may benefit her. Dana was extremely motivated to learn, and she demonstrated a willingness to explore her past and how it connects to her current money behaviors. Yet, as a clear indication of disempowerment, she displayed low confidence and a lack of uncertainty about her capacity to absorb this new financial knowledge. Dana's financial difficulties, coupled with the emotional and family issues she noted made her a great candidate for not only financial therapy but also the use of the FFEM.

Presenting Issue

As a self-proclaimed novice, Dana reported financial stress and noted feeling disempowered by her lack of financial knowledge, money confidence, and assertiveness in handling finances. Dana reported feelings of anxiety and fear when faced with money situations. She also stated that her rigid spending behaviors keep her from enjoying the money that she makes with her new job and going out with friends—instead she feels paranoid that there is never enough money and avoids spending. She was also interested in exploring her relationship with money and how her past financial experiences have shaped the way she behaves now. Dana reported that she has never sought financial help before and questioned whether she could feel or behave differently with money. Based on her initial assessments, the client was confirmed a good candidate for financial therapy work, and did not present any red flags related to anxiety, depression, and functioning.

It becomes important to note that in situations where clients do report significant or chronic depression, anxiety, and serious red-flag issues, like thoughts of self-harm, practitioners of financial therapy must recognize their professional boundaries and limitations of practice. In these cases, the client may need to be referred to a licensed psychotherapist for a more therapy-focused treatment. However, when stress, anxiety, and depression are directly related to financial issues and are of a

mild or moderate nature, the FFEM may be utilized to help alleviate symptoms, as it can target symptoms and financial difficulties simultaneously.

Practitioner Perspective

Dana suffers from a lack of empowerment with money, displaying symptoms like little confidence and limited financial education, anxiety and fear, avoidance, stress, and overly rigid money behaviors. Likely stemming from some of Dana's early family experiences, she developed ideas about life and money. Schemas or beliefs like "there is never enough money," "you cannot trust others," "you are responsible for yourself," "the world will not give you anything," and "you must work hard and spend very little to keep your head above water" were prevalent at the beginning of the financial therapy process. She also seemed to learn that strict saving behaviors and reported uneasiness in spending money in any way that she felt was frivolous. Due to her uncertainty about how to handle her money, Dana resorted to avoidance and hoarding as coping strategies.

Intervention

During the initial session, the preparation stage, the practitioner and client built rapport, explored her financial issues and behaviors, and established preliminary goals. The client shared more about her struggles with financial management and confidence, and after more assessment and discussion, the practitioner introduced the financial therapy process as a way of working with both the emotional and also the more concrete aspects of Dana's money issues. The client was interested in the process and agreed to participate in financial therapy. Dana stated that her top priorities for the process were: (a) understanding a small outstanding debt that had gone to collections and strategizing about how best to handle it, (b) organizing her financial situation now that she had a higher-paying job, (c) creating a spending plan, (d) better understanding insurance and benefits within her new job, and (e) planning for future purchases of a car and home.

Stage 2 Utilizing some common financial counseling interventions, in addition to the homework techniques popular in CBT, the practitioner asked the client to access her credit reports from www.annualcreditreport.com, and review the reports for accuracy. In addition, the client was encouraged to begin tracking her spending each day by recording them on her smartphone. The practitioner also asked the client to gather and bring to the next session any recent bank statements and paperwork related to outstanding debts. In an effort to collaborate with the client and build trust and rapport, the practitioner checked in with the client about her feelings as the preparation stage ended. Dana reported that she felt excited, positive, and relieved as the initial session ended, which the practitioner defined as an increase in empowered feelings.

In stage 2 (sessions 1–4), the practitioner and client worked collaboratively on examining her collection debt and building an appropriate spending plan based on her current income and expenses. At the beginning of each session, Dana was provided with a session agenda, and was encouraged to contribute to it with her own items, questions, and concerns. The client was also provided with handouts and self-help materials related to budgeting and creating a spending plan. The practitioner also helped Dana explore her employer's insurance options and included psychoeducation about the risks of not securing health insurance in the near future.

As the practitioner and client worked through her financial goals, she was encouraged to examine her thought process more closely. Dana focused more on how her thoughts, feelings, and behaviors around money interacted. She recognized that her automatic thoughts about there "never being enough money" influenced her feelings of anxiety and fear, which in turn increased her tendency to hoard and restrict her spending. With this new insight, Dana displayed more empowered thinking and behavior by slowly letting herself spend more freely, and feeling more confident and secure that one or two personal purchases or activity out with a friend would not break the bank.

Stage 3 In stage 3 (sessions 4–7), the practitioner and client continued to work on the client's financial goals, and the financial therapist also began to pose deeper questions related to the origins of her fear and anxiety with money. By utilizing narrative interventions, specifically deconstructive listening and externalization, Dana and the practitioner were able to continue the construction of a new, more preferred financial narrative.

In an effort to reframe the client's negative thoughts on money and assist her in constructing a new story, the practitioner incorporated an externalization intervention, which helped Dana to see her relationship with money differently. Initially, Dana communicated a significant level of anxiety and her aversive tendencies when dealing with her personal finances. The financial therapist and client explored the possible origins of these feelings and her notions about "money being, and causing, evil." Through deeper conversation, Dana recognized that her upbringing and the lack of money and education about financial matters had led to some of her ideas and negative feelings. During these discussions, the client would note feeling somewhat overwhelmed and powerless when dialogue focused on money matters and new concepts. In order to rebuild this narrative and identify sparkling moments, the financial therapist had Dana talk about recent times when she felt in control and more empowered in her dealings with money. This intervention gave the client evidence of her progress and defended against defeatist thinking. To empower Dana even further, the practitioner employed the externalization technique. The financial therapist and client dialogued about the nature of problems and how many of us connect our problems to a personal failing, thereby interpreting ourselves as the problem, and engaging in guilt, blame, and shame. The practitioner suggested the client to try to view her problem as external to her, co-creating the image of "money monsters" that keep her from feeling empowered with her money. As Dana explored her "money monsters" further, she discovered how they influenced her by "making

her feel she is incapable or that she is not doing enough and will not succeed." The financial therapist collaborated with the client to find ways to combat these ideas through continued organization and work on her financial situation, using more positive self-talk and recognition of her successes, and keeping an awareness of the "money monsters" and when she might be more vulnerable to their influence. Through stage 2, Dana noted an immense shift in her views on money. She reported that as a result of the exploration, in addition to her more organized financial state, she had come to fear money less and commented that she attached less emotion and meaning to it. Dana began to look at money as more of an object, explaining that she felt more control over it, and that "it is just there for use when I need it." This dramatic shift from anxiety to neutrality demonstrated an increase in Dana's empowerment around her money story.

As stage 3 was coming to an end, the practitioner was able to observe things that signaled Dana may be ready for termination of financial therapy. Dana demonstrated more independence from the process and in her work, as she began to research and learn about financial topics on her own, and elected to schedule fewer weekly appointments. Dana exuded more confidence in handling her finances and consistently reported not only positive behaviors, including staying within her budget, but also allowing herself to spend a little on herself and entertainment, and more future orientation, as Dana vocalized her desire to increase her savings and establish new financial goals. The practitioner discussed a termination session with Dana, who agreed that she felt ready to end the financial therapy process, as she had achieved her goals.

At the final session (8), or stage 4, termination, the practitioner congratulated Dana on her success and accomplishments. In an effort to solidify her increased empowerment, the practitioner and Dana each shared their perspectives on the process and highlighted Dana's achievements. The practitioner also encouraged the client to share feedback on her experiences with financial therapy and their work together. Dana provided valuable insight on how the techniques had worked for her and how grateful she was for the opportunity to change and improve. To end stage 4, the financial therapist ensured the client that she can check in or return for support if ever needed in the future.

Outcomes

The client and financial therapist worked together for a total of eight sessions, moving through each stage within the FFEM. As a result of the financial therapy process, Dana displayed and reported increased feelings of empowerment and consistently positive financial behaviors.

In stage 2, Dana secured her credit report, disputed the medical bill that had gone to collections, built and adhered to a new spending plan, and explored the possibility of securing her first credit card in order to meet future financial goals of buying a new car or a home by increasing her credit score. Dana's empowerment was evident

through her increase in confidence and security in her abilities. For instance, Dana took the initiative to create her own budgeting system and strategy, based on what she had learned from the financial therapist, and the handout materials she was provided in stage 2. She opened an account with Mint (www.mint.com) to assist her in her budgeting goals. The practitioner also provided psychoeducation around health insurance, building credit, and savings strategies. During stage 2, the client noted an increase in her willingness to spend more freely and worry less.

Within stage 3, the client reported experiencing a more intense change in her perspective on money. She and the financial therapist were able to co-construct a new money narrative that no longer made her feel powerless and inferior. She directly communicated her increased feelings of security and positivity and furthered her independence from the original ideas she held about money. As stage 3 ended, the client had successfully achieved her initial goals for the financial therapy process and had also developed a new savings plan, focused on future-oriented goals.

A redistribution of Dana's original assessments also evidenced positive outcomes and success in financial therapy using the FFEM. The OQ-45.2 and PHQ-9 were not redistributed as the client did not initially score in the clinical range for distress or depression. The financial satisfaction (Prawitz et al. 2006) assessment item indicated a 3 on the pre-test and a 7 on the post-test. Dana indicated a reduction in her financial stress level, from 7 on the pre-test assessment to a 2 on the post-test assessment.

Dana's post-assessment on financial knowledge (Flynn and Goldsmith 1999) also indicated a subjective increase, scoring 18 and 25 on the pre- and post-test, respectively. Changes in Dana's financial behaviors were measured using two different assessment tools—the Responsible Financial Behavior Scale (Perry and Morris 2005) and the Financial Behavior Scale (Garman et al. 1999). For the Responsible Financial Behavior Scale, the client scored 14 on the pre-test and 20 on the post-test. On the Financial Behavior Scale, Dana scored 19 on the pre-test and 31 on the post-test. Both assessments indicated improvement in financial behavior. The combination of Dana's positive subjective feedback and improved assessment scores helps to demonstrate the effectiveness of the FFEM in cases like Dana's (Ford et al. 2011).

Ethical Considerations

To be fully effective, financial therapists must take into account and be sensitive to the contextual factors with each client and explore how gender, education level, cultural background, and family relationships and upbringing influence their views and interactions with finances (Paniagua 2005; Thomas and Schwarzbaum 2006). While empowerment can seem rather straightforward, it is vital to recognize that empowerment in and of itself tends to emphasize individualism and other traditionally masculine concepts, like mastery, agency, and control (Riger 1993). Thus, developing feelings of empowerment may be quite different for clients from collec-

tivistic cultures, diverse backgrounds and educational levels, and for populations, such as women. For instance, for clients of collectivistic cultures, the concepts of "communion," "existing as part of a greater whole," influence their thoughts and beliefs, thus exploring culture and background need to be integrated into empowerment work, as it typically focuses on self-expansion and self-assertion (Ford et al. 2011; Riger 1993).

Future Directions

The FFEM is just one of many approaches that can be used in working with clients experiencing financial empowerment issues. Given the limited number of theoretically informed approaches to working with financial issues, this model provides a unique contribution to the field of financial therapy. While the FFEM specifically looks at empowerment in financial therapy, there is reason to believe that the model is flexible and broad enough to be applied to other issues related to finances. A training manual and session guide on the FFEM may be developed in the future for practitioners, educators, and other professionals.

This chapter presented a case study to demonstrate how this integrative model of empowerment can be utilized in the financial therapy process. However, more clinical research should be conducted on the FFEM to show empirically based evidence for a larger sample. Both academics and practitioners can benefit from such research to further develop theoretically informed approaches to working with clients and to establish the effectiveness of various models of financial therapy.

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Chapter 12
Stopping Overshopping Model

April Lane Benson

Introduction

You can never get enough of what you don't really need. Compulsive buying disorder, which flagrantly illustrates the veracity of this statement, is broadly defined as a maladaptive preoccupation with buying or shopping, characterized by irresistible, intrusive, and/or senseless impulses and behaviors, or results in frequent buying of more than can be afforded, frequent buying of items that are not needed, or shopping for longer periods of time than intended, even in the face of adverse personal, social, and financial consequences (McElroy et al. 1994). Though often referred to as the "smiled-upon addiction" after all, the economy is fueled by overconsumption, compulsive buying disorder is no laughing matter. It can and often does have serious, long-lasting aftershocks. In addition to the obvious financial consequences, emotional, interpersonal, and occupational problems abound, and in extreme cases, incarceration (Hajewski 2010) and suicide (Roberts and Jones 2001) have occurred. Despite the fact that compulsive buying disorder has been inching its way farther and farther out of the closet, inspired by television specials, documentaries, and reality TV shows, research interest in this widespread, often addictive disorder is still in its infancy. Compared to its psychological siblings—eating disorders, alcoholism, drug addiction, compulsive gambling, among others—financing of compulsive buying treatment studies is limited. The publication of books, such as this one, and the creation of the Financial Therapy Association suggest that the tide may be turning.

> …the proliferation of online shopping and auction sites has made the Internet a fertile environment for the growth of compulsive buying disorder…

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Following an overview of the history, epidemiology, and characteristics of compulsive buying disorder, this chapter presents a specific model for the treatment of compulsive buying disorder—the stopping overshopping model—a comprehensive 12-week experience that draws from psychodynamic psychotherapy, cognitive-behavior therapy (CBT), dialectical behavior therapy, motivational interviewing, mindfulness, and acceptance and commitment therapy (Benson and Eisenach 2013). A case illustration depicts how to use the model in practice. The chapter concludes with a brief review of results from a randomized, controlled pilot study of the effectiveness of this model (Benson et al. 2014).

Compulsive Buying Disorder

Compulsive buying was first described by Kraepelin in 1915 and later, in 1924, by Bleuler. After these early mentions, the condition was largely ignored until the late 1980s, when two factors combined to produce an increase in compulsive buying in the USA and an increase in interest among professionals. First, the income disparity between the very poor and the very wealthy in the USA widened during the 1980s and, simultaneously, the proverbial "Joneses" who used to live next door and had a lifestyle not much different from our own, were now being replaced by the "Joneses" who came into our homes through television each night. These "Joneses," even those we saw on blue-collar sitcoms, were portrayed with an upwardly mobile lifestyle, which ignited our desire for more, bigger, and better mousetraps (Schor 1998). Over the last 15 years, the proliferation of online shopping and auction sites has made the Internet a fertile environment for the growth of compulsive buying disorder (Dittmar et al. 2007; Lyons and Henderson 2000; Kukar-Kinney et al. 2009).

Evidence that compulsive buying is a grave and worsening problem is mounting. While compulsive buying is considered a culture-bound syndrome and occurs mostly in cultures that offer "mushrooming credit facilities and boundless buying opportunities," globalization has extended its reach. Scholarly articles on compulsive buying have been published in Canada (Valence et al. 1988), Mexico (Roberts and Sepulveda 1999), Brazil (Bernik et al. 1996), England (Dittmar 2004; Elliott 1994), France (Lejoyeux et al. 1997, 2007), Germany (Mueller et al. 2008; Scherhorn et al. 1990), India (Jhanjee et al. 2010), Spain (Ruiz-Olivares et al. 2010; Austria (Wolf 2010), Holland (Otter and Black 2007), Australia (Kyrios et al. 2004), China (Xiaoqing 2010), South Africa (Deon 2011), and South Korea (Kwak et al. 2003). Visitors from over 125 countries have gone to the author's website (www.shopaholicnomore.com), leading one to conclude that compulsive buying is a nearly universal problem.

A large-scale telephone survey of over 2000 randomly selected US households suggested that 5.8 %—approximately 17 million Americans—demonstrate symptoms of compulsive buying (Koran 2006). A later study examined the prevalence of compulsive buying disorder in three narrowly defined subgroups. That study

revealed that 8.9% of staff at a southern university, 15.5% of undergraduate students at the same university, and 16 % of consumers of an online women's clothing retailer scored in the compulsive buying range (Ridgway et al. 2008).

Compulsive buying affects a diverse and large group of Americans. The "typical" compulsive buyer is a 30-something female who experiences irresistible urges, uncontrollable needs, or mounting tension that can only be relieved by the compulsive buying of clothing, jewelry, shoes, and cosmetics. This "stereotypical" compulsive buyer has generally shown the previously stated characteristics since her late teens or early 20s (Black et al. 1997; Christenson et al. 1994; Scherhorn et al. 1990). However, the spectrum of compulsive buyers is wide, reflecting people who differ from one another on many dimensions, such as age, gender, socioeconomic status, patterns of buying, the intensity of their compulsion, and underlying motivation. Compulsive buyers differ, too, in their patterns of behavior. Some are compulsive daily shoppers, some go on occasional but consequential shopping "binges," and some collect compulsively. There are image spenders, revenge spenders, bulimic spenders (who need to rid themselves of their money), and codependent spenders (who enable the spending of others). Some buy multiples of each item, some compulsively hunt for bargains; others are compulsive hoarders, and still others engage in ceaseless buy–return cycles.

Compulsive buying can occur in people with any of the different money scripts (Klontz et al. 2008), and it can also be connected to most of the money disorders that have been identified in the financial therapy literature, including compulsive hoarding (Frost and Hartl 1996; Frost et al. 1998; Frost et al. 2002; Mueller et al. 2007), financial denial, financial enabling, financial dependence, financial enmeshment, and financial infidelity (Klontz et al. 2008). See Chapters 3 and 4 for more information on money scripts and disorders, respectively.

Why Overshop?

American culture is one of "competitive consumption" (Schor 1998), in which the acquisition of consumer goods and services is associated with the attainment of happiness. Women are taught that a flattering dress or the perfect hair-care product will make them irresistible to men, while men come to believe that purchasing a sports car attests to their masculinity and their success. The false belief that goods are transformative agents becomes toxic when combined with the over-availability of credit cards. In 2005, 2006, and 2007, nearly 6 billion credit card offers went out to the American population—that means more than 20 offers per year went out to each American citizen (Synovate 2007). In 2012, the total US credit card debt was US$ 793.1 billion; average credit card debt per family reached nearly US$ 16,000, 76% of college students were in possession of at least one credit card, and 56% ran an unpaid balance in the past 12 months (Credit Card Debt Statistics 2012). This easy, available credit along with the notion that buying goods brings happiness has definitely been a factor in the skyrocketing number of personal bankruptcies, in spite of recent legislation that made it harder to declare bankruptcy.

> The false belief that goods are transformative agents becomes toxic when combined with the over-availability of credit cards.

Individual and familial issues combined with cultural and societal considerations make compulsive buying disorder complex and multi-determined. Many shopaholics seek and achieve emotional relief and momentary euphoria through compulsive buying. Some overshop as a response to loss or a major life trauma, to avoid confronting something important, or to feel more in control. Others overshop to express anger or exact revenge (Elliott 1994), or use buying for others as a way to hold onto love. Some overshop as a way to belong to an appearance-obsessed society or to put forth an image of wealth and power. Underlying many of these motivations is an attempt, albeit ultimately unsuccessful, to become their ideal self or gain social status.

Dittmar (2007) explored underlying social psychological mechanisms that play a significant role in compulsive buying. From this perspective, excessive (or "compulsive") buyers have two main characteristics. They score high on a measure of materialism, believing that consumer goods are an important route towards success, identity, and happiness. They also purchase these goods in order to bolster their self-image, in an attempt to bridge "gaps" between how they see themselves (actual self), how they wish to be (ideal self), and how they wish to be seen (ideal self).

Although mood repair and higher self-esteem are many overshoppers' goals, the positive feelings do not last long. Dittmar (2004) compared the moods and self-evaluation in ordinary and compulsive buyers during three phases of consumption: (a) just before purchase, (b) just after purchase, and (c) at home. Although shopping elevates the compulsive buyer's mood and self-evaluation right after the purchase, by the time the shopper returns home, mood and self-evaluation have dropped considerably, although not quite to the pre-purchase level. Thus, the overbuying, while extremely costly financially and otherwise, is mildly successful, which is what reinforces the toxic cycle.

Stopping Overshopping Model

Overview and Structure

First developed in 2005, the stopping overshopping model is a comprehensive program, led by a trained professional, unique for its eclectic integration of treatment approaches that have been shown to be successful with compulsive buyers. The program teaches specific skills, tools, and strategies to help group members break the cycle that leads to compulsive buying and develop the capacity to lead a richer life in the process. For simplicity, this chapter merely summarizes the model and shows how it can be applied by financial therapists. See Benson and Eisenach (2013) for a detailed description of the program.

Clients read *To Buy or Not to Buy: Why We Overshop and How to Stop* (Benson 2008) in its entirety and complete the written exercises in the shopping journals, as briefly summarized in this chapter. When the model is used with a small group, there are 12-weekly 100-minute sessions. When the program is used with an individual overshopper, there is much more flexibility regarding the order in which the material is introduced, the amount of time spent on each exercise, and even whether every exercise will be included. If the client is not in treatment with another therapist, sometimes the program is interwoven with work on other psychological issues. When clients are simultaneously involved with another professional—psychotherapist, psychopharmacologist, professional organizer, financial counselor, accountant, or lawyer—it is desirable, with the client's written permission, to collaborate with the other professional.

The model is intended for teenagers or adults who are currently affected by compulsive buying symptoms, as assessed by a previously validated compulsive buying assessment, and void of evidence of bipolar I disorder, psychotic illness, suicidal intention, and/or drug/alcohol dependence. Prior to commencement of the program, the clients complete a personal history questionnaire, which asks about education, work, family, health history, social life, other symptoms, and psychotherapy experience. A demographic data form asks about income, use of credit cards, and debt, and at least two of the following four compulsive buying screeners: (a) Faber and O'Guinn's (1992) Compulsive Buying Scale, (b) Valence et al.'s (1988) Compulsive Buying Scale, (c) the Richmond Compulsive Buying Scale (Ridgway et al. 2008), and (d) the Yale-Brown Obsessive Compulsive Scale—Shopping Version (YBOCS-SV; Monahan et al. 1996). Clients also complete a 2-week purchasing recall form (Mitchell 2006) on which they list all impulsive and compulsive purchases made during the previous 2 weeks; what the purchase was, how much it cost, and how long they shopped.

There are four distinct parts to each group session, beginning with a loving kindness meditation, during which the members offer love to themselves and to others, bring to mind one of their good qualities, picture their loved ones, and follow their breath. The meditation serves to help group members center themselves, brighten their minds, and let go of outside concerns. Next, each member reports on his or her progress on the weekly goal and on any overshopping challenges experienced during the week. The following portion of the session is a time for each member to share a highlight from the writing assignments completed during the previous week. At the end of the session, the therapist introduces the next week's material and the accompanying exercises.

Throughout the week, the members engage with each other and the therapist using an online forum to post weekly goals and homework assignments, discuss what they did not have time for during the session, share information, challenges and triumphs, and give and receive support. The forum is also used by the therapist to debrief each session by posting a note that includes something specific for each group member related to what came up during the group, and a general note that underlines critical points from the session, reminds the members of their goals for next week, and encourages them with a motivational, inspirational quote. This reinforces

the session, gives each member personal attention related to his or her progress, and forms a bridge to the next session. With an individual overshopper, there is similar contact during the week via email.

The use of a shopping support buddy is another important component of the program. A shopping support buddy is an advocate, chosen by the overshopper, who helps the person as he or she moves toward stopping overshopping. How the shopping buddy is used depends on each dyad, but, in general, a shopping buddy is available to help the overshopper successfully negotiate overshopping urges, brainstorm about the written exercises, assist with formulating and following through on weekly goals, revisit what the overshopper has learned and observed during the program, and sometimes accompany the overshopper on shopping trips. Committing to a specific, measurable, realizable goal each week is a thread woven throughout the fabric of the program. Goals are created using the motivational interview format, which asks the participant to: (a) rate the importance of the goal, (b) explain why it is that important and not more or less so, (c) decide how to go about meeting the goal, including committing to a first step, (d) identify potential obstacles and how they might be overcome, and (e) assessing and substantiating the level of confidence the overshopper has in executing this goal (Miller and Rollnick 2002).

> A Shopping Support Buddy is an advocate, chosen by the overshopper, who helps the person as he or she moves toward stopping overshopping.

Content

The formal work of the program begins with an exploration of the questions "Why do you overshop?" and "How did it all begin?" Overshoppers write a short narrative about the *function* of the behavior in their lives, having been prompted by material from the text, and then answer questions about early family influences, peers, community, and media influences, and about how they learned to use money.

With the exploration completed, participants read about common overshopping triggers and common overshopping consequences, and complete personal lists of both. Next, each person begins a thorough investigation of shopping urges in the moment when the urge is present, by following a prescribed sequence of steps. This process is supplemented by an exercise that invites them to think through the path they would like to see their lives take in the future. This vital step prompts each participant to imagine the difference between their ideal future and their future with overshopping. Seeing the true cost of continuing to overshop in the years to come enhances motivation for change in the present. Having begun to shake up some of the denial about the long-term effect of their overshopping, clients formalize the pros and cons of overshopping by completing a decisional balance matrix, a way of exploring their own ambivalence about change.

Clients now extend their self-learning by creating an inventory of when, where, with whom, and for whom they shop, as well as what they buy, what they tell themselves about why they are buying it, and about their relationship with specific favorite purchases. Exercises to enhance clients' ability to becoming more mindful about their financial lives demonstrate the centrality of savings and the appalling cost of credit card debt. Recording, categorizing, and evaluating each expenditure as to its relative necessity is done from this point on.

By now, clients have laid the groundwork for a thorough investigation of what it is they are *really* shopping for. First, they identify the authentic underlying needs that currently ignite their impulses and propel them into self-defeating overshopping, and then they think through ways to meet those needs more directly and more positively, ways that enhance rather than erode their lives.

What makes compulsive buying such a difficult addiction to conquer is that shopping is unavoidable. There is no way to get around shopping for necessities, such as food, clothing, and transportation, but it is important to be able to distinguish between shopping and recreation, between wants and needs, and to resist the pull of the hype, manipulation, and pressure to buy that comes at us from all sides. In this part of the program, clients are exposed to specific, proven techniques for staying centered that are specifically targeted to each of the six major shopping magnets, including malls and stand-alone stores, Internet shopping, TV commercials, magazines, catalog shopping, and TV shopping channels. This is also the time that clients contemplate how to manage their individual danger zones, those venues that are most triggering to them, and think over ways to anticipate, prepare for, avoid, deflect, and counter the various sources of social pressure (e.g., family, friends, sales associates, and culture at large) to consume.

What makes compulsive buying such a difficult addiction to conquer is that shopping is unavoidable.

Having done this general foundational work related to shopping venues and social pressure, clients learn how to create a purchasing plan and review that plan after they have shopped. To create this very particular kind of plan, clients carefully specify the following: (a) the item(s) they intend to purchase; (b) the purpose of each and the maximum amount they can afford and are willing to pay; (c) when, where, with/for whom, and how long they will shop; (d) how they will pay for the purchase(s); and (e) the risk of overshopping with the plan. If the risk is greater than 30 %, they are required, with the help of a shopping support buddy, the group, or the therapist, to create a new and less risky plan.

The *mindful pause* asks clients, before they actually purchase an item and after they have completed the first two parts of the sequence, to ask themselves six questions.

1. Why am I here?
2. How do I feel?

3. Do I need this?
4. What if I wait?
5. How will I pay for it?
6. Where will I put it?

Although this takes a lot of restraint, asking questions such as these successfully breaks the automatic buying response, helping the overshopper realize that he or she has a choice to buy it, to put the item down and walk away, or to think it through even longer before buying. To reinforce this mindful behavior, clients are encouraged to acknowledge and affirm their progress (Mundis 2003), and then reward themselves with a free or affordable activity, which functions as both an act of self-care and a tailor-made alternative to shopping.

At this point, the clients are 8 weeks into the 12-week program. With many practical skills, tools, and strategies at their disposal, the focus goes deeper, on how to cultivate four central resources of every overshopper—body, heart, mind, and soul. Each can direct (or misdirect) us on the journey to mindful shopping. The body can be the first responder to a shopping impulse; however, the wisdom of the body is often ignored. To prevent this, clients learn how to do a body scan and practice apprehending particular physical sensations; this gives them a leg up on confronting a shopping urge and reducing its intensity.

Overshoppers have typically had little positive practice in dealing with negative emotions; instead, they learned to deny, distrust, hide or disregard them, or express them indirectly. Self-defeating buying behaviors can serve all of these purposes. While finding the right word to express a feeling can be difficult, sifting through the various shades of an emotional spectrum, which is what clients are asked to do now, can provide much more specific and useful information than an all-purpose *angry* or *sad*. The process of finding a particular emotional shade can help people make connections between that feeling and important issues and events in their life, connections that then often lead them to discover an underlying need, which they can then satisfy in a productive way.

... "What if I start again?"

Another route that clients take to gain more fluency with their emotions is a deceptively simple, yet extraordinarily powerful, technique called the money dialogue. Developed by Olivia Mellan (1994), the dialogue process helps people gain a greater awareness of their relationship with their money, credit cards, jewelry, or overstuffed suitcase. Often extremely emotional, both to complete and to share, the dialogue cracks open the code and first reveals the symbolic significance of the object to the overshopper, and then clarifies how the imagined reaction that the client's mother, father, significant other, and higher power (or inner wisdom) might have to the dialogue also figures into this complex and unhealthy relationship. Clients are often profoundly affected by this experience, which catalyzes them to pry themselves loose from the object's grip.

Moving on to the language of the mind, clients get a mini-course in CBT. First, the concepts of *core beliefs, underlying assumptions,* and *distorted thoughts* and the relationships among them are introduced. Then, clients are presented with a survey of the most common categories of distorted thinking. Finally, they are taught a technique for challenging those distorted thoughts (Beck 1995) that helps them discover how unexamined, automatic thoughts can powerfully shape their feelings and behavior. To highlight matters of the soul, clients are introduced to the strengths of transcendence, which include spirituality, appreciation of beauty and excellence, gratitude, hope, and humor, all of which can balance and lighten the weight of the desire for material things.

The troubling question as the end of treatment approaches is "What if I start again?" It is critical to discuss this possibility at length before the end of the program, so clients are prepared for the next leg of the journey. First, a general discussion of common lapse and relapse triggers occurs, and then clients create their own individual lists (Mitchell 2011). After that, strategies for anticipating and managing lapses and relapses are discussed, such as how to prevent them, how to prepare for the possibility that they can and will occur, and how to position oneself to learn from any lapse or relapse that takes place. Clients do two experiments—the mental and dress rehearsal—both of which fortify against lapses by preparing them for a high-risk situation. In the mental rehearsal clients choose a triggering situation from their list and visualize, in painstaking mental detail, what it would be like to confront this situation and actually resist making a purchase. Then, in the dress rehearsal experiment, the clients actually put themselves into this triggering situation and commit to exiting from it without purchasing anything. Finally, to further prepare to be on their own, clients create a *lapse and relapse prevention plan* (Mitchell 2011) that will help them plan for any upcoming high-risk situation. In order to create a robust plan, they need to revisit and reuse all of the major tools and skills they have acquired during the prior 12 weeks. Before the end of treatment, the question "How much is enough" is discussed. We are often so busy looking for happiness in the next purchase or the next or the one after that, we miss precious opportunities to become deeply attached to the things we already own, to say nothing of the people we love. Seeing that the benefits of having more stuff are far outweighed by the costs of getting and maintaining it helps put shopping into perspective. Distilling the program to its essence by writing about what the biggest obstacles and challenges have been, what the most important takeaways have been, and how it feels to be at the end of this soul-searching endeavor, is the final grounding exercise.

Case Study

Background Information

To Buy or Not to Buy: Why We Overshop and How to Stop (Benson 2008) contains the model in its entirety. Reviewing a case study of someone who successfully

completed the stopping overshopping model heightens the understanding of the program.

Meet Lauren. In New York, street vendors selling handbags spring up after the New Year like mushrooms after a rain. Lauren could not deny that her shopping had gotten out of hand when she could not pass one without buying, despite the fact that she already had over a 100 purses. Severe skin allergies to any fabric other than natural fibers narrowed Lauren's clothing choices. Feeling deprived by these constraints, she wanted to dress up her "basic and boring" wardrobe with colorful accessories—handbags, scarves, jewelry, and shoes that add interest and style. The best thing about these items is that she could be of any size, weigh any amount, and they all still fit her, unlike some of her clothing. She could blissfully select the item in the store, buy it and take it home, without ever having to set foot in a fitting room. It was the "quick fix."

If not for the fact that she and her husband, Phil, had recently rented a small apartment in the city, her out-of-control shopping behavior might have continued unabated. Faced with a much smaller space than she had in her suburban New Jersey house and the complaints of her very organized, and in her estimation, rigid husband, she could not avoid the ever-growing clutter. That, coupled with his request that she streamline and simplify, intensified her anger and reignited her feelings of being crazy, incompetent, overwhelmed, hopeless, and helpless, and reinforced her compulsive consumption of self-help books and courses.

Lauren describes Phil as withdrawn, robotic, extremely resistant to change, and unempathic, especially toward her. "The kids love him. He will give them the shirt off his back. He's an enabler, people pleaser, but to a fault. He's very naïve, almost child-like, extremely loyal." Mostly everything Phil says or does seems to rub her the wrong way, and she believes her overshopping is both an act of revenge against his unavailability and an attempt to self-soothe and to dazzle. A self-described workaholic, Phil had created a successful business that Lauren described as the "other woman," which seemed like the love of his life and where he spent all his quality time. She had grown up in a home where the identical scenario had played out. Her passive, stay-at-home mother did the lion's share of the parenting, and her volatile, workaholic father, was married to his store. He often yelled at her mother, believing she was responsible for any of the children's misbehavior. Lauren's sister, 8 years older, had married young and left the house as soon as she could. Her brother, just 1 year her junior, became physically abusive toward their mother and was "sent" to the Navy at 17, in the hope that the structure would straighten him out. Instead, he came out addicted to heroin. Lauren married Phil when she was only 19, her honorable discharge from her family's "the war zone," as she described it:

> I'm attracted to and driven by a fairly high level of chaos, anxiety, drama and excitement, since that's what I'm used to. So, the adrenalin rush and "high" I get from always doing, moving, going shopping, eating, staying up late at night, living in clutter, having over-reactive/explosive arguments with my husband, etc. feels "comfortable" and "knowable" to me. Peace and serenity does not. I think that my awareness about this self-destructive quality in myself will help to motivate me to pursue the healthier constructive alternative of developing self-soothing, calming practices.

With the help of a relative, both of Lauren's parents had emigrated to the USA from Europe during the Holocaust. They had lost almost all of their respective families in concentration camps and although Lauren's mother was pretty silent, sometimes her father talked about what they did to his family. As a child, she did not want to listen to her father's depressing Holocaust-related rants, but rather chose to believe that her father was either exaggerating or making most, if not all, of it up. A "lack" mentality was a constant undercurrent; almost every penny had to be saved. One summer, her parents scrimped and saved to rent a bungalow in the Catskills; they had brought everything they needed for their time away in paper shopping bags, as there was no money for luggage. When her mother received a gift, she always "saved it" for some nebulous future time, which never seemed to arrive.

She and her two siblings were not permitted to throw anything out, especially food. Born underweight, Lauren's view is that her parents tried to fatten her up from day one. She has struggled with food, eating, and weight for most of her life and believes the struggle will be a lifelong one.

A yo-yo dieter and binge eater since her early adolescence, Lauren has never been anorexic or bulimic. As an adult, her weight has fluctuated about 60 pounds, and she is perpetually trying to lose 15–20 pounds. She tried Overeaters Anonymous, but found it too rigid; food plans like Jenny Craig, were more to her liking. Her hope in joining the stopping overshopping group was that she would be able to use some of the same skills, tools, and strategies that she would learn in the program to also help curb her issues with food and eating.

Lauren's pain about "not fitting in" spread beyond clothing. Psychologically, she felt as though she did not belong, struggled with feelings of inferiority and shame about being different. Not only was her family the only Jewish family in an Irish Catholic neighborhood but they were also the only ones in the neighborhood without a car, and her parents spoke a mixture of German and Yiddish at home.

Intervention

In the 2 weeks before the first stopping overshopping group meeting, Lauren had shopped 20 times, had spent 22 h shopping, and had spent over US$ 3000. Her scores on all four of the compulsive buying measures were solidly in the compulsive buying range. On the structured clinical interview for diagnosis (SCID-I; First et al. 1996), she scored positive on the recurrent major depressive disorder scale, although she was currently in full remission. She also scored positive both for binge-eating disorder (which was in partial remission) and compulsive–impulsive Internet use on the modified ICD-SCID module (First 2007).

Shortly after the group began, Lauren had a 1-week pre-planned trip to Amsterdam with her family. She planned carefully for what she foresaw as being in a "vacation" state of mind, which in the past had translated into an expensive "shopping spree." However, this time, she decided to participate in group meetings via an online conferencing system. Historically, she had felt the need to bring back some

tangible souvenir items from her trip as a reminder of experiences and feelings she had during that time. Given the possibility that she might never go back again to these vacation sites, she felt a time pressure to buy it right then. In order to deal with this urge on the upcoming trip, she told the group that she could bring back other reminders, such as photos, journal writings, and her mental memories.

During the motivational interview process, she committed to using only her debit card, cash, or checks for personal purchases rather than using her credit card, which she used constantly for small purchases like coffee at Starbucks. The biggest obstacle she foresaw was not wanting to give up the "perks" that she got by using her credit card, like the instant gratification, delayed payment, mileage for travel, cash and/or gifts back on purchases. She reminded herself that the "benefits" are not truly benefits, and that the positive long-term consequences of not using credit cards would far outweigh any perceived losses. She was determined to give it her best shot. At the same time, she worried about overdrawing her checking account and having to pay overdraft fees. These fees loomed over her head like the sword of Damocles, serving as a deterrent to overspending and propelling her to review her checking account balance regularly. Saving money became a goal for the first time. To that end, she reduced her cable bill by downgrading her plan, cancelled a data plan for her smartphone that she decided had been a hasty, unnecessary add on, and resisted the purchase of a tablet that she had been researching for weeks.

Lauren had a propensity to make an impulsive purchase and then almost immediately tear up the receipts to "hide the evidence," in an effort to feed her major denial, and try to get rid of the painful aftershocks of her overshopping "crime." She walked a fine line between returning items because she thought better about the purchases and returning them because she was trying to get rid of the painful feelings that came with being out of control. Resolving to save receipts from any purchases that she considered to be impulsive or unnecessary, she felt she needed to maintain a balance between shopping and returning. She did not want to add "returnaholic" to her other "aholics." With her heightened awareness that constantly purchasing handbags was "a terribly misguided" attempt to symbolically fill the "empty black holes" in her soul, she also knew that filling those same holes with sweets was just as destructive. "I could never buy enough purses to get what I really need—which is real, authentic, honest, healthy, spiritual connection to myself and others." To nurture that healthy connection, her second weekly goal was to engage in soul-feeding, life-enhancing activities for at least an hour each day. Such activities would allow her to "chill," play, and have more fun, as opposed to pursuits that were highly goal-directed (e.g., ways to "fix" herself) or too serious. Laughter, yoga, and more playtime with her beloved dog were at the top of her list.

Lauren's capacity to see so many underlying similarities between her food and shopping issues, combined with the success she was having in learning how to shop and buy mindfully, translated into making better food choices as well. While she still occasionally indulged in a (shared) decadent dessert and/or a "not so politically correct" restaurant meal, she told the group:

> If I felt that I could never do this, I would feel very deprived, probably rebel, and give in to destructive urges to binge and overeat. I'm feeling a similar way about shopping—that both eating and shopping mindfully includes occasional, spontaneous shopping with a certain amount of abandon. Shopping and eating can be true joys and pleasures in life. I need to remind myself that hopefully in the future, when I feel ready, I will be able to make a purchase occasionally, of something that I love, even if it wasn't planned for, that was not necessary, but that I will use and enjoy—just like a yummy piece of chocolate cake—and not then relapse into mindless, compulsive overshopping again.

At the 5-week point, Lauren had only made one compulsive purchase, a handbag that she had bought when she got home from her trip, a purchase she made out of a need to reward herself for having resisted overshopping while she was away. With the group's encouragement, she subsequently returned it, but felt somewhat down rather than the "adrenalin rush" of shopping. Reaching out to the rest of the group helped her to "sit" with the unpleasant feelings that she had historically medicated away with overshopping and/or overeating.

As a group activity, the participants had agreed not to buy anything unnecessary for a period of 3 weeks, and it was during this time that a favorite annual crafts fair was held, an event where Lauren typically shopped without much restraint. Rather than resist going to the fair at all that year or breaking her commitment not to buy anything unnecessary for 3 weeks (she now felt resentful that she had agreed to it), she hinted to Phil that if she saw something really special and unique, he could buy it for her upcoming birthday. Not surprisingly, there was a pair of handcrafted earrings that fit that bill, her husband bought them for her, and she wore them soon thereafter, not waiting for her birthday. Was this cheating, manipulative, or dishonest? Lauren was not sure. She did know that she was feeling sorry for herself (even after her husband bought the earrings) because she could not enjoy shopping or eating like all the "normal" people around her at the fair. The truth was that she was not yet able to consistently shop or eat in a healthy, truly nourishing way; in both activities, she needed to be acutely aware and mindful of her thoughts, intentions, feelings, and behaviors.

Concurrent with the language of the soul part of the program, Lauren committed to begin developing a regular practice of meditation, focusing on mindfulness, which she would continue each day, even when she felt caught in an emotional tempest. As part of her spiritual action plan, she wanted to develop a more accessible higher power. To that end, she vowed to continue to work in Codependents Anonymous, read, write, work on the steps with her sponsor, and perform some traditional Jewish rituals. Her hope was that it would make her feel more connected to some form of higher power or an inner wisdom that would guide her.

In between weeks 9 and 10 of the group, Lauren shared how she had refrained from purchasing two books on Amazon.com that she already had on her e-reader. Also, aware of how much she did not need another scarf, no matter how beautiful, unique, or inexpensive, she made a conscious effort to wear a different scarf each day rather than save the best for a special occasion that never seemed to come, as her mother would have done and advised her to do. Associated with this was a weekly goal to begin going through all of her scarves, she chose the ones she truly loved and donated the rest. As she went through them, she committed to counting them, which helped her face the reality of her overshopping.

Lauren assumed that creating clutter in her home kept her from overshopping. Her fear was that if she put things away, she would feel the need to fill the empty spaces. The group suggested that if she put things away, she might need to feel the presence of those empty spaces, but that ultimately she would feel more serene. To that end, she tested her underlying assumption, “Having my place cluttered helps me to stop shopping” thoroughly, and decided the assumption was fallacious. The group encouraged Lauren to take a picture of her apartment and share it, so that the other group members could bear witness to her growth.

As she went through them, she committed to counting them, which helped her face the reality of her overshopping.

Her last “official” weekly goal was to continue to avoid any of her “trigger” stores, and continue her de-cluttering and sorting, part of which involved taking books out of the many shopping bags sitting on her dining room table and putting them away neatly. Her apartment was becoming much more livable and enjoyable. Lauren found and rediscovered scarves that she really loved, but had long been hidden. “So now, I get to wear and enjoy them again, and in some strange way, they’re brand new. Finding those scarves was like me refinding my creative talents and my love for color, texture, and movement. It was pretty amazing.”

As a student at a specialized high school for art and design, majoring in fashion illustration, she was not very confident, frequently compared herself invidiously with the other students, and did not pursue fashion illustration as a career. She had tried to express her creative urges in various ways, like running an art supply shop, and knitting quite a few of the scarves that she owned. What she had come to understand about her attachment to scarves, handbags, shoes, and jewelry was that she needed to start directing her creative urges in more practical, healthy ways, rather than continuing to accumulate an endless supply of accessories to fill a void. The scarves gave her permission to explore her artistic side with a new freedom and enthusiasm. She also took a camera-less photography course where she was able to “play” with the art materials in an enjoyable, relaxed, nonjudgmental way.

Outcomes

Lauren decided that a shopping trip to her favorite store to find attractive scarves would be the source of her mental rehearsal. Careful attention to the thoughts, feelings, and body sensations she imagined having when she was there and knowing what she would tell herself and what she would do when they surfaced, allowed her to do the actual dress rehearsal in the store, albeit with a cart full of feelings. She was anxious about meeting the challenge of going in and not making a purchase, excited about going into her “old haunt” again, and resentful about taking the time

to do the assignment. The scarves and the store altogether had both lost their "luminosity;" she was annoyed at wasting time there and just wanted to leave and, in retrospect, quite thrilled that the store had lost its allure. Nevertheless, on her way out, she saw a jean-colored cashmere sweater that she loved and knew she would use a lot. After wrestling with the decision of whether to buy it, she opted to leave the store empty-handed because she wanted to allow herself to feel the distress, knowing that at some future time, if it was that important, the sweater could be a planned purchase, if it was still there and, if not, it was no huge loss. "Imagine that … now that's progress!" she wrote.

Distilling her experience of the program to its essence was an opportunity for Lauren to step back, look clearly at the journey through the 3 months of hard work that the program entailed. Lauren described the group as one of the most powerful, life-changing, healing experiences of her life; it was the ongoing, strength, caring, and support of the group that allowed her to make changes that she believed would have a permanent effect, changes that she never dreamed would have been possible, and in a relatively short time:

> I have been pushed and challenged (sometimes kicking and screaming) to really look at deep-seated, longstanding, underlying issues and then, with this new, heightened awareness to change negative, compulsive behaviors into more constructive, positive, life-affirming ones. I no longer use a credit card for any personal purchases and don't browse in stores for recreation. When I do shop, it is mindful, and I remember these two key phrases: "You can never get enough of what you don't *really* need," and "When in doubt, leave it out." The lessons I have learned have affected my life in other ways, too, including my relationship with myself and my husband as we try to reconnect, and my relationship with food. I'm getting regular exercise and putting more time, effort, and energy into truly fulfilling endeavors, such as volunteering and community involvement, learning, laughter, yoga, spending more time with friends and family, "de-cluttering" my life, and as I do, I am enjoying life more and having fun. This more joyful, sane, healthy, authentic, serene life is a gift and I thank God for guiding me on this journey with the help of a group of angels and our angel leader.

The words are impressive, but do Lauren's post-group scores tell the same story? Happily, yes. Immediately post-group, her compulsive buying scale scores were solidly in the normal buying range, and this is still the case, 3 years later. The results of the final 2-week purchasing recall 6 months after the treatment and 3 years after the treatment were quite similar. Lauren spent approximately $ 35 on compulsive purchases both times, spent 10 min shopping compulsively in the 2 weeks following the group, and less than an hour during the 2 weeks I asked her to record this, which were 3 years post group. Both were a far cry from the over $ 3000 and more than 20 hours that she had spent in the 2 weeks before starting the group. Her out-of-control food behaviors are considerably better than they were in the past, and she has not gained any weight since the group, although she says that she is still struggling with food.

> Immediately post-group, her compulsive buying scale scores were solidly in the normal buying range and this is still the case, 3 years later.

Her anger toward Phil, still unresolved, no longer comes out in revenge shopping, but is borne, metabolized, and worked with in their couples therapy. Even a very serious health crisis in the family, which necessitated Lauren being totally available for a period of months to take care of her grandson, did not trigger a relapse.

De-cluttering persists. Lauren has donated costume jewelry, which have brought in considerable revenue for a lymphoma organization in which her daughter-in-law, a lymphoma survivor, is very involved.

Ethical Considerations

Confidentiality and privacy are paramount in therapy and psychoeducational coaching and when working with a group, this is even more challenging. The discussion of confidentiality occurs during the intake meeting and is reiterated at the first official session of the group. If new circumstances warrant at another point, we revisit this issue.

I begin by telling individual clients and group members about my commitment to maintaining their confidentiality and also about the limits of confidentiality**.** I tell them that I will only release information about our work to others with their written permission or if I am required to do so by a court order or if I am legally obligated to breach their confidentiality to protect others from harm. These situations rarely occur, but if such a situation does occur, I tell clients that I will make every effort to discuss it with them before taking action. I also tell them that I will not use any of their material without their express written consent and without appropriately disguising any potentially identifiable information. I remind clients that it is difficult to protect the confidentiality of information which is transmitted electronically. Even wireless telephones also may not be secure from eavesdropping.

For the group setting to be a safe space in which to do the work of the program, clients need to be confident that what they say in the group stays in the group. Clients are told that if they want to talk about the group outside of the group, that they talk about their experience, not mention any names or identifying details of other group members, and that they limit their comments to general themes rather than specifics. Clients are also asked not to play any audio recordings of the sessions for anyone outside of the group.

Since the nature of the group is very structured, there is less “group process” than in open-ended groups. Nevertheless, it is important to screen potential individuals and group members to make sure they have no concurrent condition that would make it difficult for someone to use this particular method productively or make it difficult for the group to coalesce. Clients who show evidence of bipolar I disorder, severe mental illness, active suicidal ideation, and drug or alcohol dependence within the past 6 months or drug abuse within the last month are not good candidates for this program.

When the work occurs by telephone or online conferencing, the nature of it is psychoeducational coaching, rather than therapy. Clients join the group for the

purpose of helping them to understand, control, and eventually, stop their overshopping. Although I am a licensed psychologist in New York, with training and experience treating emotional and psychological syndromes and there are some similarities between coaching and psychotherapy, I will not conduct Diagnostic and Statistical Manual (DSM)-driven psychotherapy during this educational coaching. This means I will not create a medical diagnosis, or provide treatment for, or advice regarding, any medical or mental health condition or illness. These coaching sessions are not psychotherapy and are not a substitute for psychotherapy. I outline that my job is to help clients take information, skills, and strategies that they will acquire in completing the stopping overshopping program and help them to stay motivated and focused on making and maintaining the changes they create. I add that I am committed to having an open, fair, and respectful relationship.

Clients sign a psychoeducational coaching agreement and memorandum of understanding, which describes the nature of my services, indicates that they have had the opportunity to ask me any questions they might have, and that they agree to abide by its terms during our professional coaching relationship.

To run these groups effectively, the facilitator, who might be a financial counselor, coach, or mental health professional, needs to have resolved any significant compulsive buying issues he or she may have had, know about the disorder, and have training in this particular modality of treatment. That training consists of a four-session didactic overview of compulsive buying and a 12-session experiential training, during which two or three compulsive buyers are followed throughout the entire program. Often one of the trainees is both a mental health professional and a financial counselor, who has a problem with compulsive buying and wants to use the training to work on his or her individual issues.

Future Directions

After reviewing the history, epidemiology and clinical characteristics of compulsive buying disorder, this chapter presented a model for the treatment of compulsive buying disorder—the stopping overshopping model—a comprehensive 12-week experience that draws from a variety of evidence-based treatments shown to be effective either with compulsive buying disorder or other addictions (Benson and Eisenach 2013). To conclude the chapter, a brief review of results from a randomized, controlled pilot study of the effectiveness of this model are provided (Benson et al. 2014).

To date, approximately 80 people have completed this program, either individually or in a group. Data have been collected on most of these 80 people. The pilot study described below was done with 11 participants. An in-depth analysis of an empirical test of the Stopping Overshopping model can be found in Benson et al. (2014). Further replication of the model will further justify its use in clinical practice.

The Benson et al. (2014) study used a preliminary randomized, controlled trial design that compared participants in an experimental group (EXP) who began the

12-week stopping overshopping program immediately after condition assignment in the fall of 2010, with a wait-list group (WLC) who received the same treatment after the 12-week waiting period, which was in the winter of 2011. Researchers hypothesized that there would be a statistically significant drop in the severity and frequency of participants' compulsive buying symptoms and behaviors after participation in the stopping overshopping program as determined by improved scores on the primary outcome variables: the four compulsive buying scales and the purchasing recall data. It was also predicted that there would be no significant change on any of the measures in the control group after the 12-week waiting period.

Potential participants had to be at least 18 years old and had to present with symptoms of compulsive buying disorder as assessed by the Diagnostic Criteria for Compulsive Buying (McElroy et al. 1994), but not meet the diagnostic criteria for other named disorders. Eleven individuals were randomly assigned to one of two groups: experimental (EXP; six members) or WLC (WLC; five members). All participants were females and between the ages of 33 and 59 with a mean age of 47 ($SD = 8.64$). Fifty-five percent of participants were married, one was living in a marriage-like relationship, one was divorced, and the rest (27 %) were single. Sixty-four percent identified themselves as white, one reported as Hispanic/Latino, and three reported as "other." Each participant owned between 3 and 12 credit cards, with a mean of 5 ($SD = 2.57$). Two participants reported having no credit card debt, four reported debt between $ 1,000 and 3,000, one reported debt between $ 10,000 and 25,000, two reported debt between $ 25,000 and 50,000, and two reported debt exceeding $ 50,000. There were no significant differences in age, marital status, ethnicity, frequency of current psychotherapy, psychotropic medication use, number of credit cards, or amount of credit card debt between the experimental (EXP) and control (WLC) groups.

The groups met for 100-minute weekly meetings once a week for 12 weeks. To measure participants' progress throughout the program, researchers used four compulsive buying scales as shown in Table 12.1.

The results of the effectiveness study confirmed that participation in the 12-week stopping overshopping program is accompanied by a significant drop in the reported severity and frequency of compulsive buying symptoms as measured by the participants' scores on the four compulsive buying scales. Results further suggest that participants are able to maintain this improvement over time, an improvement made more notable by the fact that the mean participant scores on all of these measures began in the clinical range and improved into the nonclinical range between pre- and post-treatment (see Fig. 12.1). Participants also exhibited a significant drop in amount of money and time spent shopping compulsively, and in the number of compulsive buying episodes over the course of the study. This improvement was largely maintained at 6-month follow-up (Fig. 12.2).

There are many possible explanations for the results acquired in this study. As other researchers have demonstrated, there is a good deal of data that suggests the group method is an effective approach to treating compulsive buying (e.g., Mitchell et al. 2006; Mueller et al. 2008; Mueller et al. 2012). Elements of the stopping overshopping Model that likely contribute to the positive findings are that

Table 12.1 Compulsive buying scales

Assessment	Author	Purpose	Scoring
Valence et al. compulsive buying scale	Valence et al. (1988)	Assess tendency to spend, urge to buy, and post-purchase guilt	Score of 37.5 and above indicates the presence of compulsive buying
Richmond compulsive buying scale	Ridgway et al. (2008)	Assess presence of impulsive buying habits that classify the disorder as partly obsessive compulsive and partly an impulse control disorder	Score of 25 and above indicates the presence of compulsive buying
Faber and O'Guinn compulsive buying scale	Faber and O'Guinn (1992)	Identify feelings and beliefs about spending habits	Score of less than—1.34 indicates the presence of compulsive buying
Yale-Brown obsessive compulsive scale—Shopping Version	Monahan et al. (1996)	Identify behaviors associated with compulsive buying	Higher scores measure severity rather than presence of compulsive buying

it establishes a homogenous group setting that diminishes feelings of aloneness and increases feelings of being understood, exposes participants to feedback from other compulsive buyers to help break through denial, and constitutes an opportunity to witness others in various stages of recovery. In addition to each group session, members of the stopping overshopping group have the opportunity and encouragement to participate in a listserve between sessions, which provides a forum for discussion and allows members to offer and receive support to and from each other during the week, in essence to function as shopping support buddies (Benson 2008).

As delineated by Benson and Eisenach (2013), in addition to cognitive behavioral aspects (e.g., identification and restructuring of automatic thoughts), the stopping overshopping model includes aspects of psychodynamic psychotherapy, psychoeducation, dialectical behavior therapy, motivational interviewing, acceptance and commitment therapy, and mindfulness. Psychodynamic elements aid participants in understanding the historical antecedents of their behavior, current familial influences, and underlying authentic needs. The psychoeducational elements encourage participants to develop media literacy, look at the role of culture, the high cost of credit card debt, and the centrality of savings, and eventually record and evaluate expenditures daily. Distress tolerance and interpersonal effectiveness, components of dialectical behavior therapy, are targeted in a variety of exercises. Aspects of motivational interviewing include a thorough exploration of ambivalence about change. The methods related to acceptance and commitment therapy encourage participants to be mindful of their thoughts, feelings, and actions surrounding overshopping, and to treat themselves with compassion in the current moment.

While this study points to the significant effectiveness of the stopping overshopping model, its limitations should also be noted. The sample sizes of both the treatment and wait-listed groups were small; all participants were female, and therefore the generalizability of the findings is limited. Follow-up extended only

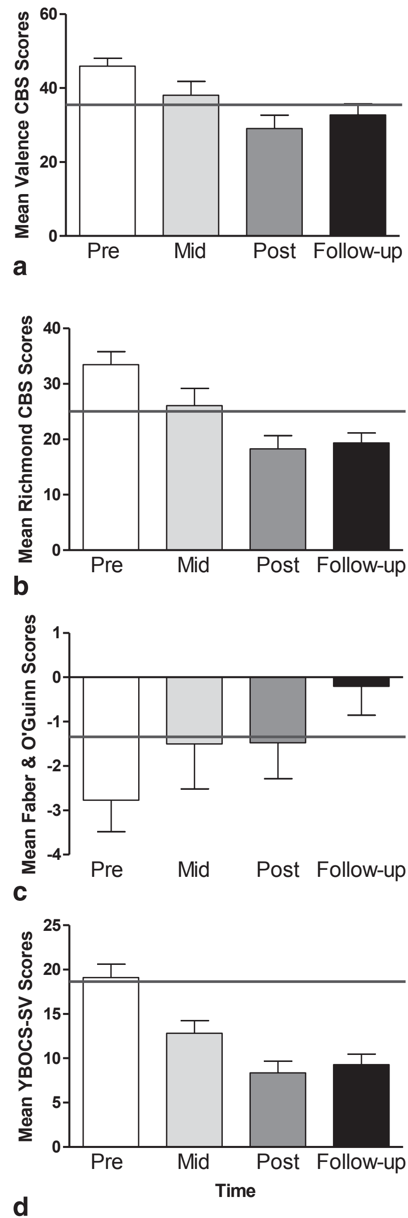

Fig. 12.1 Pre-treatment, mid-treatment, post-treatment, and 6-month follow-up analyses of compulsive buying measures in all participants ($N=11$). RM-ANOVA show significant improvements in all compulsive buying measures, with maintained improvement through the 6-month follow-up ($p<0.01$). *Horizontal lines* in each graph represent the value that indicates the threshold for the presence of compulsive buying. Scores *above* the each line indicate clinical levels, except for the Faber and O'Guinn CBS (*C*) where scores *below* the line indicate clinical levels

to a single assessment 6 months after completion, which is a relatively limited window of time in which to track participant progress, given that compulsive behaviors of this nature are so often chronic. Furthermore, all measures were dependent on participant's self-report, which could potentially bias the results stated here. Additionally, future investigation could examine the efficacy of the stopping overshopping model as it might be applied to other clinical treatment models (i.e., indi-

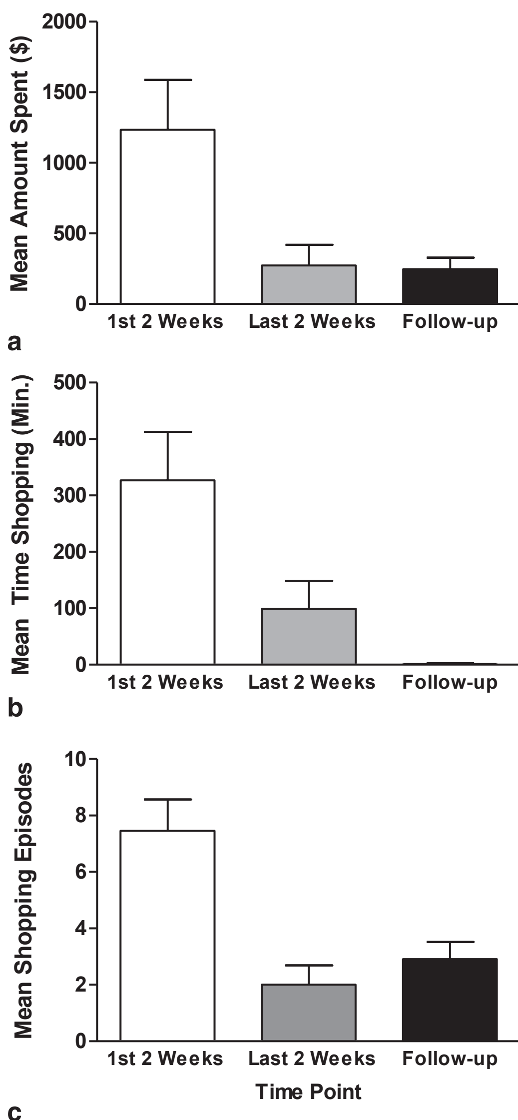

Fig. 12.2 Mean money and time spent compulsive shopping and mean compulsive shopping episodes during the first 2 weeks and last 2 weeks of the study and at 6-month follow-up. RM-ANOVA indicate show that there was a significant improvement in all three measures between the first and last 2 weeks of treatment, and that this improvement was largely maintained at 6-month follow-up ($p < 0.01$)

vidual treatment or self-help), given that empirical research on the effectiveness of individual treatment of compulsive buying is virtually nonexistent (Mueller et al. 2012).

As the growing body of research suggests, the severity and frequency of compulsive buying symptoms can be addressed clinically to great effect. It is imperative to study the best conditions under which these improvements can occur in order to continue to deepen our understanding and develop effective treatment options for this serious, and extremely prevalent, clinical issue.

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Part III
Financial Therapy Practice-Based Models

Chapter 13
Systemic Financial Therapy

Kristy L. Archuleta and Emily A. Burr

Introduction

Imagine that you are a financial therapist who works with clients experiencing financial stressors. You have agreed to meet with a couple who is experiencing financial difficulties. You inquire about the difficulties and learn that the husband has accrued large debt and the couple has recently filed for bankruptcy. They are coming to you to work on a plan to move forward. You ask about goals, and the wife reveals that they need to build trust in the couple's relationship in order for any financial plan to work. She becomes tearful as she explains that her husband did not tell her about any of the debt he accrued until the debt became so overwhelming that the best option for them was to file for bankruptcy. The wife said she has had very little involvement in the family finances in their 10 years of marriage, but wants to be more involved now. The husband explains that he has been reluctant to let her be involved because he did not want to burden her with the stress he was feeling. The wife becomes angry at this notion and screams, "I am perfectly capable of handling our financial situation! Why don't you trust me?" You, the professional, are not sure what to do. How can you explain the relationship dynamics of this couple and how should you intervene?

This situation is not uncommon for any helper working with couples. Research has shown that one-third of couples seeking relationship therapy report some level of financial difficulty, and one-third of couples seeking financial counseling report a relationship problem (Aniol and Snyder 1997). Most therapists and family educators are not trained to work with finances and most financial advisors and counselors are not trained to work with emotions and relationship dynamics. However, all too often, the two co-occur. Furthermore, a theoretical gap in the literature exists to

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help practitioners and scholars address the phenomena of the relational dynamics of finances. This chapter explores how systems theory can be applied to financial situations in family relationships with a specific focus on couple relationships.

Most therapists and family educators are not trained to work with finances and most financial advisors and counselors are not trained to work with emotions and relationship dynamics. However, all too often, the two co-occur.

Systems Theory

General systems theory (GST) was developed to explain complex phenomena not explained by mechanistic (i.e., focused on individual parts rather than the interactions or relationships among parts) or linear models (Whitchurch and Constantine 1993). Ludwig von Bertanflanffy, an Austrian biologist, first applied universal principles to all kinds of groups of phenomena termed as *systems* (Whitchurch and Constantine 1993). Gregory Bateson as well as Don Jackson, Jay Haley, Margaret Mead, and James Miller were among influential thinkers and therapists who began to consider how GST concepts apply to families (White and Klein 2008). Wedemeyer and Grotevant (1982) explained that systems theory, when applied to families, does not limit focus to isolated relationships between isolated variables. Instead, the focus is on complex networks of patterned interactions between definable units and their specific environmental contexts.

Family systems theory, along with cybernetics, has been a major influencing theory in the field of marriage and family therapy. Additionally, systems theory has been foundational in the development of family-focused therapy modalities, like Bowen family therapy, structural family therapy, cognitive-behavioral family therapy, strategic family therapy, narrative therapy, and solution-focused therapy. The usefulness of the application of systems theory with family relationships stems from the concept of systems and the major assumption of interdependency. A system can be thought of as “a group of interrelated parts plus the way they function together” (Nichols 2010, p. 104). Whitchurch and Constantine (1993) described systems thinking as a way of looking at the world in which objects are interrelated with one another. As a result, patterns of relationship dynamics among systems are developed. A change in one of those systems will produce a change in another system(s) in order for the systems to adapt to the new dynamic created as a result of the change. For example, imagine a mobile hanging above a baby’s crib with several objects dangling from it. If one of the objects on the mobile was to be moved, the mobile would become off-balanced. However, when one or more objects on the mobile are repositioned in reaction to the first object being moved, the mobile will become rebalanced. Maintaining this balance is known in systems theory as homeostasis, a central concept of family systems theory. The process by which the system rebalances itself to maintain homeostasis is known as feedback loops.

Concepts

Concepts of modern family systems theories stem from information theory, cybernetics, family process theory, and GST (Whitchurch and Constantine 1993; White and Klein 2008). In addition to homeostasis and feedback loops, other major family systems concepts derived from these theories include: boundaries, circularity, equifinality, subsystems, systems, and suprasystems, and levels of hierarchy (Jurich and Myers-Bowman 1998; Nichols 2010; Whitchurch and Constantine 1993; White and Klein 2008). Boundaries are "invisible barriers that regulate the amount of contact with others" (Nichols 2010, p. 102). Circularity refers to problems being maintained in the family through an ongoing series of actions and reactions, rather than by linear cause and effect. As discussed previously, feedback loops refer to how the system gets the information necessary to maintain a homeostatic state. Feedback loops can be negative or positive. A negative feedback loop maintains the equilibrium, also known as homeostasis. A positive feedback loop alters the homeostasis and the equilibrium from which the system deviates (Whitchurch and Constantine 1993), meaning change is introduced into the system and the system's equilibrium is offset. Equifinality is the idea that a goal can be met through more than one way.

In addition to homeostasis and feedback loops, other major family systems concepts derived from these theories include: boundaries, circularity, equifinality, subsystems, systems, and suprasystems, and levels of hierarchy (Jurich and Myers-Bowman 1998; Nichols 2010; Whitchurch and Constantine 1993; White and Klein 2008).

Nichols (2010) described the structure of families in terms of subsystems, which are determined by generation, gender, and function. Examples of generation subsystems are the grandparent subsystem, parent subsystem, and children subsystem. Gender subsystems refer to male and female subsystems within a family, while function subsystems refer to household roles (e.g., managing finances, cooking, cleaning, lawn care, child care) and careers (e.g., farmer, homemaker, attorney). Systems are arranged by levels of hierarchy. For example, a collection of subsystems make up a larger system (i.e., a higher-level hierarchy). Suprasystems (Whitchurch and Constantine 1993) encompass systems beyond the family system, such as extended family, racial and ethnic subcultures, community, geographic region, and national systems. Subsystems, systems, and suprasystems are seen as interconnected.

The major assumptions associated with systems theory are: (a) holism, (b) systems are hierarchically organized, (c) living systems are open, (d) nondetermined and active, (e) human systems are self-reflective, and (f) reality is constructed (Jurich and Myers-Bowman 1998).

Major Assumptions

The major assumptions associated with systems theory are: (a) holism, (b) systems are hierarchically organized, (c) living systems are open, (d) non-determined and active, (e) human systems are self-reflective, and (f) reality is constructed (Jurich and Myers-Bowman 1998). Holism refers to understanding the system as a whole, rather than the sum of its parts (Whitchurch and Constatine 1993). Holism assumes that all parts of the system are interconnected and, when one part of the system is impacted, the whole system is impacted (White and Klein 2008). The assumption that living systems are open, non-determined, and active, refers to the degree to which energy and information is exchanged within its environment (Jurich and Myers-Bowman 1998). Jurich and Myers-Bowman (1998) offered the example of an open system as a spouse who is employed to make money for the family and provide expertise to his employer. This opens the family system to exchange within the suprasystems, such as the work system. Living systems not only respond passively to stimuli from their environment but they also engage in transactions, which they initiate, so they are both active and reactive. Therefore, systems are, to some degree, self-determining and not solely determined by external forces. Whitchurch and Constantine (1993) explained that human systems are self-reflective because humans have the ability to reflect on their own behavior and interactions within the system. Jurich and Myers-Bowman (1998) described the final assumption that reality is constructed as a way of better understanding the world. They explained that "observations of the world are never independent of the knower, and reality is constructed rather than discovered" (p. 75).

Couples and Finance Theory

Some theory has been developed to help address financial stress and family dynamics. Most notably is the family stress model of economic hardship developed by Conger et al. (1992). The family stress model is a linear model and was originally developed to describe the impact of economic hardship and emotional distress on marital and parental behavior and the direct effects on early adolescent development. Conger et al. later adapted this model to test resiliency of couples facing economic hardship (Conger et al. 1999). Conger et al. (1999) found that high marital support reduced the association between economic stress and emotional distress.

As noted previously, systems thinking has been used to help explain both family and couple functioning. It also has been useful in explaining the financial process (Deacon and Firebaugh 1988). For example, Deacon and Firebaugh (1988) developed the family resource management theoretical model. Their model was the first to apply systems theory to family resource management as a way to understand the complexities of demands and resources of a family as related to personal finance issues (see Deacon and Firebaugh 1988, for a more detailed explanation).

Introduced by Archuleta (2008), couples and finances theory (CFT) integrates systems theory and financial processes and specifically applies it to couples.

Due to the circular nature of systems theory, it can be a useful lens for explaining the interdependency of the two subsystems: couple relationships and financial process. The couple relationship subsystem and the financial process subsystem function together within a larger system and the context in which they operate as described by the couples and finances framework (Archuleta 2008, 2013). Introduced by Archuleta (2008), CFT integrates systems theory and financial processes and specifically applies it to couples. CFT was inductively created to explain relational finances (i.e., the interconnectedness between the couple relationship and the financial process), as a circular phenomenon, using empirical evidence to establish propositions (see Archuleta 2008, for a more detailed of each of these propositions). As a result, CFT presents four general propositions:

1. General Proposition 1: Individual partner attributes influence each component of the couple relationship system and the financial process system.
2. General Proposition 2: Couple relationship characteristics (CRCs) and marital quality (MQ) are interrelated.
3. General Proposition 3: The financial process is interrelated with three components—financial inputs, financial management practices (FMPs), and financial satisfaction (FS).
4. General Proposition 4: The association between the couple relationship and the financial process is circular.

The goal of CFT is to help therapists, financial planners, financial counselors, and researchers understand how couples interact with each other in order to advance services and research.

Concepts

To understand CFT, its theoretical terms and concepts must first be clarified and defined in addition to its propositions. The first concept of CFT is individual partner attributes (see Fig. 13.1). This concept encompasses individual factors that each partner brings into the relationship, such as age, education level, gender, personality, attitudes, self-esteem, perceived quality of life, and social experiences. Individual financial attributes are also considered, like money scripts, money disorders, financial behaviors, financial knowledge, financial stress, and risk tolerance. The individual partner attributes that each partner brings to the couple system impact each component of the couple relationship system and the financial process system. Since 2008, the concept of individual partner attributes has evolved to encompass both of these systems rather than only affecting the couple relationship as originally presented (Archuleta 2008, 2012, 2013).

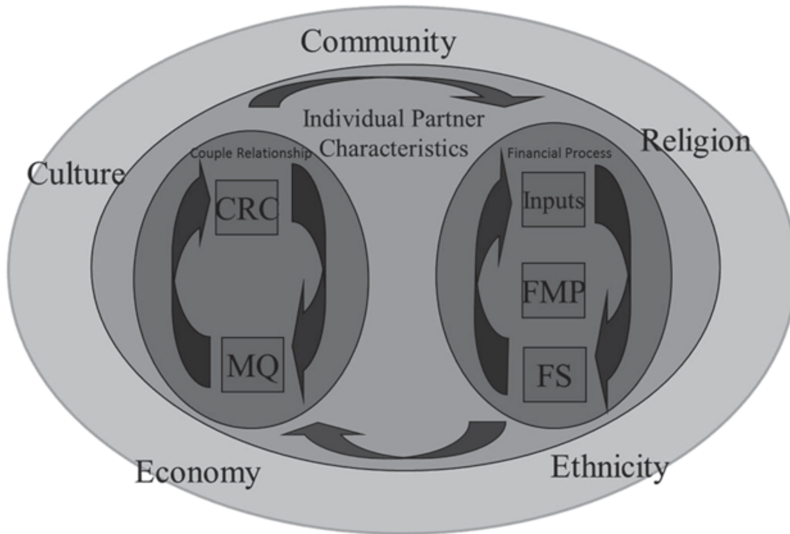

Fig. 13.1 Couple and relationships model (adapted from Archuleta 2008 and 2013)

> The individual partner attributes that each partner brings to the couple system impact each component of the couple relationship system and the financial process system.

The couple relationship system, for the purposes of this theory, is considered a system comprised of two components: (a) *CRCs* and (b) *MQ*. *CRCs* ("*CRC*" in Fig. 13.1) are defined as factors contributing to the interaction between the two partners in the couple relationship. The final component of the couple interactional system is *MQ*. MQ ("MQ" in Fig. 13.1) refers to self-reported marital satisfaction and overall self-reported quality of the couple's relationship. The CRCs and the financial process are dynamic. CFT proposes that when couples positively interact with each other, MQ improves. When MQ increases, couples are more likely to implement positive CRCs. Gottman et al.'s (1998) research provides support for this proposition. They discovered that the only variable predicting both marital stability and marital happiness among stable couples was the amount of positive affect during conflict. Couples who were stable and happy in their marriages showed a pattern of working through conflict.

> Britt et al. (2008) found that the relationship between household income and relationship satisfaction is, in fact, curvilinear where income predicts relationship satisfaction up to a certain point, then income becomes less significant.

Figure 13.1 is an adaption of the model presented by Archuleta (2008 and 2013). The current model recognizes that individual partner characteristics affect both the couple relationship and the financial processes and introduces the concept of relational finances as the interaction between the couple relationship and the financial process.

The *financial process* system consists of three components, including *financial inputs, financial management,* and *FS*. This process is loosely based on the systemic family resource management model created by Deacon and Firebaugh (1988) and empirical research using the model designed by Mugenda and Hira (1990). For the purposes of CFT, the financial process is similar to the systemic nature of Deacon and Firebaugh's model. Financial inputs (*Inputs* in Fig. 13.1) are elements entering into the financial process that influence how financial management is practiced, such as income level and savings level. FMPs (*FMP* in Fig. 13.1) refer to activities related to effective and efficient management of money and include accounting practices, record-keeping, financial solvency (e.g., ability to pay bills), financial decision making, and access to financial resources. CFT proposes that when financial inputs are positive, FMPs are increased. For example, if household income is increased (i.e., Input), an individual is more likely to be financially solvent (i.e., FMP) (Joo and Grable 2004). CFT also suggests that better financial practices will lead to couples experiencing higher FS. FS (*FS* in Fig. 13.1) refers to the satisfaction with one's current financial situation and overall financial well-being. Satisfaction with the current financial situation could refer to the achievement of financial goals. Research suggests that those who practice more desirable financial management tend to be more satisfied with their financial situation (Joo and Grable 2004). In addition, CFT also proposes that financial inputs are positively related to FS. This is similar to Bonke and Browning's (2009) findings that income is a significant predictor of FS.

The final concept is *relational finances* (see Fig. 13.1). The term relational finances refers to the interaction between the couple relationship and the financial process. Relational finances is demonstrated by General Proposition 4, which states that the association between the couple relationship and the financial process is circular. More specifically, CFT offers several propositions that reflect the reciprocal nature of the relationships between the couple relationship and financial process elements. For example, financial inputs are seen to impact CRC and MQ. This proposition is supported by research that suggests that having lower income is associated with decreased marital satisfaction (Dakin and Wampler 2008; Britt et al. 2008). Britt et al. (2008) found that the relationship between household income and relationship satisfaction is, in fact, curvilinear where income predicts relationship satisfaction up to a certain point, then income becomes less significant. In relationship to inputs and CRC, Britt et al. (2010) found that wives with the highest levels of income are least likely to be a part of a money-arguing couple. However, wives who earn more than their husbands are more likely to be in a money-arguing marriage. Furthermore, couples in a high-net-worth household are less likely than couples in a low-net-worth household to argue about money.

FMPs are seen to impact CRC and MQ. More specifically, the more positive FMPs are in the couple relationship, the more likely the couple will have positive

CRCs and higher MQ. Consider Kerkmann et al.'s (2000) research, which revealed financial problems and how finances were managed (FMPs), was significantly related to MQ. In addition, Dew (2008) discovered that couples who completely paid off all consumer debt (FMP), excluding mortgage and student loan debt, were likely to have increased MQ. The more debts that couples assumed (FMP), the more likely couples were to spend less time together, argue about their finances, and feel that their marriage was unfair (CRC) (Dew 2008).

Another proposition is that couples who have higher FS will have higher MQ. Likewise, due to the circular nature of the theory, CFT assumes that couples who have higher MQ will have higher FS. FS has been linked to MQ (Archuleta et al. 2011; Britt et al. 2008; Grable et al. 2007), in which FS was positively related to relationship satisfaction or MQ. Archuleta et al. (2011) found a significant relationship between marital satisfaction and the interaction of financial stressors and FS, indicating that when financial stressors are high and FS is low, partners are more likely to entertain the thought of leaving their spouse. Britt et al. (2008) explained that if a person perceives one of the largest areas of the relationship finances to be satisfactory, then it is likely that the overall relationship will also be seen as satisfactory. Likewise, Grable et al. (2007) found that FS was a significant factor in predicting who had and who had not thought about divorce (i.e., had higher MQ).

CRCs are seen to impact all three elements of the financial process (i.e., Inputs, FMP, and FS). For example, Megunda and Hira (1990) found that there was a positive relationship between communication (CRC) (i.e., "the frequency and nature of communication about money matters with spouse, friends, professionals and family members" (p. 350)) and FMPs; i.e., frequency of estimating household income and expenses, reviewing and evaluating the family's spending habits, or figure the family household's net worth. In addition, Archuleta (2013) discovered that having shared goals and values (CRC) were strongly associated with FS.

> …household finances impact the couple relationship and the couple relationship impacts the household financial domain in the relationship.

Although research has largely been conducted on specific relationships between elements of each subsystem—the couple relationship and the financial process—the findings support the interconnectedness of these subsystems. Elements of the couple relationship impact the financial process and elements of the financial process impact the couple relationship.

Major Assumptions

Building on the theoretical foundations of family systems theory and borrowing from social exchange theory, six major assumptions evolved for CFT. One assumption of CFT is that financial difficulties are linked to couple relationship problems

in a circular fashion (Cano et al. 2002; Geiss and O'Leary 1981; Johnson and Booth 1990; Pittman and Lloyd 1988; Rosenblatt and Keller 1983). This means that the household finances impact the couple relationship and the couple relationship impacts the household financial domain in the relationship. Similar to systems theory's concept of holism, the three subsystems of individual partner attributes, couple relationship system, and financial process are interdependent—when one of the systems is impacted, the whole system is impacted.

A second assumption of CFT is that human systems are self-reflective. Whitchurch and Constantine (1993) explained that humans have the ability to reflect on their own behavior and interactions within the system. Empirical research supports the notion that individual partner attributes affect both the couple relationship system and the financial process system. However, CFT assumes that partners in the relationship can be reflective of their own behavior and change the way they interact or behave in order to produce different results for the couple relationship and the financial process.

A third assumption of CFT is borrowed from social exchange theory (SET) and assumes that the interactions among the individual partner attributes, couple relationship system, and the financial process are based on rewards and costs. According to White and Klein (2008), a reward is something that is viewed as beneficial, pleasurable, or satisfying to an individual. A cost is something that is perceived as negative or hindering to a person when making a decision. SET makes the case for profit, which is the ratio of rewards to costs for any decision. CFT assumes that individuals and/or the couple unit make decisions that will benefit the individual, relationship, and the financial process. CFT assumes that when couples make decisions together they will maximize their joint utility or weigh the rewards compared to the costs and base their decision on what will bring about the greatest rewards or the least costs.

Equity and social resources are both concepts borrowed from SET as assumptions for CFT. Equity refers to the fact that the rewards and costs are not exactly fair from an objective standpoint, but they can be perceived to be so (White and Klein 2008). Social resources give one person the ability to reward another through interpersonal behavior exchange of a thing (Foa and Foa 1980). Foa and Foa (1980) identified six types of resources, including love, status, services, goods, information, and money.

> CFT can be used as a lens for explaining the dynamics of the couple relationship in regards to their financial situation. At the heart of these strategies is focusing on process rather than content.

A final theoretical assumption in the development of CFT is that the couple relationship and the financial process operate within a larger context called an "ecosystem" (White and Klein 2008, p. 249). The ecosystem is similar to the suprasystem described in systems theory. This means that the elements of religion, economy,

culture, community, and ethnicity impact individual partner attributes, the couple relationship system, and the financial process (see Fig. 13.1). Each element of the ecosystem as well as the three subsystems operates interdependently.

Principles and Strategies

CFT can be implemented using strategies of systemic family therapy as outlined by Nichols (2010). CFT can be used as a lens for explaining the dynamics of the couple relationship with regard to their financial situation. At the heart of these strategies is focusing on process rather than content. Process focuses on the underlying relationships of the members in the system. Content focuses on the facts and figures of a given situation. Process focused means that circular questions are used. Nichols (2010) identified three key questions that must be addressed: "What is keeping the family stuck? What is the force keeping them from adapting to the pressures of development and change? What is interfering with their natural problem-solving abilities?" (p. 88). Nichols (2010) pointed out that "process questions are designed to explore what's going on inside people and between them" (p. 126). Additionally, process questions asked by the counselor help to slow clients down, which allows for reduced anxiety and a clearer, less reactive thought process. Another goal of process questioning is to help individuals and couples look more deeply into the process of their issues, rather than being weighed down by the content (Nichols 2010).

Systemic therapy is implemented in four stages: (a) first interview, (b) early phase, (c) middle phase, and (d) termination (Nichols 2010). Drawing from Nichols (2010), the goal of the first interview is to establish rapport with the family members and develop hypotheses about what is going on to cause the problem. Joining or developing a working relationship with each individual of the family is key to successfully implementing a system theory approach. Providing compliments on positive actions and strengths as well as maintaining empathy for individuals and respect for the family's way of doing things are among the crucial tasks of this phase (Nichols 2010).

Once a working alliance has been established, therapeutic goals are developed, and hypotheses are formulated, the early phase of treatment is entered. The goal of the early phase is to figure out what is keeping the family or couple from changing. To understand how the problem is being maintained, systems therapy encourages having each member of the system be involved in the process by sharing his or her views about the problem. As hypotheses are further refined as to the relational dynamics in the family, the approach shifts to challenging the family to change (Nichols 2010). Challenging the family means that interpersonal conflicts must be addressed. When one person is identified as the problem, then a systems-oriented therapist must address how each person is involved in the conflict. Helping family members recognize their own role in the conflict versus blaming the other person can be a difficult task. Nichols (2010) also pointed out that assigning

homework to help "address problems and the underlying conditions supporting them" is a helpful strategy in the early phase (p. 64).

Throughout the phases of systems therapy, two major techniques are used, including genograms and process questions.

The middle phase focuses on developing skills to achieve individual responsibility and mutual understanding. The therapist challenges the family members in order to reduce resistance and increase empathy. In this phase, the therapist can begin taking a less active role as they encourage family members to increasingly interact with each other. Here, the family talks more to each other, and the therapist often observes the process. Nichols (2010) noted that families can get bogged down in their conversations, meaning that the dialogue can become unproductive for clients often, due to increased anxiety and reactivity. In this phase, the therapist can point out what the family members are doing wrong or encourage them to keep talking. Regardless, the therapist should intervene in conversations that become unhelpful and destructive.

The termination phase is primarily looking at the progress of the clients to see what improvements they have made towards the presenting problem (Nichols 2010). At this stage, it is important to create dialogue within the family about what they believe they have accomplished as well as thinking of ways to handle future difficulties. Once the termination phase has ended, it is customary for the therapist to check in a few weeks later to see how the family is doing. For more information on each phase of the systems therapy approach and helpful interventions, see Nichols (2010).

Throughout the phases of systems therapy, two major techniques are used, including genograms and process questions. According to Nichols (2010), a genogram is a "schematic diagram listing family members and their relationships to one another" (p. 124). Dates of important events, such as births, marriages, divorces, and deaths, are included in a genogram along with lines that indicate relationship dynamics among the family members. A money genogram as proposed by Mumford and Weeks (2003) facilitates a process-oriented discussion about how money plays a role in the family, both individually and relationally. Example questions include: Who earns income in the family? How income is allocated? Are family members spenders or savers? How are financial decisions made within the family? For more information about these types of questions, see Mumford and Weeks (2003). A sample money genogram is shown in the following case study. We propose that money related aspects should be added to the visual representation of the genogram. For example, money personalities (Mellan 1994), money scripts (Klontz et al. 2011), money disorders (Klontz et al. 2012), highest education level, and employment status should be added to the genogram. In addition, relationship dynamics specifically related to money should also be noted, such as conflict over a family member not paying another family member back for a loan.

Case Study

Background Information and Presenting Issue

Consider the case presented at the outset of this chapter. Now, let us take a closer look at them. Marcus (37) is a small business owner, living with his family in a small town in the Midwest. Angelique (35) is his wife and a stay-at-home mother. The couple has been married for 10 years and has three children, Jamel (7), Carter (5), and Ajali (4). They both hold bachelor's degrees. Eric's degree is in finance and Angelique's degree is in mass communications. The family considers themselves very traditional in terms of gender roles and a clear hierarchy has been established between the parent and child subsystems. The family describes themselves as close-knit because they like to spend time together especially doing outdoor recreational activities.

> To conceptualize the case through a CFT lens, the couple's ecological system, the individual partner attributes, couple relationship dynamics, and the financial process must be explored.

Although they are still engaging in activities, like camping as a family unit, Marcus and Angelique admit that there has been tension between them for the past 2 years, which escalated when Angelique found out about the extreme amount of debt Marcus incurred. Since filing for bankruptcy, Marcus has been working for a friend in an accounting firm. He is withdrawn and depressed because he feels like he has failed as a businessman, as a husband, and as a father. Angelique's anger has intensified because Marcus did not let her know about the financial situation. She often yells at Marcus and her children, is increasingly suspicious of Marcus's actions, and stays awake at night worrying about their financial future. She wants to take over the family finances and wants to know any purchase Marcus makes, but Marcus insists that he continue to be the financial manager of their finances. Angelique has also been looking for a job because she wants to contribute to the family financially, but is struggling to find a job that pays enough so that they can afford to put their youngest child, Ajali, in daycare. Marcus insists that Angelique stay at home until Ajali goes to kindergarten. As a result, Angelique and Marcus's arguments have increased in quantity and intensity. They recognize that they are growing apart, but want to make their marriage work. However, they are unsure what to do or where to seek help. A friend referred them to a financial therapist to help them with their relational issues and financial situation.

Case Conceptualization

To conceptualize the case through a CFT lens, the couple's ecological system, the individual partner attributes, couple relationship dynamics, and the financial

process must be explored. As previously noted, the couple lives in a small community where traditional gender roles are the norm and everyone knows everyone else's business. Being a male, Marcus feels the pressure of his community's culture to be a successful businessman and provide financially for his family so Angelique can stay at home with the children.

Marcus's money script is that he is a money worshipper and his money personality is a spender. Angelique's money personality is that of a saver and often disagrees with Marcus on how money should be spent in the family. She believes he spends money on things that are unnecessary and blames him for their current financial situation. They both believe they are fairly knowledgeable about personal finance, but they both assume that Marcus has more knowledge about the subject than Angelique because of his background in finance. Both are suffering from financial anxiety as a result of the financial distress they have encountered. Using a CFT lens, all of these individual partner attributes have impacted both the couple relationship and the financial process.

Angelique has lost trust in Marcus; coupled with her blaming him about the debt that he has incurred, their marital satisfaction and FS has lowered. The only times they interact with one another is when they argue about their financial situation. When they are not arguing about their financial situation, they are emotionally distant from each other. These examples reflect the couple relationship and the financial process interacting with one another. These examples are also influenced by the individual partner attributes.

Intervention

There are many interventions that are available to a systems-oriented therapist. To apply the stages of treatment described earlier in this chapter, the first interview would focus on building a working alliance with both Marcus and Angelique. The financial therapist should compliment Marcus and Angelique on the things that are going well, such as the couple making an effort to not argue in front of their children about their financial situation and continuing to do activities together with their children. The financial therapist may note that arguing about their finances is a good sign towards progress because now they are talking about their situation with each other rather than avoiding it. In addition, the financial therapist will want to begin to understand how the couple has dealt with the problem, including ways they have tried to solve the problem, solutions that have worked well, and attempts that have not worked well.

To develop hypotheses about the unhelpful interactions in the relationship, the financial therapist may ask her/himself: "What is the function of the problem?" "What is keeping the couple from changing?" "What is interfering with the couple's natural problem-solving abilities?" "What is keeping the couple stuck in the pattern?" Using this approach, a financial therapist may hypothesize that traditional gender roles have given Marcus a sense of needing to protect and provide for his family, which resulted in him sharing minimal information about the finances. Angelique may feel that because she is female that Marcus does not see her as competent in regard to finances. Because she blames him for their current situation

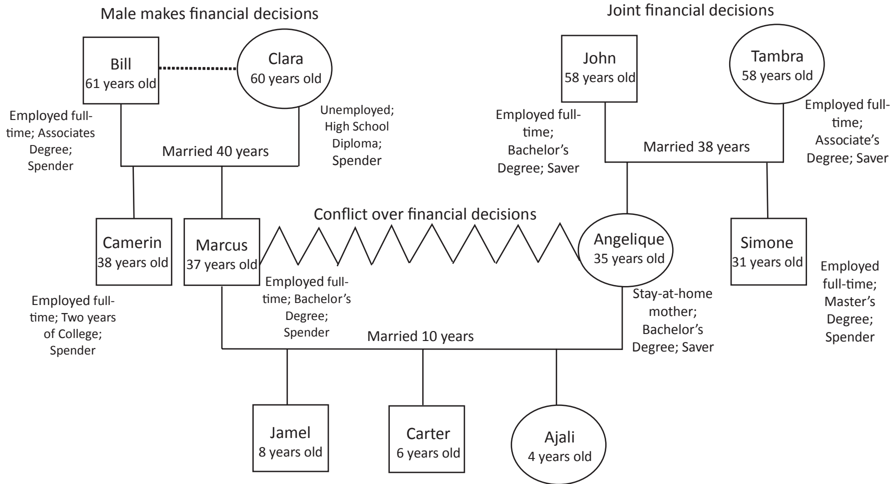

Fig. 13.2 Family genogram

and has lost trust in him, the couple is stuck in this situation and is unable to see each other's perspectives.

Remember Marcus and Angelique's dialogue at the outset of the chapter? Marcus explains that he has been reluctant to let Angelique be involved in the finances because he did not want to burden her with the stress he was feeling. She responded angrily by stating, "I am perfectly capable of handling our financial situation! Why don't you trust me?" This dialogue could have easily occurred when the financial therapist asked the couple what brought them to seek the financial therapist's help. The systems-oriented financial therapist could respond by saying that it seems like there are many factors at play and a genogram may be a useful tool for each of them to understand what is going on.

There are many interventions available to a systems-oriented therapist; a genogram is one of the hallmark assessments and intervention tools related to systems theory. The genogram in Fig. 13.2 represents both an assessment and an intervention in this case. A financial therapist can use a combination of a traditional genogram and a money genogram (described previously) to gain helpful information about the family's current relationship and history around finances. In this case, Marcus has an older brother, Camerin, and Angelique has a younger sister, Simone. Although we are highlighting Marcus and Angelique specifically, it is important to note important people in the couples' lives. In this case, Marcus and Angelique have noted their siblings who are single, work full-time, and are both considered spenders. Furthermore, the couple learns about each other's individual partner attributes and relationship dynamics among family members, especially in relation to money. For example, the genogram notes the conflict between Marcus and Angelique with a zigzag line. The genogram also shows differences in financial decision making and employment statuses between Marcus's parents (Bill and Clara) and Angelique's

parents (John and Tambra). It was used as an intervention for the couple too see and begin to understand their partner's upbringing, specifically how money was handled. Throughout the exercise, Marcus begins to recognize that his parents' (Bill and Clara) emotionally distant marriage (indicated by the dotted line) was fueled by his father's insistence that he be in charge of the family finances. His mom did not argue with his father about her desire to be informed about the financial situation, but instead withdrew emotionally. He also begins to understand that making financial decisions jointly is important to Angelique, and that she wants to be a part of the financial decision making. Angelique begins to understand why Marcus has been insisting that he be in charge of the finances and take sole responsibility for financially providing for the family. She also learns why Marcus has made certain financial decisions without consulting her and did not want to burden her with their financial problems. Marcus and Angelique realize that they have different views about money. A financial therapist can continue to use process questions to elicit information from the couple, slow down the conversations between Marcus and Angelique, help the couple think about relationship patterns among family members, and gain insight into their own behaviors and relational dynamics.

The genogram can help create mutual understanding between Marcus and Angelique because they have both gained insight into their own behavior and how they each contribute to the situation. However, the insight may not lead to Marcus and Angelique making changes that will impact their relationship and their financial situation. At this point, what happens when Marcus explains he does not want to burden Angelique with the finances and insists that he continue to manage the family's financial situation alone? Because the couple has gained some mutual understanding of the problem, the financial therapist has moved the couple to the middle phase of treatment. Here, the financial therapist can help the couple deal with the problem on their own. One way is to help each partner identify ways they are both contributing to the problem and develop and implement strategies in order to change the interaction between the couple relationship and the financial process. One idea may be that Marcus and Angelique begin having weekly money conversations. They may limit the money conversation to 30 min or an hour in order to not overwhelm either of them. When Angelique begins to understand their financial situation better, her financial anxiety may go down, and her trust in Marcus may increase. Likewise, Marcus may experience decreased financial anxiety because he is not keeping their finances secret any longer. This strategy will help them work together in solving their financial problems. All of these outcomes will increase both marital satisfaction and FS. Strategies may not even be directly related to the financial situation itself. The couple may decide that they need to spend time with each other alone and not talk about their finances. They may choose to implement a weekly or monthly date night where they can reconnect with each other without the stress of talking about finances. By enjoying time with each other, Marcus and Angelique can rebuild trust and increase their ability to communicate more effectively. As a result, their marital satisfaction will rise, and they will be better able to work together on their financial situation, increasing their FS. Regardless of the strategies implemented, it is best that the couple come up with ideas that they believe will work for them.

Once Marcus and Angelique have reached their financial therapy goals, the termination phase is entered and maintenance plan is developed to help keep the couple on track. In this final phase, the financial therapist can help the couple anticipate potential barriers to the couple's progress and identify ways to counteract those roadblocks. Once the process is terminated, Marcus and Angelique may want to check in with the therapist several weeks or months later to follow-up with progress they have made or obstacles they have encountered.

As with any case where a facilitator is working with clients on issues, there is the chance that triangulation with the facilitator can occur. This means the facilitator could become another person triangulated within the family systems conflict.

Outcomes

Looking through the CFT lens and using the systems-oriented interventions, the couple was able to understand their own core beliefs about money management and begin to see into their partner's views as well. For Angelique, realizing that her husband kept the financial decisions away from her meant he was trying to protect the family like his father did. For Marcus, he was able to realize that in Angelique's family, joint decision making around finances was very important. They began the process of understanding each person's point of view and identified strategies that each could implement to help change their own behavior and make a difference both in their marriage and their financial situation.

Ethical Considerations

As with any case where a facilitator is working with clients on issues, there is the chance that triangulation with the facilitator can occur. This means the facilitator could become another person triangulated within the family systems conflict. From a systems theory perspective, the therapist does become part of the client(s)' system and is actively involved in the family (Nichols 2010). The danger of becoming part of the system is the notion of counter transference, in which the therapist overidentifies with a client(s). Counter transference can happen with any case, but when the counter transference is unconscious, the interactions between therapist and client(s) can become detrimental to the client because the therapist may give advice or make suggestions based on his or her own experience rather than what is in the best interest of the client (Nichols 2010).

Another ethical consideration is that of the facilitator staying within their boundaries of previous training and education. The boundaries that a financial therapist who has training in both personal finance and mental health may be vastly different

from facilitators who, for example, may have backgrounds only in personal finance or only in mental health. The degree to which diagnoses can be made and the sophistication of a financial plan may vary as a result. Referrals to or consultations with professionals trained in the opposite field can be very helpful to provide clients the best and most holistic services possible.

Future Directions

CFT continues to develop as new research emerges. Various types of professionals (e.g., financial planners, mental health practitioners) can utilize CFT as a useful lens to conceptualize the dynamics among the ecological system, individual partner attributes, the couple relationship, and the financial process. These professionals can use a systems theory approach in working with their clients. Due to the circular nature of systems theory, conducting research on the theoretical framework is difficult. Regardless, research should be conducted to test the interdependency of the theory and clinical research should be conducted to test the effectiveness of systems theory interventions. Conducting a true experimental designed study, using a control group with a large and diverse sample that encompasses a broad population, would be ideal.

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Chapter 14
Narrative Financial Therapy

Megan A. McCoy, D. Bruce Ross and Joseph W. Goetz

Introduction

Narrative financial therapy (NFT) was first introduced in the *Journal of Financial Therapy* (McCoy et al. 2013). This chapter is a modified and updated version of that article. Professionals in financial and mental health fields increasingly comment on the interwoven nature of relational and financial challenges for clients. Financial planners indicate that they spend about one-quarter of their time with clients addressing nonfinancial topics, such as relational family challenges (Dubofsky and Sussman 2009), and about one-third of clients undergoing marital therapy report financial stress or problems (Aniol and Snyder 1997; Miller et al. 2003). As a response, the field of financial therapy is emerging as an effective way to treat relational financial issues.

NFT incorporates narrative questions into the already well-established six-step financial planning process (CFP Board 2013).

Recently, Asebedo et al. (2013) surveyed members of the Financial Therapy Association and found that there is not yet a consensus on what financial therapy actually entails. Some see the practice of financial therapy as a collaborative model involving both mental health and financial planner working with a client (Kim et al. 2011), while others believe one practitioner trained in both mental health and financial areas may provide financial therapy. Many professionals are clamoring for the latter (an integrated approach), but past literature primarily references models that either

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involve professionals working collaboratively or just addressing relational or financial needs on a cursory level (see McCoy et al. 2013). In response to this need, this chapter presents an integrated theoretical approach to financial therapy for a sole practitioner that combines components of both mental health and financial planning models, called NFT. The NFT intervention model is designed for use by professionals trained in therapy, counseling, coaching, or financial planning.

Narrative therapy was developed through the metaphor of stories and the epistemological stance of social constructionism (White and Epston 1990). The metaphor of stories allows practitioners to think of clients' problems as stories that are in the process of development.

Theory

NFT incorporates narrative questions into the already well-established six-step financial planning process (CFP Board 2013). The combination of the mental health and financial planning processes allows for an integrated approach to financial therapy. This chapter discusses narrative theory and the six-step financial planning process before providing an explanation and illustration of the step-by-step process of NFT.

Narrative Theory

It is the authors' position that individuals do not have to be a classically trained narrative therapist to incorporate valuable aspects of narrative theory into their practice. However, a general understanding of the underpinnings of this theory is important. Narrative therapy was developed through the metaphor of stories and the epistemological stance of social constructionism (White and Epston 1990). The metaphor of stories allows practitioners to think of clients' problems as stories that are in the process of development. Social constructionism shows how these stories can be cowritten by social, cultural, and political contexts (Freedman and Combs 1996). Consequently, healing in the narrative approach is not focused on solving problems, but broadening the stories of one's life to include more positive memories and thoughts. If a client comes in stating they are depressed, they are creating a thin description of themselves as depressed. This is called a thin description because it does not allow for alternative descriptions (Morgan 2000). For example, the client may be a successful businessman, a loving father, or a caring son, but he perceives himself as simply a depressed person. The narrative approach recognizes how the client's entire persona and life becomes encapsulated within the thin description of being a depressed person. Thus, part of the narrative therapist's role is to thicken the story by helping the client see themselves as a strong, smart, and resourceful person who is fighting against depression during this period of their lives.

These thin stories have been created and developed over time. Stories, which are created by powerful social, cultural, and political contexts of individuals' lives,

usually include thick descriptions of who they are as people (O'Hanlon 1994). For instance, a man who is experiencing financial strain after becoming unemployed may feel like he is a failure as a husband for not being able to support his family. A narrative therapist may thicken his narrative as a bad husband by including all the times where he has supported his wife and loved her as a good husband would. The thickening of the story through highlighting memories that reject the thin description of being a bad husband allows clients to create new variations of their story with new possibilities for their future (Morgan 2000). The promotion of new possibilities occurs through uncovering the origins of the problem, externalizing the problem to help them have a thicker description of themselves, and then reconstructing a preferred story that allows for happiness in the present and possibilities in the future (Freedman and Combs 1996).

…the focus is on externalizing the problem, the underlying assumption is that the client is not the problem and that the problem is not found within family structures or interaction patterns. The problem is separate from the client.

Each stage of narrative therapy has questions that can help move toward a preferred narrative. In Fig. 14.1, the five different types of narrative questions are provided: (a) deconstructing, (b) externalization, (c) sparkling events, (d) amplifying the preferred narrative, and (e) audience questions. An example of each question is provided to show how a financial therapist could address common financial issues that clients may present within financial or therapy sessions. These questions can facilitate a financial therapist to cowrite with their clients a thicker story that shifts the clients' perception of reality away from the internalized problem, and the internalized maladaptive discourse to move toward a new story of possibility (Freedman and Combs 1996).

It is important to clarify that narrative therapy is based on a nonpathologizing stance; This means that practitioners who utilized this approach emphasize clients' strengths rather than their weaknesses. In addition, because the focus is on externalizing the problem, the underlying assumption is that the client is not the problem and that the problem is not found within family structures or interaction patterns. The problem is separate from the client. People, therefore, are not blamed for problems (Morgan 2000). Thus, the focus can shift to the future and client strengths, rather than fixing past problems.

The Six-Step Process of Financial Planning

Incorporated in the NFT model is the six-step financial planning process as outlined by the Certified Financial Planner Board of Standards, Inc. (CFP Board 2013). The six-step process includes the following sequential actions:

1. Establish and define the client–planner relationship.
2. Gather client data and discuss goals.

Type of Question	Financial Strain
Deconstructing	How has financial strain impacted your ability to talk to each other about purchases? What did you learn from your parents or culture that made you feel like money was not something that you could talk to your partner about?
Externalization	What name would you give the problematic influence that is currently convincing you that you cannot talk to your partner about money?
Sparkling Events	In the past, can you recall a time when you talked about money with your partner? What did your partner do that helped you think it was safe to talk to him/her about money?
Amplifying Preferred Narrative	How has your new ability to talk about money together impacted other aspects of your relationship?
Audience	As you continue to improve the communication in your relationship, how will you show others how it has positively affected your relationship? What will they notice that leads them to believe that you are happy in your relationship?

Fig. 14.1 Examples of narrative questions. Previous researchers and clinicians have created questions and question types that assist the main tenets of narrative therapy: deconstructing, externalizing, sparkling events, amplifying the preferred narrative, and audience. These questions were adapted from the examples provided by White and Epston (1990); Freedman and Combs (1996); Shapiro and Ross (2002). This figure provides just a few examples of how to structure narrative questions, but practitioners are encouraged to change the wording to fit their communication style and their clients' needs

3. Analyze and evaluate client's financial status.
4. Develop and present a financial plan.
5. Implement the financial plan.
6. Monitor the financial plan.

In the proposed model, these six steps are incorporated into a manualized approach to narrative therapy shaped by the writings of narrative theorists (White and Epstein 1990). Narrative therapy is not typically used in a manualized version because narrative therapy does not always follow linear steps. Due to this nonlinear nature, financial therapists may need to cycle through previous steps depending on their clients' needs and what is being addressed in sessions (Vromens and Schweitzer 2011). A condensed version of the objectives designed for each step of the six-step process is found in Appendix 1.

It is important that clients feel safe and understand the unique boundaries around this new style of intervention.

Principles and Strategies of Narrative Financial Therapy

Step 1: Establish and Define the Therapeutic Relationship

The objectives of the first step are threefold. First, it is important to differentiate financial planning and traditional therapy from financial therapy. It is important that clients feel safe and understand the unique boundaries around this new style of intervention. Clients need to have a clear understanding of the boundaries and ethics regarding services. Clarification on the limits of confidentiality should be disclosed, because they may differ in financial therapy depending on the primary discipline of the practitioner. In providing services for clients, it is important to remember that for every disappointment, there is an unmet expectation. Providing proper informed consent and clarity around scope of service is crucial before any services begin.

The second objective of the first step is for practitioners to join and create a *therapeutic alliance* with their clients. A therapeutic alliance refers to a strong emotional bond between the practitioner and client as well as a high level of agreement regarding the tasks and goals of the meetings and overall process. One way of creating an alliance with a client is to not initially focus directly on the problem. Instead, practitioners can discuss who the client is outside of the problem through asking about interests or other aspects of the client's life. This process is in accordance with narrative therapy's stance that the practitioner should not assume pathology or a problem in the clients' systems in regard to their relationships or their finances (Vromens and Schweitzer 2011). The practitioner should create an open space that invites the clients to share their story. Questions are not meant to assume any problems, but instead are meant to provide knowledge and insight into who the clients are as individuals. The practitioner should also highlight any strengths and resources the client may possess.

The gathering of financial material and participating in financial assessments may be empowering to the client or could evoke feelings of anxiety, frustration, and stress in clients.

Similarly, Tomm (1987a, b, 1988) discussed the importance of using open-ended questioning to facilitate further dialogue instead of shutting it down. Open-ended questioning allows a dialogic process through reflective and circular questions instead of simple yes/no questions. This process allows the client to be open and to share more information about themselves, in turn supporting the development of the therapeutic alliance. It also prevents the practitioner from internalizing the thin problem narrative the clients may be seeking to initially treat.

Step 2: Gather Information and Establish Goals

The second step focuses on gathering the financial information from clients. Many times, the best way to gather information is through assigning tasks for clients to complete between sessions. These tasks assigned (the session's homework) are designed to implement change toward the client's goals. The homework assigned may include locating and organizing information related to the client's financial situation in preparation for the following session.

The collection of this material allows the financial therapist to better assess the clients' financial situations, and provides insight into what each client's belief system is around money. The gathering of financial material and participating in financial assessments may be empowering to the client or could evoke feelings of anxiety, frustration, and stress in clients. Normalizing the client's emotional response is important so that clients do not feel as if they are alone in this process. It is also important to provide advice on how to achieve their homework to remove any potential hurdles. Furthermore, the service provider should validate the efforts that are made, as well as any positive financial decisions in order to develop and support positive behaviors.

Alongside the financial discussions, the practitioner also has the clients discuss their money scripts (Klontz and Britt 2012). Clients spend time sharing how their differing stories around money affect their financial behaviors today. Many people have developed certain schemas, or belief systems, about how finances influence their life. It is important to discuss these beliefs and how they influence clients' behaviors and interactions. When working with couples, practitioners discuss how their clients' differing stories can help each other, as well as how they can hinder their clients' interactions. The money script exercise is integral in this stage because the clients are able to see that their partner's underlying views on money may not be that different from own. They may also be a result of dominant discourses that their partner has internalized (e.g., "I need to look rich so that people see me as competent" or "I need to be stingy with money to protect our children because as a woman I am in charge of the family").

The client's money scripts could be related to the dominant discourses around gender, relationships, culture, power, and privilege. The practitioner should introduce deconstructing listening and deconstructing questions at this stage to uncover the dominant stories present in the client's life so that their effects can be explored. This loosens the grip of the powerful discourses in our society that were regulated by those with power and privilege (Freedman and Combs 1996). In other words, some clients accept and believe unhelpful money messages from society about success or self-worth related to wealth that can be a driving force for unhealthy financial behaviors. In Fig. 14.1, examples of how to frame deconstructing questions to uncover the dominant discourses that are impacting the clients' views on their financial situation are provided.

Once the dominant discourses around finances are deconstructed and brought to awareness, the problematic discourses can be externalized away from the clients. This externalization process helps clients to begin dealing with the problem instead

of fighting or blaming others. Externalizing is a process that involves taking the language clients use and modifying it to objectify the problem outside of themselves. Vromens and Schweitzer (2011) suggested practitioners describe the problem so that it is externalized and nonpathologized outside of the client. Thus, the problem assumes its own identity as separate from the client. Externalizing requires a particular shift in attitude, orientation, and use of language that positions the problem outside of the client (Morgan 2000).

This technique of shifting the client's perspective of concerns around money facilitates the formation of a new healthier relationship with money. Once the problem is seen to be separate from the person, then boundaries may be constructed as well as ways to combat the problem. A thorough exploration and personification of the problem may be performed through asking follow-up questions on the problem's way of operating, rules, purposes, and techniques. Refer to Morgan (2000) for ways to understand how to more effectively externalize the problem. An example of an externalizing question around finances can be found in Fig. 14.1. Once externalizing occurs, it is easier to move to the final objective of this step—creating goals.

It is critical for the practitioner to complete the final objective by establishing goals that reflect the attitudes and wishes of the clients. It is important that the presenting problems are first defined in concrete terms. By describing the problem in this way, the goals become measurable and the practitioner and clients both know if the treatment plan is working. Practitioners seek to alleviate the unproductive behavior and cognitive patterns surrounding the problematic narratives that were created, in part, by dominant discourses in society. When working with a couple, assessing both partners is important to ensure all needs are defined and addressed within the goals. The practitioner may want to incorporate a therapeutic contract or service agreement with the clients, which specify the goals of therapy. This therapeutic contract is written out and lists the specific responsibilities of both the practitioner and the clients, so that it becomes clear to all parties how the goals of therapy are addressed through the course of treatment (Sills 2006).

> Looking for financial red flags is also important for any practitioner using this model to understand that there are some financial issues that could have detrimental consequences for the clients if not dealt with immediately by a specialist.

Step 3: Analyze Information and Develop Plan

The third step focuses on analyzing the information and determining the possible avenues clients can take to alleviate financial strain and improve financial well-being that will eventually be used to develop a financial plan of action. A financial therapist should focus on defining the options for a client, and provide guidance toward the most productive solutions. Through presenting options, the practitioner can help clients construct a new and preferred way of thinking about and addressing finances.

Looking for financial *red flags* is also important for any practitioner using this model to understand that there are some financial issues that could have detrimental consequences for the clients, if not dealt with immediately by a specialist. This could be discovering the client owes back taxes or child support, which could result in garnished wages or even jail time. If a practitioner sees any financial issues that they believe are outside of the scope of their training, then a referral should be made. Practitioners must be knowledgeable about the financial information they gather, the stressors that clients experience, and therapeutic approaches utilized.

Once the practitioner decides there are no red flags that would prohibit him or her from continuing, the practitioner's job is to continue to find exceptions in the problem-saturated story. This is a period when the practitioner actively finds events that contradict the painful and problematic stories and help the client use these examples to transform the story of their life into the preferred story. In other words, the practitioner helps find openings for a new story to take the forefront in their life. This is done with the aid of audience questions and *sparkling events*, a term coined by White (1991). Sparkling events are instances in the client's life when they had power over the problem. This step includes time spent on encouraging clients to see the problem as a result of external forces rather than their partner's desires when working with couples. At this point, goals become their shared goals without the externalized issues that were derived from culture.

Step 4: Present Plan

This step requires presenting a financial plan of action. This will be a list of action steps that the clients can take to alleviate financial strain and improve financial well-being. To make this model appropriate for multiple disciplines and congruent with the narrative therapy's belief in the client's knowledge of their abilities and the problem, the financial action plan should be co-constructed with the client. This step should focus on presenting techniques and options for the client so they can feel a stronger sense of agency and empowerment around the plan, increasing intrinsic motivation and self-sufficiency.

> It is important for the practitioner to address and normalize any anxieties that the client may exhibit…

At times, the clients may feel discouraged about their ability to implement the plan. The practitioner may need to spend some time focusing on events in the clients' lives that could not have been predicted by the problem story (White and Epston 1990). These alternative accounts are called unique outcomes or sparkling moments. These events are usually not yet apparent to people at the start of therapy, but it is important to look for glimpses of these sparkling events and ask questions that elicit the

client's discovery of them. The practitioner can notice in-session sparkling events and expand meaning around them. The practitioner should strive to be curious about and thicken these stories of the sparkling events of their client's life.

Once there is a description of the sparkling event, inquire about the client's experience of this action or thoughts at that time. Strength-based questions about the client's skills and knowledge can further develop a rich present and past account of the sparkling events, as can questions that invite consideration of future possibilities that exist in relation to these. Continuing to ask questions that explore interpretation and meaning of the sparkling events in terms of identity expands the story, invites forward a description of the preferred self, and building more connections to intentional states and values (White and Epston 1990). Vromans and Schweitzer (2011) stated the practitioner should highlight the differences between existing and preferred ways of living for the clients. The retelling of alternative stories that contrast with previously held assumptions become stronger with every additional telling. Each retelling develops the preferred narrative of the client and thus, becomes more richly described, has a stronger hold within the client, and exposes new possibilities in relation to combating the problem.

The externalizing language developed in previous steps should continue to be utilized. The client may be experiencing self-doubt in their ability to change their thoughts and behaviors around money. It is important for the practitioner to address and normalize any anxieties that the client may exhibit during the presentation of the plan in the previous step. Clients often possess the resources and ability themselves to combat their problems, their resources and abilities simply need to be magnified to remind the clients of their presence. The acknowledgement and appreciation of a clients' own knowledge and strengths may lead to a greater sense of agency (Monk et al. 1997).

> Additionally, clients need reinforcement from their friends and families to aid the externalization process.

Step 5: Implement Plan

This stage is very important, as the practitioner must make sure clients understand all the components of the action plan and their specific roles in its implementation. Plan implementation involves motivating the client to take those steps as set forth in the cocreated plan. At this stage, the practitioner continues to incorporate externalizing language and sparkling event questions at points where the clients may feel unsure about their ability to implement the plan. The practitioner also should take time to highlight strengths of the clients, validate struggles, and the progress being made. Furthermore, the practitioner may suggest that the clients keep a journal to identify what triggers their externalized problem while the plan is being implemented.

After assigning such tasks, it is important the practitioner spends some time addressing the client's homework in the following session. Similarly, the practitioner should discuss problem solving techniques with the clients so that they may address unforeseen problems that arise between sessions on their own. Practitioners should focus on highlighting the strengths of the clients and how they are overcoming their deconstructed and externalized problems to work toward their goals. Mistakes should be seen as moments where the externalized problem simply overcame the clients, but they were only momentary successes for the problem. The practitioner should emphasize that clients have the power to fight the problem and that they see support systems and other resources as sources of strength and allies rather than the problem.

Step 6: Monitor Performance

This stage involves evaluating the effectiveness of the plan in achieving the client's objectives. The goals of the client may have not been fully reached, or new concerns may have surfaced that need to be addressed. Continue having the client(s) journal to keep a record of the progress of the client, as well as to identify any triggers that may maintain financial difficulties or stress. Unsatisfactory progress or performance requires that corrective action be taken (e.g., the market is down and the client is willing to accept lower returns).

This step includes the practitioner implementing a technique called amplifying the preferred narrative (see Fig. 14.1 for examples). Once the client system has found the strength to fight the problem, they can begin to identify an alternative envisioned future. This envisioned future provides strength in describing what their story looks like in the absence of the externalized problem. The practitioner can help their clients amplify the preferred co-constructed narrative that was created over the course of therapy using narrative questions (Bermudez et al. 2009). Amplifying the solution creates the reinforcement needed to help clients fight their old narrative by solidifying their new story over time (Bermudez and Parker 2010). Continued encouragement of the skills, knowledge, and sense of agency the client has developed is crucial to this step.

Additionally, clients need reinforcement from their friends and families to aid the externalization process. White and Epstein (1990) referred to this use of identifying and recruiting an audience as *spreading the news of difference*. Friends and family members get the opportunity to be recruited to support the newly defined preferred narrative and they have a chance to help reinforce and strengthen it, and the ability to avoid strengthening the old problem-saturated story (Bermudez and Parker 2010). Asking the clients audience questions can encourage the clients to find support in their friends and family to strengthen the preferred narrative, and to help them overcome the oppressive discourse. Additionally, it is important for the practitioners to highlight and validate any positive behaviors the clients display in order to reinforce the desired behaviors and develop a pattern of maintaining said

behaviors. The goal is to make the clients see themselves as capable of overcoming any obstacles with the help of their social capital.

The goal is to make the clients see themselves as capable of overcoming any obstacles with the help of their social capital.

Case Study

Background Information and Presenting Issue

This section illustrates the utilization of the NFT model through a case example. Mary (33) and Robert (34) are meeting with a marriage and family therapist for couple's therapy after 8 years of marriage. The couple reports that they are experiencing increased marital conflict recently after the birth of their second child. For the past 8 years, Mary and Robert both had stable, well-paying jobs, which have enabled them to adequately provide for their family. Now, with the arrival of their second child, Mary states that she has decided to quit her job to stay home to care for their two small children, Emma (3 months) and Max (6 years). Without her supplemental income, Robert begins to feel mounting financial stress as the sole provider of the family. Robert and Mary both report they are seeking therapeutic services as they have found themselves arguing over money quite often now.

Case Conceptualization

Robert and Mary have been able to work in financially secure jobs over the past 8 years. Robert has traditionally always managed the finances and has never expressed worry. With their dual incomes, supporting a three-person household has been relatively easy, and afforded them a life of being able to have small luxuries. However, the birth of their second child, while a happy and planned decision, has brought a strain on their current financial situation. Robert has already begun to implement cutting back on expenses, such as date nights and family trips. The financial condition is further tested for Robert when Mary announces she wants to become a stay-at-home mother and care for her young children. Robert agrees with Mary wanting to take care of their children, but is increasingly troubled by how they will afford the same lifestyle they have become accustomed to living. Robert believes that Mary is not concerned with their financials, and Mary believes that Robert is overly concerned. The following treatment plan highlights the implementation of NFT for the couple.

Intervention

The therapist, who is NFT trained, listens intently and respectfully to how the couple's arguments often revolve around money. The therapist decides to offer financial therapy services instead of traditional couple therapy, given the emphasis on financial stressors for the couple. The couple is intrigued and agrees to NFT services. Throughout this first session, the therapist spends time defining the therapeutic relationship and joining with the clients. The therapist clarifies that even though they would be discussing financial topics, she would still be practicing under her marriage and family therapy license. She provides the couple with proper informed consent about mandated reporting, prohibitions against dual relationships, and clarity around her scope of financial services. She also explains that she is not a licensed financial planner, and thus has limitations to what she can provide by way of financial advice. She informs the couple that if at any point in treatment they decide they need more detailed or specific financial advice, that a referral would be made. This process takes the entirety of the first 50-min session. At the session's close, the therapist and couple agree to meet weekly for 50-min sessions to resolve their financial conflict.

The second session occurs the following week. The therapist's only focus is creating a therapeutic alliance with the couple. The therapist does not focus directly on the problem, but rather asks the couple how they met, what drew them to one another, and what they do for fun together. The therapist also highlights their strengths and resources they as a couple have together. Through simple open-ended questioning, the couple describes their whirlwind of a romance that was built on their mutual love of traveling and food. They appear to enjoy talking about their dating history; however, towards the end of the session, the tone of the conversation shifts as Robert mentions that they are no longer able to travel or visit fancy restaurants, now that they have children and bills are piling up. Mary becomes defensive and claims she is working hard to raise their children. Both become silent, each brooding over the value of their own contributions to the family. The therapist acknowledges the stress of the finances for Robert, and the strain of raising young children for Mary. The therapist suggests that it may be a good time to go over the homework that the clients will need to complete for the following week. The therapist assigns the couple two homework assignments. First, they are to find pictures from their honeymoon and recount their adventures together. Second, they are to gather important financial information. They are asked to bring their credit reports, credit scores, bank and credit account statements from the previous month, and a recent tax return to the next session. The therapist facilitates the experience of collecting their financial information by directing them to creditkarma.com for their credit scores and annualcreditreport.com to view their credit reports. The therapist also minimizes anxiety by stating the clients can call or email if they encounter any confusion over the assignment.

At the beginning of the third session, the therapist makes sure to ask both Robert and Mary about their homework assignments. Each client shares that they enjoyed

the process of talking about their honeymoon, but did not enjoy viewing their financial situation. The therapist acknowledges the stress they experienced around their finances, and explained how these feelings of stress and anxiety were common in her experience. In order to further normalize the situation, she tells them an anecdote from her own experience about being locked out of her own credit bureau account for incorrectly answering security questions. The couple laughs at the anecdote and becomes visibly relaxed in session. The therapist observes the couple has very good credit scores, but their account statements reveal that they have depleted much of their savings over the past few months as they have adjusted to one income. The therapist also reviews the clients' credit reports, account statements, and tax return for any issues that could be creating additional strain for the couple.

As the session continues, the therapist focuses on making sure the conversations about their finances were very neutral and nonpathologizing. However, Robert is very negative about their current financial situation and appears very anxious about the family's future. He states several times that he doesn't know what they will do, if they keep doing what they are doing, or even worse, if he is laid off from his job. In a reactive manner, Mary minimizes Robert's feelings every time he shares a concern by claiming that they will be fine. She maintains he is becoming hysteric about these hypothetical issues that probably will never arise. The therapist points out that they appear to be very entrenched in their viewpoints. Robert states that they were just raised differently around money and are too different to find a sort of middle ground. Mary nods her head in agreement with Robert. The therapist decides to challenge this belief system and provides the couple with a money scripts inventory to complete for homework over the following week. She asks that each take the inventory separately and not share their answers until the following session.[1]

The fourth session focuses on exploring the clients' conscious and unconscious beliefs surrounding money through the use of the money inventory assigned for homework. The couple is very surprised to see that their money scripts are scored similarly in certain areas. The therapist points out that they both score high on seeing money as important for enjoyment and safety, and both score low on money as a symbol of status and power. These similarities provide a common ground from which the therapist and the couple can work from. However, after reviewing the scores, Robert and Mary both still feel like the inventory did not encapsulate all of their partner's beliefs. Robert states he feels Mary never worries about the security of the family and that the anxiety falls squarely on his own shoulders. Conversely, Mary says she absolutely worries about the financial security of the family, but that Robert is so focused on the future well-being of his family that he is missing out on their present well-being. The therapist acknowledges the concerns expressed by Robert and Mary, and points out that again, there is common ground between them. Both worry about the security and well-being of their family, they are simply approaching the issue from different sides.

The therapist uses this time in session to ask deconstructing questions to Robert about where this fear of their future financial situation stems from. Robert recounts

[1] For available assessments, see Grable et al. (2011); Klontz and Britt (2012).

how his father was a sole provider for the family and often struggled to provide for his family. He admits that he feels it is his duty to provide for his family, and if he cannot, then he is a failure. This belief has further cemented now that Mary has decided not to work, and he has become the sole financial contributor to the family. Mary is moved by Robert's vulnerability and admits that she is worried about their financial future too, but every time Robert brings the issue up, she feels he is blaming her for staying home. Robert shares he is happy that she is home taking care of their children and it is worth the financial sacrifice. The therapist continues to use deconstructing questions (e.g., " Robert, when did you first start to believe that Mary didn't worry about your savings" and "Mary, when did you stop talking to Robert about the ambivalent feelings you were having about staying at home?") and deconstructing listening throughout the session to further explore the couple's belief systems.

The following session focuses on externalizing the couple's anxiety about their future financial state. The couple no longer sees the anxiety as "Robert's fear," but rather as a shared problem that is plaguing their relationship. They decide to call the problem *the future worry*. The therapist spends time creating an identity for *the future worry* with the couple. "When did *the future worry* around money start convincing you that you can't think or talk about it?" "What does *the future worry* sound like?" "When is *the future worry* the quietest?" By the end of the session, the couple is laughing and ready to combat *the future worry* together. The therapist assigns them a homework assignment to think of financial and couple goals they would like to accomplish together by the end of treatment.

During the sixth session, the couple brings in their goals to discuss and place into a treatment/action plan. With their therapist, Robert and Mary's goals are formulated to be specific, measurable, attainable, realistic, and time related (SMART goals). By describing the problem in this way, the practitioner and clients both know if the treatment plan is working. The couple decides their goals are:

1. To create a spending plan based on reduced household income.
2. To build a savings account to decrease the power of *the future worry.*
3. To start saving for a vacation for Mary and Robert without the children.
4. To have a date night to a new restaurant once a month.

Since the couple does not already have a budget in place, the therapist assigns creating one as homework.

In the next session, the budget is reviewed to ensure there will be enough for their different savings goals (i.e., emergency fund/foodie vacation/date nights). Prioritization of expenses and family interests is discussed, and the couple decides which spending areas can be reduced. The therapist makes helpful suggestions such as using Groupon for date nights or keeping their savings in an online savings account for the high interest rates, but does not direct the couple on specific financial decisions. The therapist's role is to simply provide options to help the clients navigate their own issues, creating a sense of agency where the couple can combat *the future worry* on their own. The therapist can use sparkling event questions to overcome insecurities in their ability to stay on the same team (e.g., When was a time

where you were able to save up for a trip together?" "When has Mary been more stressed about finances then Robert?" "When has Robert been able to stay more in the present instead of only focused on the family's future?"). This line of questioning allows for openings in the couple's problematic narrative.

At this point, Mary and Robert begin to implement their treatment plan. Much of the work has to be completed outside of the therapy room (making smart financial decisions), thus it is important the therapist emphasizes the need for support. When in session, the therapist continues using externalizing language and sparkling event questions to highlight the strengths of the clients and validate their struggles. However, there is a focus shift toward monitoring progress. As the couple progresses, sessions are less frequent in order to allow them to increasingly combat the future worry on their own. The beginning of *each session monitors Mary and Robert's progress towards their goals*. As they progress on their goals, the therapist begins to ask audience questions to help develop support for the couple within the community. Mary joins a coupon cutting club that helps to reinforce her spending habits and provide an alternate behavior to shopping. Robert begins meeting with his brother for coffee once a week to talk about the pressures they both feel as men and providers. This allows a shift in that Mary and Robert find support in their friends and family instead of the therapist. Eventually, Robert and Mary achieve their goals and a sense of competency over managing their *future worry*. At this point, treatment is concluded, as the couple is able to combat the issues together and without the aid of the therapist.

Outcomes

Through NFT, the couple was able to thicken their thin narrative from "Robert is stingy and worries too much about the future, and Mary is frivolous with money and not thinking about our future" to a preferred narrative of "Mary and Robert are making financial sacrifices so that Mary can stay home with their children and they can save for the future." They started to see themselves as a team fighting against *the future worry*, instead of entrenching themselves in their perspective to fight one another. In addition, from deconstructing the powerful dominant discourses around gender, Robert was able to be more open and vulnerable with his wife which increased their level of intimacy.

As written for this case study, progress was made linearly. However, it is important to remember that in the real world, a couple will hit obstacles and will backslide in their progress. This is okay. But it is also when it is most important to be flexible as a practitioner and ensure that the problem has been completely deconstructed and externalized. Some steps will take many sessions, while other steps will only need 15 min. A hallmark of narrative theory is that no case, no client(s), no story is the same. Thus, the approach cannot be identical every time. Similarly, the case study is treated from a marriage and family therapist's perspective and although the goals were very financially focused, the therapist's intervention was more focused

on the relational component of treatment. If the practitioner had been a financial planner, the sessions would have been very similar, but may have provided different techniques toward financial progress. These methods are just valid and can still be applied to NFT.

Ethical Considerations

Awareness of ethical considerations, especially when applying tools and theoretical frameworks from differing professions, is vital to the treatment process. It is necessary for practitioners to educate themselves on the standards, responsibilities, and ethical codes of financial and mental health disciplines. Financial therapists must also understand the limitations of practicing outside one's expertise. However, professionals from the financial and mental health disciplines can benefit from considering interdisciplinary and integrated approaches in an effort to intervene with clients more holistically.

Future Directions

There is strong need for the development of additional frameworks and methods for delivering various financial therapy interventions designed to improve financial behaviors and decision making (Goetz and Gale 2014). Additionally, there is a need to broaden the current knowledge of the new field of financial therapy by increasing funding, research, and writing (Gale et al. 2012). One approach is to provide methods and models for professionals from both fields to implement financial therapy interventions into their practice to more effectively serve their clients. NFT is a coherent, integrated, theoretical-based, and manualized approach for both mental health and financial planning professionals to use in their work with clients. However, future research and empirical evidence through randomized clinical trials is needed to support this approach to further justify its implementation.

Appendix 1

Narrative Financial Therapy: Condensed Manualized Approach

Step 1: Establish and define relationships

Objective 1. Define narrative financial therapy process and achieve informed consent of the new approach, define scope, and ethics.

Objective 2. Create a therapeutic relationship using a non-pathologizing, strength-based, and normalizing stance.

Step 2: Gather and establish goals

Objective 1. Collect information through homework, but address potential obstacles and anxiety as well as potential benefits.
Objective 2. Use a money script exercise to create deconstructing questions.
Objective 3. Use externalizing questions to loosen the grip of the problematic narrative.
Objective 4. Co-create goals for treatment that address relational and financial concerns.

Step 3: Analyze the data

Objective 1. Look for financial red flags and decide if appropriate to continue.
Objective 2. Use sparkling event questions to magnify strengths and resources within the clients.

Step 4: Develop and present the plan

Objective 1. Co-create a collaborative action plan that is focused on the path toward the preferred narrative.
Objective 2. Continue using sparkling event questions to overcome insecurities in their abilities.
Objective 3. Continue using externalizing questions to ensure the plan is focused on defeating the externalized problem.

Step 5: Implement the plan

Objective 1. Monitor progress to ensure the action plan is being implemented as expected.
Objective 2. Use journal to identify potential triggers of the externalized problem.

Step 6: Monitor the plan

Objective 1. Amplify the preferred narrative to ensure the couple is ready to fight their thin description with their new thickened story.
Objective 2. Begin incorporating audience questions to spread the news of difference.

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Chapter 15
Feminist Financial Therapy

Roudi Nazarinia Roy and Yolanda T. Mitchell

Feminist Theory

There is no one single grand "feminist theory," instead there are a collection of theories and they do not fall on a well-ordered spectrum. Rather than being unified, it has been argued that branches of feminist theory are in direct conflict with one another (Osmond and Thorne 1993). When we think about the term feminism and how some feminist females choose to live their lives these conflicts are brought to life. For example, young women who consider themselves feminist may pursue higher education and careers, but when they have children, their lives may take different paths. Some will continue to work and outsource their "traditional" role responsibilities, in order to keep up with their workload, by hiring a nanny, while others may take a break from their careers to stay home with their children for the first few years. Although their professional and personal lives are very different, both women view themselves as feminists. Both women would be correct in their views because feminist perspectives vary, and this variation is often overlooked as many people in the general population are led to believe that feminists are all career-focused women who do not believe in marriage or having children. These perceptions are often due to the reality that feminist scholarship has emerged from, and continues to have, a reciprocal influence on movements for social change. In this chapter, we briefly explore the history of feminist theory and discuss some of the branches of feminist thought. For the purposes of this chapter, we will limit the discussion on history to key individuals and their publications. We then examine the assumptions, concepts, and propositions within the feminist framework and how they can be incorporated into financial therapy. Gender roles and the division of household labor as well as

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financial dependence and their application to feminist financial therapy are considered. In conclusion, we discuss the benefits and limitations of feminist theory.

History

In the USA, feminist theories emerged in the late 1800s when the women's rights movement attracted widespread support. During the same time, women were encouraged to pursue higher education and the focus of feminist theorists was on women's rights and equality. In 1898, Charlotte Perkins Gillman, a feminist theorist, published *Women and Economics* in which she argued that men have economic power in the family, and marriage controls women because men bring home an income and women receive no income for their household labor contributions (Osmond and Thorne 1993). In the early 1900s, anthropologist Margaret Mead published many ideas that had feminist implications; from her ideas on motherhood being a shared responsibility, which she saw in other cultures, to sexuality being more casual and open. Perhaps her greatest contribution to feminist scholarship was in her research on the sociocultural determinants of masculine and feminine personality traits (Osmond and Thorne 1993). During the same time frame as these women's publications, more women in the USA pursued higher education and entered the workforce. In fact, women's pursuit of education and labor force participation had implications for both women's delay of entry into marriage and parenthood (Roy et al. 2014).

A reemergence of feminist theories occurred in the 1960s as the women's movement shifted from a focus on rights and equality to a focus on liberation and a struggle against oppression. This second wave was characterized by the outspokenness of various branches of feminism, mainly liberal, Marxist/socialist, radical, and socialist. Liberal feminists, like Betty Friedan, spoke out against the subjugation of women particularly in the workforce and the limited opportunities for women to take significant roles in society. They aimed to achieve gender equality and remove barriers that prevent this equality such as laws, institutions, and discriminating individuals (White and Klein 2007). Friedan's book, *The Feminist Mystique,* published in 1963, attacks Freudian assumptions about sexuality and gender and encourages women to take the opportunity to improve their lives (Coontz 2011). Friedan's ideals were mainly based on research she conducted on middle-class college educated peers. She exposed the feelings of dissatisfaction and depression experienced by women living the American dream and although her book was based on middle-class White women, current scholars believe it was relevant to the lives of African-American and working-class women as well (see Cootnz 2011). Regardless of how applicable Friedan's writing was to all women, it is indisputable that many American women were impacted by this publication. This is perhaps a main reason why her publication has often been seen as the guiding factor for the second wave of the feminist movement, and why we speculate that most feminists in America view themselves as liberal feminists.

Marxist/social and radical feminism emphasize the oppression that women face due to their biology and the power and authority that men have in society. For example, before the advent of birth control, women had no guaranteed means of

controlling their reproductive systems and even when these medications became available, certain states banned their use (Roy et al. 2014). Where Marxist/socialist feminism emphasizes the exploitation of women in their reproductive and household labor roles, Radical feminism emphasizes male dominance as the problem with society. Although women's roles within both the home and the labor force have changed dramatically since the inception of the feminist movement of the late 1800s, there still remains a gender gap in our society. This is perhaps most evident when we examine gender differences in the labor force. For example, theories of labor force participation, such as segregation with jobs—specific occupations are thought to be women's jobs and are paid less—and occupational sex segregation—women are channeled into specific occupations (e.g., nurse instead of doctor, secretary instead of CEO), illustrate that women and men are continuously guided into gender specific careers. Other theories of labor force participation even take women's biology—her ability to bear children, into account. For example, the cyclical employment effect takes into account the fact that women are likely to cycle in and out of the labor force due to their childbearing and childrearing roles and are thus more likely to be paid less, fail to accrue seniority, and are blocked from higher status positions. On the other hand, the male superiority effect considers men as the primary "breadwinners" supporting their families and thus having a greater need for higher salaries. In addition, men's reduced role at home allows for more flexibility in terms of their work schedules and sets them up for a greater likelihood of being promoted. These examples illustrate the oppression of women due to their biology and their roles in the family unit. Cultural feminism is perhaps the most conflicted branch of feminism because it emphasizes the uniqueness of the *female nature* or *female essence* (Alcoff 1995). Historically, cultural feminists have been at odds with liberal feminists because they have argued for women to be valued for their feminine attributes rather than wanting to be equal to their male counterparts. In other words, while liberal feminists fight for equality of rights for women, cultural feminists fight for acceptance and appreciation of women's roles whether biological or social. While feminist theories are not in agreement on all aspects, there are a general set of assumptions, concepts, and propositions that can apply to each of these branches.

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Assumptions

In all areas of the feminist framework, women's experiences are central in providing the roots for understanding the assertions of the theory (White and Klein 2002). Essentially this assumption acknowledges that the experiences of women

in society are not only real but also that their experiences (e.g., thoughts, feelings, and actions) are different from those of men, and women have the ability to make moral decisions and control their destinies (Tuana and Tong 1995). Because each woman's experience is central, the feminist framework has many voices (White and Klein 2002). As discussed earlier, two feminist women may take different paths after completing higher education in relation to raising their children. Each woman's path is individual to her circumstance but still holds various feminist perspectives. This example of multiple paths characterizes the assumption of many voices in feminist theory; a woman's understanding of time, place, culture, and other areas of her life influence her singular, and potentially vastly different, experiences, but each is afforded equal status and respect. These two assumptions can seem divergent, so it is important that we recognize that the conflictual nature of these assumptions is acknowledged among feminist theorists (see Duran 1998; Harding 1987). By stating that women's experiences as a whole are central, while at the same time diverse, we are expounding on similar principles of other marginalized groups in society. For example, the same way that individual members of the African-American and lesbian, gay, bisexual, and transgendered (LGBT) communities do not have the same daily experiences as one another and one member's experience does not serve as the "spokesperson" of all the other members (multiple voices), the circumstances of the group as a whole (experiences as central) still need to be recognized. The final assumption of the framework asserts that feminist theory is emancipatory; meaning that while we recognize the individual and group aspects of the feminist framework, as a practical theory, feminism must also reveal the oppressive social arrangements that continue the cycle of inequality, specifically patriarchy.

Concepts

In theory building, concepts are a method of categorization related to how data are described and interpreted. You can think of concepts as the ideas for which the theory is developed while propositions are built based on the connections between the concepts. White and Klein (2002) described four concepts that make up feminist theory: sex and gender, family and household, public and private, and sexism. According to feminist beliefs, in some way, shape, or form, these concepts all relegate women to being subordinate to men.

Sex and Gender The most popular concepts of the feminist framework are that of sex and gender. Sex refers to our biologically determined male or female status. Gender is the social meaning and behavior attributed to one's sex. Over the years, three distinct dimensions of gender have been identified (White and Klein 2002). First, individual or personal gender is the dimension of gender which focuses on the way individuals acquire their personal construct of gender such as feminine and masculine—also referred to as an individual's gender identity. Second, structural gender hierarchically organizes and categorizes gender such that certain tasks or roles are seen as men's work and others are seen as women's work. Third, symbolic

or cultural gender captures the reality that the idealized constructions of what is masculine or feminine vary by culture and are not static. Thus, these three dimensions illustrate that gender is a very rich and complex concept that not only has individual meaning but also has societal expectations that can vary across cultures. The distinction between sex and gender can be difficult to make at times because the two are so closely interrelated. In many ways, the sex-gender argument is an argument of nature versus nurture and leaves us questioning whether individual attributes are innate and biological, or learned and social.

> Gender is a very rich and complex concept that not only has individual meaning but societal expectations that can vary across cultures.

Family and Household Family and household in feminism is defined differently than it is in most traditional theories. Family is viewed as a concept that maintains privilege in society. It is distinct from household in that the term household refers to "coresidential units," whereas family is defined by the philosophy of being related and explains who should reside together as well as share income and fulfill certain household duties. This idea of family has an underlying belief that certain household tasks are women's responsibility and women are favored to care for children because they possess an "inherent maternal ability."

Public and Private The public–private dichotomy separates men and women into different spheres where men are equated with the public sphere and women are with the private sphere of family. There is a great deal of history surrounding these two separate spheres and the inequality in the division of men and women's roles. In the USA, for example, during the preindustrial era, women's subordinate role in society was attributed to their reproduction abilities and the division of labor by sex and male dominance (Osmond and Thorne 1993). During early industrialization, the separate spheres were conceptualized as men's public work took them away from the family and into factories, while women mainly remained at home and focused on the private sphere. Over the decades, we have seen a greater shift in women's roles in the public sphere as younger generations of women have attained higher levels of education and entered the work force. In the late 1980s, sociologist Arlene Hochschild captured the reality of the lives of dual income couples in her work, *The Second Shift*. Through qualitative interviews that took place in the homes of her middle-class participating couples, Hochschild identified three distinct gender ideologies, based on the sphere with which the women of the house most identified. The first two gender ideologies are clear: *traditional*—in which the wife identifies her home as her sphere, and *egalitarian*—in which the wife identifies with her husband's sphere. The third ideology is *transitional*—a blending of the traditional and egalitarian ideologies. Hochschild speculated that the ideology that women most identify with determines the sphere they want to identify with (work or home) and the amount of power they want in their marriage (less, more, or equal amount). Her

work is often cited because she was one of the first social science researchers to highlight the reality that women's work in the public sphere does not necessarily eliminate their work in the private sphere; she brings to light the reality that continues to take on the majority of the responsibilities at home. More importantly, she captured the reality of the separate spheres as it pertains to most American families.

> The concept of sexism includes behaviors carried out by those who believe sex is indisputable (as it is genetically determined) and then employ detrimental attributions to all persons of that sex.

Sexism The concept of sexism includes behaviors carried out by those who believe sex is indisputable (as it is genetically determined), and then employ detrimental attributions to all persons of that sex. The term sexism captures a practice or behavior that is meant to be harmful or damaging to an individual based on their biological sex categorization (White and Klein 2002). For example, participation of women in the labor force as a characteristic of the social system has demonstrated that the rate by which females participate in the labor force increases with higher rates of economic development (Semyonov 1980). So we would expect that the USA would have greater levels of workforce opportunities for women than less developed countries. Although women have been "closing the gap" and making huge progress in the workplace, they continue to be paid less and are not given the opportunities that their male counterparts receive. We can only speculate that the differential treatment of women in the workforce is due to the stratification of women in our society. This stratification, or class, that women are placed in is primarily due to their biology and is therefore sexist.

Propositions

Theoretical propositions are formed from relationships among a theory's concepts. Connections between the aforementioned concepts are seen in the following six propositions as discussed by White and Klein (2002).

Gender Structures Our Experiences Some differences between men and women are biologically determined by sex. However, every culture elevates these differences through socially constructed ideas about gender differences.

> Each society uses gender as a basic distinction between classes.

Gender Structures All Societies For example, biologically both men and women contribute to creating a child with the difference that a mother becomes pregnant and has to deliver the child. However, all cultures have socially constructed gender differences between parenting traits with mothers being more nurturing and fathers

being more disciplinarians. This is how a small biological difference can be escalated into a lifelong gender difference.

Women as a Class Are Devalued and Oppressed Men are in a higher class than women, as women are viewed as being both physically and mentally inferior to men. These class differences perpetuate sexist societies and promote patriarchy.

> The family is a central institution for the reproduction of oppression.

As a Result of Sex, Gender Beliefs, and Historical and Continuing Sexism and Oppression, There Exists a "Female Culture" Harmony, pacification, cooperation, and nonviolence are elements of the female culture, which serve as an alternative to the dominant patriarchal world view. This proposition highlights how the social construction of gender, and gender class distinctions, over time has led to the creation of an alternative to a patriarchal society. The female culture is one in which there is cooperation and nonviolence. In other words, noncooperative violent societies are a result of the patriarchal values within that society. This is particularly important to note when discussing domestic violence later in this chapter.

The Family Is Not Monolithic Social functions (norms) have been assigned to the family as an organization that men and women believe they must follow, or else their family will fail and the detriment of society will follow. Proponents of feminism conduct research to change this monolithic view of family and promote diversity in family relative to norms such as family roles and labor and sexual preference.

> Feminists argue that the field of family therapy has by and large ignored gender issues in conceptualizing family life except to focus on women's roles as nurtures and caretakers.

The Family Is a Central Institution for the Reproduction of Oppression The family itself can serve as a central organization "responsible for the reproduction of oppression through socialization and social expectations" (p. 184). The family can both help and hinder women as they encounter social oppression.

Feminist Financial Therapy

In the late 1970s and early 1980s, several pioneering studies (Avis 1985; Gilligan 1982; Goldner 1985; Hare-Mustin 1978) faulted existing family therapy models for failing to pay sufficient attention to gender and power differences in male–female relationships, ignoring how gender and patterns influence internal family interactions and the social context of family life. We know power in families is usually gained in a variety of ways such as gender, age, earning power, respect, and/or

fear. Within a societal context, power is unequally distributed based on such factors as gender class, race, ethnicity, age, sexual orientation, profession, and degree of physical ability. In the late 1980s, critique of family therapy argued that family therapists, reflecting the ideology of the larger society, often reinforced traditional gender roles (Avis 1996).

Later work by Walters et al. (1989) called attention to the constraining experiences of women and helped develop a nonsexist set of therapeutic interventions that take gender considerations into account. For example, feminist clinicians discredit cybernetic concepts such as *circular causality* (a systems-based concept that designates a repetitive pattern of mutuality reinforcing behavior in a male–female relationship) because it implies that each participating partner has equal power and control in a transaction. In cases of physical abuse by men against women, they reject the cybernetic notion that both partners are engaging in a mutual causal pattern that results in the violent event (Goldner et al. 1990). This mutual causation then implies that no one is to blame for the violence, and therefore the victim is blamed for colluding in her victimization either by being a contributing participant or by remaining in the relationship.

Feminists argue that the field of family therapy has by and large ignored gender issues in conceptualizing family life, except to focus on women's roles as nurtures and caretakers. Thus, feminist therapy evolved with a purpose to promote the understanding of women's experiences within their societal context and to construct nonsexist theory of female development. Since feminist therapy initially focused on the needs of women and the root of feminism is femina (woman), the general population has viewed feminist therapy not applicable to male clients. However, we refer back to our aforementioned discussion on feminist theory; the concepts of gender and sex and the propositions that gender structures our experiences and all society, and the notion that there are expectations for both genders. Today, more than ever before, we believe males are facing greater pressures, not only by their families but also by society, to fulfill many roles both in the home and in the labor force. As a greater number of women who are wives and mothers enter the workforce and maintain careers, their male counterparts are called upon to share greater domestic responsibilities. Although women have continuously performed the greater amount of domestic labor, younger generations of men are doing more at home than ever before.

When we consider the application of feminist theory to financial therapy, we believe that perhaps the most important concept that must be adapted to the new field of financial therapy is a gender-sensitive perspective. Regardless of a client's cultural background, gender has been socially constructed for them and their identity, views, and beliefs have been impacted by their gendered experiences. In the next section of this chapter, we review the literature on gender roles and the division of household labor as well as financial dependence and what it means for women.

> With women's growing presence in the paid workforce, traditional marital trends are changing.

Applications of Feminist Financial Therapy

Gender Roles and the Division of Household Labor

Since 1970, the employment of women, especially mothers, has risen by well over 20% with current reports estimating that over 61% of married women are in the workforce (US Census Bureau 2011). While dual-earner couples make up the majority of adult households, there has been a shift in traditional gender roles when only one partner works. Of the 30% of nondual earning married couple households in the USA, 22% report a traditional male breadwinner and 7% report a female breadwinner (US Census Bureau 2011). Women tend to expect more egalitarian divisions of housework than their husbands (Frisco and Williams 2003).

Unfortunately, research suggests that women's increased paid labor force participation has not led to greater equality in shared household tasks (Fuwa and Cohen 2007; Lincoln 2008). Although husbands in unconventional marriages do more domestic work than their conventional counterparts, they still do not do more than their wives, nor does an unconventional wife's income give her more control over money or decision-making power in her marriage (Tichenor 1999). In fact, women continue to perform 2–3 times more of the household labor than their partners (Coltrane 2000) regardless of their family structure or employment status (Demo and Acock 1993).

Although there are currently only a small number of families in which a husband and wife share domestic work equally (Gershuny and Sullivan 2003), there has been a great increase in the nontraditional gender attitudes of younger generations of women over the past decades (Brewster and Padovic 2000). In fact, women's rising labor force participation and their increased access to earnings have both been linked to gender role attitudes (Brooks and Bolzendahl 2004). Researchers have specifically examined the influence of women's employment on the gendered nature of household tasks (Bittman et al. 2003). For example, gender role attitudes have been associated with the amount of time women spend in paid labor while no such association has been found for men's paid labor (Atkinson and Huston 1984).

Recent research has shown that household chore decisions are more related to traditional gender role attitudes (Askari et al. 2010; Kroska 2003). Young, unmarried women still perceive that they will engage in more household chores than their heterosexual partner despite both sexes having a preference for more egalitarian relationships (at least in terms of household chore division of labor; Askari et al. 2010). However, young married women have been found to report lower relationship satisfaction when they perceive their partner doing less housework while young married men's relationship satisfaction is not significantly affected by their partner's household task performance (Britt and Roy 2013). In fact, more recent research suggests that partners actively consider the division of household chores in the partner selection process (Askari et al. 2010). Career-oriented seek out family-oriented partners with the expectation of having to engage in fewer household chores (Orrange 2002).

The adoption of more nontraditional attitudes towards gender has different consequences for men and women in the family system. Women with more nontraditional gender attitudes are likely to have lower subsequent levels of marital satisfaction, whereas men with these nontraditional attitudes experience higher subsequent levels of marital satisfaction (Amato and Booth 1995). This is perhaps due to the fact that a man with more nontraditional gender attitudes is more likely to perform a larger portion of household chores than his counterparts who hold traditional gender attitudes and are thus in happier relationships. Women with nontraditional gender attitudes will most likely expect more assistance from their partner with household tasks; yet, these expectations may be violated leaving working women with a heavy load of domestic work to complete at home.

A feminist scholar would argue that the balance of household tasks and marital power are not income or status related but gender related.

From the literature, we understand that the gendered nature of household division of labor will perhaps always exist, even when women and men work the same amount of hours outside the home and bring in relatively equal pay. Interestingly, even when women have resources and/or status advantages (greater income, more prestigious careers), the majority still continue to take on the greater burden of household tasks and their husbands hold greater decision-making power (Tichenor 1999). A feminist scholar would argue that the balance of household tasks and marital power are not income or status related, but gender related. As such, women who take on traditional male roles are constantly defending their choices while men are praised when they contribute to the traditional female roles. In reality, everyone does it and in many ways, it is done on an unconscious level. For example, we praise a father who is out alone in the park with his children, but we do not think twice about seeing a mom there alone with her children. Professionals working with couples struggling with issues such as equity in the division of household labor should recall the realities of the private and public spheres as they are discussed in this chapter. Only time will tell if the younger generation of working professional couples can overcome these gendered inequalities.

Financial dependency is a key factor in why women stay in abusive relationships.

Financial Dependence

Financial dependence as a money disorder has been defined as "a feeling that money comes with strings attached, resentment, fear of being cut off from nonwork income, and an acknowledgment that their nonwork income stifles their motivation, passion,

creativity, and/or drive to succeed is associated with financial dependence disorder" (Klontz et al. 2012, p. 28). In our own professional experiences with women whose lives have been impacted by domestic violence, we know that financial dependency is a key factor in why women stay in abusive relationships. There is a general misconception that there is a particular "type of woman" who is susceptible to domestic violence and only she would be willing to stay in such a relationship. The reality of the situation is that any woman, regardless of her resources (income, career, family of origin) is susceptible to such a situation and financial dependency.

For example, Megan, a highly educated professional who brought home a substantial amount of income, married David who was equally educated and employed. Although David had never been physically violent towards Megan, he did on occasion say some hurtful things to her. The first time he used such language towards her, Megan thought he was joking because he had been so kind and charming towards her when their relationship first began—so she simply brushed his words aside and thought he must just be stressed. But their relationship dynamics changed after they had their first child and Megan started cutting back her hours at work. Though she had a brief maternity leave with pay, it was hard for her to go back full-time and as a couple they chose to have Megan work only 3 days a week. Unfortunately, during this same time, David's anger and frustrations escalated and he became physically abusive towards Megan. Again, Megan thought to herself he must just be stressed from the new baby and the fact that she was taking time off work. She thought maybe the burden of living primarily on his salary was getting to him.

A feminist scholar reading this would argue that patriarchy, a social organization involving the systematic subordination and control of women by men, causes partner violence because men internalize patriarchal norms. Thus, violence is about the systematic control and domination of women by men and we speculate that in this situation the client's husband has to show his superiority to his wife so that she understands he is in control. Although Megan and many other female victims of domestic violence believe that high levels of stress, or their behavior, has caused their partner to become violent feminist scholars would say this is a myth.

For Megan, leaving her husband David was never an option; she felt that breaking up her family would be the worst thing she could do for her child. Megan had a second child but things did not get better with David. Once the second child came along, Megan became even more dependent on her husband's income—if she did not want to be a single mother with one child she definitely did not want be one with two children. In our society, single-mother households are more likely to be in poverty than any other type of household and this has led to the term "feminization of poverty." Aware of her circumstances and what her children's lives would be like if she left their father, Megan chose to stay in her marriage until her children were in their teens. A decision she now regrets but at the time she did not feel like she had a choice.

> We continue to see inequalities in opportunity and pay for women, as traditional roles are now the unspoken expected norm.

When we look at the economic reality of gender differences in our society, we see that all women are left vulnerable to financial dependency for two reasons. First, due to their biology women's lives will always be impacted more greatly if and when they choose to have children. Meaning their employment can be impacted by motherhood more so than their partners (see discussion above on theories of labor force participation). Second, there continues to be a general gap in the earning of women compared to their male counterparts. Not only do the fields in which we see more women pay less, but women also make less when they are in the same position with the same level of education and experience as their male counterparts. These factors contribute to the causes of financial dependence among women and their potential susceptibility to remaining in situations where there is domestic violence.

In our society single mother households are more likely to be in poverty than any other type of household and this has led to the term "feminization of poverty."

Ethical Considerations

All theoretical perspectives have limitations and feminist theories are no exception. Therefore, when applying the feminist perspective to financial therapy, it is essential that we recognize its limitations. Perhaps the greatest limitation of this perspective is that its propositions cannot be empirically tested and therefore the theoretical framework is often viewed as an ideology rather than an empirical theory. A second limitation is based on the premise that violence against women is a societal norm, at least among men. This assumption is flawed when we consider that the vast majority of men find violence towards women unacceptable with only a minority of men perpetrating violence against women. This assumption also does not account for women's violence in same-sex relationships. We feel it is important that professionals working with families understand these limitations and use their best judgment when working with individuals and families.

Future Directions

The feminist perspective was meant to be more than a theory; it was meant to focus on social change that created a more equitable society. A society in which no social class category, such as gender or race, would be oppressed and where all individuals would have the same opportunities. While there are a vast variety of personal feminist perspectives, most recognize and understand that gender structures our society and our experiences. Although there are more unconventional gender roles in existence today with women in the workforce, and men contributing more to the division of household labor, things are not as equitable as they may seem on the surface.

Unfortunately, these unspoken expectations create inequalities that make women vulnerable and dependent. It is our hope that professionals in the field of financial therapy, regardless of their personal ideologies towards feminism, recognize and understand how gender shapes the experiences of women and men in our society.

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Chapter 16
Acceptance and Commitment Financial Therapy for Women

Joni Klontz Wada and Bradley T. Klontz

Introduction

Money issues are often neglected in the field of psychology, despite the fact that since 2007, the American Psychological Association's annual *Stress in America*™ survey has found money to be the number one source of stress in the lives of three out of four Americans (American Psychological Association 2012). Money is associated with every level of Maslow's hierarchy of needs, from physiological and security needs (e.g., food, shelter, health insurance, living in a safe environment) to social, esteem, and self-actualizing needs (e.g., belonging, social recognition, fulfilling one's potential; Poduska 1992). Although it seems evident that money plays an important role in one's life, many women still have a negative view of money (Newcomb and Rabow 1999). In a study by Newcomb and Rabow (1999), women not only had a negative outlook on their future financial earnings but they also viewed individuals who place a high value on money as being immoral. Negative views about money are associated with negative financial outcomes. For example, money avoidance beliefs have been associated with lower net worth and lower income (Klontz et al. 2011) and are significant predictors of disordered money behaviors including compulsive buying, compulsive hoarding, workaholism, financial denial, financial dependence, and financial enabling (Klontz and Britt 2012).

Money is associated with every level of Maslow's hierarchy of needs, from physiological and security needs (e.g., food, shelter, health insurance, living in a safe environment) to social, esteem, and self-actualizing needs (e.g., belonging, social recognition, fulfilling one's potential) (Poduska 1992).

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Research suggests that families have been moving away from traditional gender roles and more than half of the work force is comprised of women (Anthes and Most 2000). However, many women remain unprepared for their financial futures when faced with divorce, widowhood, or old age (Anthes and Most 2000). Research on the socialization of women around money reveals that women have limiting beliefs about money that prevent them from getting their needs met and living a life in line with their values. This chapter explores the socialization of women around money and offers financial therapy exercises to help women foster a healthy relationship with money, using strategies based on acceptance and commitment therapy (ACT) including mindfulness, acceptance, and a commitment to value-based financial goals.

Women and Money

In helping women transform their relationship with money, it is important to take a close look at their values and how their values are related to their financial behaviors. Research has shown that taking care of family members is often a very strong value for women (Orel et al. 2007). Women spend a great deal of their lives in the caregiver role and it is suggested that this is often not only expected of women but also in line with their values (Orel et al. 2007). Women comprise approximately 75 % of all family caregivers (Atchley and Barusch 2004). However, women often do not adequately consider the role money plays in providing for and keeping family members safe and secure.

Women spend a great deal of their lives in the caregiver role and it is suggested that this is often not only expected of women, but also in line with their values (Orel et al. 2007).

When lost wages, pensions, social security, and retirement benefits are taken into account, it is estimated that women who leave the workforce early to take on a caregiver role experience a net loss of approximately US$ 325,000 (Metlife Mature Market Group and National Alliance for Caregiving 2010). Research has suggested that women avoid thinking about what would happen if they were in a situation where they needed to take on multiple caregiver roles and/or be financially independent (Berger and Denton 2004). This may be because women often believe the financial messages of their childhood, indicating that money should be a man's concern, as opposed to making decisions based on what they are currently witnessing or experiencing with regard to the need for their own financial planning. Most women have either personally experienced or witnessed a friend or relative struggle financially after a divorce, attempt to raise a child as a single parent, or unexpectedly need to take care of a grandchild or elderly parent. Thus, it is hypothesized that

when women start noticing the important role that money plays in relation to their caregiver role, and the potential benefits of achieving a sense of financial security and freedom to make meaningful life choices, there may be a natural desire for women to change their financial behaviors to be better aligned with their values.

Despite the growing number of women in the workforce, poverty is still primarily a woman's issue (Anthes and Most 2000), which is even more pronounced in the lives of minority women (Ezeala-Harrison 2010). More than half of the occupations that women typically enter will not support a family at an income level above the poverty line, and in general, single women do not typically fare well financially (Into 2003). It has been argued that fiscal policy is an important factor underlying the gender poverty gap (Pressman 2002) as well as differences in labor force participation, different jobs, and the need for government support, which are not always met (Pressman 2003). Although a large percentage of young women are married and may defer financial responsibilities to their husbands, it has been estimated that half of marriages will end in divorce (Copen et al. 2012) and the average age of widowhood is 56 (Headley 2002).

A comprehensive review of the literature exploring women and money in the areas of gender socialization, parental influence, self-efficacy, math skills, financial self-confidence, gender differences in earning potential, childrearing and financial stability, financial beliefs, power in relationships, poverty in female-headed households, and financial security for older women has been explored elsewhere (Wada 2009), and is outside the scope of this chapter. This review of the literature provides clear and compelling evidence that women are at greater financial risk than men and there is a significant need for women to prepare adequately for their financial futures and foster a more egalitarian role within their marriages to protect themselves and their children from financial destitution (Anthes and Most 2000). As women age, they become even more financially vulnerable, representing 75 % of the elderly poor (Lightly 1999). Given their financial vulnerability, there is a strong need for financial interventions for women, not only focused on how to manage money but also on how to deal with limiting thoughts and negative emotions associated with financial matters.

> …there is a significant need for women to prepare adequately for their financial futures and foster a more egalitarian role within their marriages to protect themselves and their children from financial destitution (Anthes and Most 2000).

Acceptance and Commitment Therapy

ACT was chosen as a theoretical foundation to create financial therapy exercises to help women move towards financial behaviors that are congruent with their values, despite possible limiting beliefs and emotions. ACT is part of a "third wave" of

behavioral interventions, which include dialectical behavior therapy (DBT; Linehan 1993) and mindfulness-based cognitive therapy (MBCT; Segal et al. 2002).

…interventions based on ACT could help women gain awareness and acceptance of their limiting financial beliefs and emotions and help women detach from these thoughts and feelings to move towards their value-based financial goals.

The difference between this third wave and the second wave of behavioral therapy, which included cognitive behavioral therapy (CBT) and rational-emotive behavioral therapy (REBT), is that the third wave of behavioral therapies avoids challenging, disputing, or trying to eliminate dysfunctional or maladaptive thoughts (Ciarrochi et al. 2005). According to Hayes (2007), "the research evidence confirms the paradoxical proposition that trying to change your unpleasant thoughts and feelings typically just makes them more entrenched" (p. 49). This is consistent with research on motivational interviewing, which shows that confrontation increases resistance and decreases the likelihood that change will occur (Miller and Rollnick 2002). Instead, ACT focuses on increasing acceptance of internal and external experiences, decreasing experiential avoidance, increasing behavioral flexibility, and helping individuals act in accordance with their values (Hayes et al. 1999). It is hypothesized that financial therapy interventions based on ACT could help women gain awareness and acceptance of their limiting financial beliefs and emotions and help women detach from these thoughts and feelings to move towards their value-based financial goals.

ACT offers a useful theoretical foundation given the research that suggests women's beliefs about money and their financial abilities often lead to feelings of anxiety, depression, and hopelessness (Anthes and Most 2000). It can also be concluded that the social problems that lead to what has been called the feminization of poverty (Goldberg and Kremen 1990) are associated with misguided beliefs about what women need to do to be financially secure and the desire of women to avoid uncomfortable thoughts and emotions about money. Faulty messages from society and caregivers in concert with attempts to avoid thoughts of financial inadequacy may keep women from taking steps to secure their financial future, including embracing the role of provider and/or learning the fundamentals of saving and investing. ACT is based on the premise that such problems arise for individuals when they operate from rigid and inflexible beliefs and rules, and avoid experiences, in the attempt to escape unpleasant thoughts and feelings.

Financial therapy interventions based on the ACT model address women's lack of financial preparedness through encouraging a new sense of willingness to accept limiting financial beliefs and associated uncomfortable emotions, and help women commit to behaving in ways that move them towards their valued financial goals by helping them clarify their personal values. The purpose of these exercises is to teach women skills, such as mindfulness, acceptance, and detachment from thoughts, to

empower them to make financial choices based on their own values and experiences rather than based on the financial beliefs that they learned from others.

General Description of ACT

ACT is based on the theory of functional contextualism and relational frame theory (RFT). RFT has a large research base and describes the nature of human language and cognition (Hayes et al. 2001). A major tenet of RFT is that cognitions—defined as thoughts, feelings, body sensations, and memories that have been verbally labeled—are powerful, not because of their form or frequency, but because of the context in which they occur. Research on RFT has suggested that verbal constructions are often so powerful that individuals tend to trust them over their actual experiences, even if their experiences are contradictory (Ciarrochi et al. 2005). Therefore, the contexts in RFT where one experiences problems are thoughts, feelings, and behaviors that "need to be controlled, explained, believed, or disbelieved, rather than being experienced" (Hayes et al. 2004, p. 38).

Most psychopathology is seen from the ACT perspective as: (a) an unhelpful way of controlling thoughts, emotions, and memories; (b) a way of perceiving the world through cognitively based functions instead of functions based on actual experience; and (c) the result of unclear core values and a lack of ability to act in ways that are congruent with one's values (Hayes et al. 2004). In ACT, a lack of behavioral effectiveness and flexibility is thought to be the cause of psychological distress.

A lack of behavioral effectiveness and flexibility is thought to be the cause of psychological distress.

Negative or dysfunctional thoughts and feelings are viewed differently in ACT than in many other forms of therapy. ACT perceives negative thoughts or emotions as harmless in and of themselves. Thoughts and emotions are only viewed as potentially damaging when individuals employ various strategies to avoid them (Hayes et al. 1999). The behaviors that people use to avoid or attenuate undesirable thoughts and feelings include substance abuse and other self-harming behaviors (Hayes et al. 1999) as well as the basic act of avoiding people, places, or things that elicit negative emotions (Blackledge and Hayes 2001).

ACT is often conceptualized as an acronym delineating the stages of therapy: **A**ccept, **C**hoose, and **T**ake action (Hayes et al. 1999). The goal of ACT is to help clients move from attempting to get rid of unpleasant emotions to fully experiencing and accepting these emotions, while moving towards their personally valued goals (Blackledge and Hayes 2001). Research has found ACT to be effective with individuals with a variety of mental health problems, including polysubstance abuse, major depression, anxiety disorders, psychosis, and eating disorders, as well

as other problems in living such as fear of public speaking, chronic pain, and work-site stress (Hayes et al. 1999).

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Money avoidance and the denial of one's financial reality have been associated with poor financial outcomes and destructive financial behaviors (Klontz and Britt 2012). To avoid the tendency for experiential avoidance in response to unhelpful thoughts and unpleasant emotions, ACT utilizes a variety of techniques. Common techniques of ACT that can be useful in financial therapy include: (a) acceptance, (b) cognitive defusion, (c) being present, (d) self-as-context, and (e) expression of values. A brief description of how these concepts are and how they relate to financial therapy is presented below.

Acceptance Klontz and Klontz (2009) identified shame as being a significant impediment to changing financial behaviors. Financial therapy using ACT focuses on helping individuals embrace their unwanted thoughts and feelings about money, including shame, guilt, anxiety, and anger, instead of trying to avoid them. The goal of "acceptance" is for individuals to end their struggle with unwanted thoughts and feelings without needing to challenge, change, or eliminate them (Hoffman and Asmundson 2008).

Cognitive Diffusion Cognitive diffusion is an ACT strategy used to help individuals realize that their attempts to change their unwanted thoughts and emotions are part of the problem, not the solution. Clients are encouraged to give up their need to control their thoughts and feelings and to end the ongoing struggle with their evaluative and critical mind.

Being Present In financial therapy with ACT, clients are encouraged to directly experience events as they occur from a nonjudgmental stance. Being present helps clients detach from their cognitive rules and beliefs and allows for increased psychological flexibility (Hoffman and Asmundson 2008). In their study on the treatment of money disorders, Klontz et al. (2008) identified mindfulness exercises aimed at encouraging a nonjudgmental acceptance of one's thoughts and feelings and focus on present body awareness as an important component of their treatment model.

Self-as-context In financial therapy with ACT, clients are encouraged to develop a different perspective from which to view their relationship with money through mindfulness, metaphors, and experiential exercises. This perspective helps them realize that they may not be able to control internal events (e.g., thoughts and feelings); however, there are ways they can learn to perceive their internal experiences in a more helpful manner (Hayes et al. 1999).

Expression of Values In financial therapy with ACT, clients are encouraged to explore their chosen financial and life directions in various domains and markers, or goals, along their journey. Additionally, they are encouraged to look at the ways that choices based on experiential avoidance block the path towards these valued directions (Hayes et al. 1999).

Acceptance and Commitment Financial Therapy Exercises

Women are often caught unprepared when they are forced to take responsibility of their financial lives. As a result, they often experience dire emotional and financial consequences. Whether this occurs while single, in a relationship, after a divorce or separation, or in widowhood, many women find themselves lacking the financial knowledge and self-confidence to take the steps needed to achieve financial health in service of their values and goals. The following exercises are based on research that suggests that women's beliefs, thoughts, and feelings are related to their lack of preparedness for their financial futures, which leads to negative psychological and financial consequences. As mentioned above, ACT operates on the premise that problems arise when individuals operate from rigid and inflexible beliefs and avoid experiences to avoid unpleasant thoughts and feelings (Hayes et al. 1999). Overall, the goal of ACT is for people to defuse from their thoughts, fully experience their emotions, and move towards living in accordance with one's values.

> The ACT principles of acceptance and willingness are introduced to help women to learn to identify and accept their own difficulties with money and encourage their willingness to move forward despite the circumstances.

The following financial therapy exercises are based on six foundational themes of ACT. They were designed to help women overcome psychological barriers to financial health through: (a) fully accept limiting thoughts and negative feelings about money, (b) identifying values, (c) evaluating the important role that money plays in goal attainment, and (d) preparing to take positive behavioral steps towards improving financial and psychological functioning. Some of these exercises are specifically designed for use in small groups while others can be used in either individual or group therapy settings. Process questions are provided at the end of the exercises. These questions are designed to help focus, anchor, deepen, and reinforce client insights and learnings, and can be of particular benefit in small group settings where clients can benefit from the experiences of other group members.

Theme 1: Acceptance and Willingness

The ACT principles of *acceptance* and *willingness* are introduced to help women identify and accept their own difficulties with money and encourage their willingness to move forward despite the circumstances. The goal of *acceptance* is for individuals to end their struggle with unwanted thoughts and feelings without needing to challenge, change, or eliminate them (Hoffman and Asmundson 2008). *Willingness* is about making the choice to experience one's thoughts, beliefs, emotions, and sensations, instead of fighting against them. It is not about liking these experiences, but it involves letting go of the resistance, the opposite of control or avoidance. If thoughts, feelings, sensations, or experiences are no longer considered the enemy, one can give up the struggle, and release new energy for being compassionate with oneself and for changing the things that can be changed (Forsyth and Eifert 2008).

Financial Tug-of-war This exercise can be done in individual therapy or with a small group to help illustrate the ACT concepts of acceptance and willingness in one's relationship with money. In the case of a therapy group, the therapist breaks the group into two teams. In individual therapy, the therapist will act as the opponent to the client. Have tape marked on the floor signifying where each team or individual would need to cross to win. Each person or team will wear a nametag, indicating an aspect of the internal struggle between fear and the judgment of fear regarding money. One side wears tags with common fear-based financial beliefs identified earlier in the session (e.g., "you will be a bag lady," "girls don't know how to handle money," "if you focus on money you will not have love"). The other side will wear tags with some of the judgments that come up when uncomfortable thoughts or feelings arise (e.g., "you shouldn't feel that way," "if you feel that way you should do something about it," "stop thinking that way, it's stupid"). Then, the opponents engage in a game of tug-of-war. Just before one side wins, stop the exercise and instruct all participants to drop their side of the rope.

The following questions could be asked after the exercise to help participants process what they learned during the activity. What happened after you dropped the rope? What was the difference between your experience before and after you dropped the rope? Which part of the exercise illustrated willingness? What do you think "dropping the rope" in your own life would look like? What is the pay-off for staying in the struggle? What are the benefits of dropping the rope? How does this relate to your relationship with money?

The Financial Swamp The purpose of this exercise is to distinguish "willing" from "wallowing" by using an experiential metaphor of moving through a swamp. The swamp represents an unavoidable barrier standing in between us and where we want to go. The goal of the exercise is to help clients understand that acceptance and willingness does not mean liking or condoning, it means accepting what we must go through in order to get to our goal and being willing to have the experiences to get there.

Give the client (or each client in the case of a group) six nametags and have them write three financial goals (e.g., to be financially independent, to be able to retire)

and three barriers to their financial goals (e.g., fear, lack of education). If working with a group, break group members into three groups. Group A will represent the swamp (wearing all of the nametags with barriers) and Group B will represent the goal (wearing the nametags with financial goals). Group C will have the task of crawling through the swamp to get to their goal. As the group members try to pass to the other side, Group A (also on their knees) will try to hold them back. Group B will encourage Group C to get to their goal. In individual therapy, goal tags can be taped to an opposing wall and barrier tags can be taped to the therapist who tries to impede the client's progress in some fashion.

The activity should end with a discussion of the following questions: Why would you decide to enter this swamp? Why would you not want to enter the swamp? How is acceptance illustrated through this exercise? How is willingness illustrated through this exercise? How does this relate to your relationship with money?

Financial Behaviors and Beliefs of Women This exercise encourages acceptance of the financial reality of women. It entails a review and discussion of demographic trends around women and money. The therapist facilitates discussion in either individual or group settings around the financial challenges facing women, their causes, their cures, and their impact on the financial health and psychological well-being of women and their dependents.

- 50% of marriages end in divorce (Copen et al. 2012).
- The median age of widowhood for women in the USA is 59–60 years old (United States Census Bureau 2011).
- The percentage of older women living alone (37%) is almost twice that as the percentage of older men living alone (19%; Association for Community Living 2014).
- With the rate of divorce and the early age of widowhood, women have approximately an 85% chance of living without a husband later in life (Perkins 1995).
- Despite the odds, research shows that most women are still caught off guard and unprepared when there is a divorce or their husband dies, and as a result suffer financially (Headley 2002).
- According the Association for Community Living (2014), households headed by men over 65 have a median income of US$ 27,707 and when a woman of 65 is the head of the household their median income is US$ 15,362.
- 72% of all the poor over 65 are women (Richardson 1990).

Theme 2: Cognitive Detachment

The purpose of these exercises is to explore the origins of women's beliefs about money and to introduce cognitive detachment as a tool to change one's relationship with recurrent thoughts and associated unwanted emotions. It is helpful for women to identify the beliefs and emotions that have been a source of suffering in the past and the ways that they are accustomed to dealing with them. Cognitive detachment

offers an alternative way to deal with one's thoughts and beliefs. Cognitive detachment is an ACT strategy used to help individuals realize that their attempts to change their unwanted thoughts and emotions are a part of the problem, not the solution. Clients are encouraged to give up their need to control their thoughts and feelings and to end the ongoing struggle with their evaluative and critical mind. It is pointed out that clients can act in accordance with their values and goals with the unwanted thoughts and feelings, metaphorically taking these thoughts and feelings "along for the ride" (Hoffman and Asmundson 2008). The concept of cognitive detachment is demonstrated through the experiential exercises.

Women's Beliefs and Values Around Money This exercise is intended to help women identify the origins of women's money beliefs. The therapist reviews with the client or clients the following statements about women and money, based on the findings of Newcomb and Rabow (1999). The therapist facilitates discussion around the source and content of women's limiting and destructive financial beliefs. This discussion could include process questions, such as: (a) What did your mother teach you about money? (b) What did your father teach you about money? (c) If you had a brother, did they teach him something different? (d) How did their messages to you about money shape your own money scripts? (e) How have these beliefs impacted your relationship with money? (f) What messages do you wish your parents would have given you around money?

- One of the sources of women's limiting financial beliefs and self-efficacy as an adult is their parents' influence.
- Parents often communicate their beliefs about their children's financial responsibilities through their expectations of their child's contribution to the family.
- Parents communicate dramatically different expectations about money for their male and female children.
- Sons are expected to know how to work and save and to understand the family finances at an earlier age than daughters.
- Male children are expected to work more than female children and are offered less financial support.
- Women more than men have conflicting feelings about money that are mostly negative and often fear that making more money than their parents would make them feel guilty.

Titchener's Milk Exercise and Carry Cards This exercise helps clients break through the illusion of language and realize that words are just sounds and sensations and have no literal meaning behind them. It can be used in individual therapy or group therapy. The goals of this exercise include: (a) being able to carry limiting thoughts and still move forward towards one's goals, (b) realizing that thoughts are just words that come and go and do not have to impact behavior, and (c) giving clients tools to notice the thoughts without getting "attached" to the meaning.

Give clients a small notecard and have them write down two or three limiting thoughts associated with money that they learned while growing up. For example, money scripts such as "women shouldn't have to worry about money," "financial concepts are too difficult to understand," or "I will never have enough money" may

emerge. Have clients share the thoughts while the therapist records them (e.g., on a whiteboard). The therapist will use the statements to come up with one word that is similar to the examples of statements given (e.g., helpless, dependent, inept) and clients say the same statement as loud and fast as they can for 45 s. Ask clients if they might be able to carry their cards with their limiting beliefs with them and still behave in ways that are different from what the cards say.

The therapist should then ask the participants the following questions. What was your experience in this exercise? What happened to the meaning of the word? How did the meaning of the word change from the first time you said it and the last time you said it? How might this exercise illustrate the concept of detachment? What does this have to do with your relationship with money?

Cognitive Detachment This exercise is designed to give clients the experience of cognitive detachment, and is appropriate for individual and group therapy settings. Review with clients the following list of techniques (adapted from Hayes and Smith 2005) to allow them to detach from thoughts and feelings. Help clients choose their favorite or design their own unique technique.

- **If It Had A Color.** Identify a painful experience around money and answer the following questions: If it had a color, what color would it be? If it had a size, how big would it be? If it had a shape, what shape would it be?
- **Say it Very Slowly.** Say your limiting financial beliefs or name your painful feelings very slowly.
- **Create a Song.** Make a song out of your difficult financial beliefs or adapt the lyrics to a popular song and make it your own.
- **Pop-up Mind.** Imagine that your limiting financial beliefs are like pop-up balloons floating over your head.
- **Thoughts are Not Causes.** If beliefs seem to be controlling your behaviors, consider, "would it be possible to have this belief and still do…?" Try deliberately thinking the thought while doing the behavior that the thought is saying you can't.

Theme 3: Self and Context and Women, Money, and Relationships

The exercises in Theme 3 are designed to explore the dynamics of money in relationships and to help women view their thoughts and feelings from a different perspective. The concept of self-as-context is demonstrated through experiential and didactic exercises. Self-as-context encourages clients to develop a different perspective from which to view life through mindfulness, metaphors, and experiential exercises. This perspective helps clients realize that they may not be able to control internal events, such as their thoughts and feelings; however, they can learn to perceive their internal experiences in a more helpful manner (Hayes et al. 1999).

Women, Money, and Relationships This is a consciousness-raising exercise designed to shed light on the dynamics of money and relationships for women.

The therapist reviews the following research findings about women, money, and relationships and discusses with the client/s the reasons for these realities and their implications for women's financial health:

- Women have less confidence in their financial abilities than men (Regnier and Gengler 2006).
- 47 % of women (vs. 30 % of men) perceived themselves as not being knowledgeable about investing (Regnier and Gengler 2006).
- In a survey of 1000 spouses (500 spouses and 500 wives) conducted for Money magazine, it was found that 66 % of men believe that they take bigger risks in investing whereas only 31 % of women believe that they take the bigger risk (Regnier and Gengler 2006).
- With regard to financial responsibility, men claim to be more responsible than women for investment decisions (73 % vs. 22 %), retirement planning (66 % vs. 25 %), and buying insurance (60 % vs. 34 %), whereas women are more responsible than men in areas of daily money maintenance such as paying bills (women—57 %, men—42 %), budgeting (59 % vs. 33 %), and day-to-day spending (64 % vs. 22 %; Regnier and Gengler 2006).
- Although money maintenance is helpful on a day-to-day basis, it is not as helpful at promoting a sense of long-term financial security, especially in old age.
- Women often abdicate long-term financial decisions to men (e.g., investing, retirement planning) due to their fear of risk taking.
- By taking the responsibility for more menial financial tasks (e.g., balancing the checkbook), women may overlook the more important aspects of financial planning.

The Chessboard Metaphor This exercise demonstrates a different way of looking at one's problems and limiting thoughts. Its purpose is to help clients practice self-as-context by helping them to see themselves as being the holder of the thoughts and emotions, but not necessarily being part of the struggle. This exercise can be done in individual or group therapy settings.

Group A chooses positive emotions or statements about money (e.g., financial independence, happiness, confidence, wealth, "I can achieve anything I put my mind to") written on nametags from a bag titled "Positive." Group B chooses negative emotions or statements about money (e.g., debt, poor, fear, depression, "I am going to be a bag lady") written on nametags from a bag titled "Negative." Group participants put on the nametags and Group A goes to one side of a set up chessboard while Group B goes to the other side. Participants are instructed that they will work as a team to try and beat the opposing team. As a team, they will decide which participant will be a type of piece (e.g., all pawns, all knights, the queen, the king). Using a group effort, Group A and Group B will then compete for a specific amount of time (e.g., 15 min). In individual therapy, the tags could be put directly on the game pieces, and the therapist could act as the client's opponent. The therapist will narrate the game (e.g., "Anxiety made a great move", "I can achieve anything took out depression").

The following is a list of suggested process questions: (a) In the entire chess game, which part of the game would you like to be and why? For example, would you like to be "happiness" because that is your most important value?

(b) Would you like to be the chess player—because he has all the control? (c) Would you like to be all the positive words? (d) If you were to be the chessboard, what would be the benefits of that role (e.g., you would hold all the pieces, you would be able to watch the battle without being a part of it, you would have a greater sense of calm or peace). (e) What was it like identifying yourself as "positive" or "negative"? (f) How might this exercise demonstrate self-as-context? (g) How does this exercise relate to your relationship with money?

Theme 4: Being Present and Women, Earnings, Children, and Financial Hardship

The purpose of these exercises is to explore more difficult topics for women including the inequity in pay between men and women, how childrearing impacts women's financial independence, and financial hardship in general. The introduction of mindfulness is particularly useful in learning how to deal with painful thoughts and feelings. The concept of mindfulness is demonstrated through the experiential exercises and homework. With the ACT concept *being present,* clients are encouraged to directly experience events as they occur from a nonjudgmental stance. Being present helps clients detach from their cognitive rules and beliefs and allows for increased psychological flexibility (Hoffman and Asmundson 2008).

Guided Meditation: Awareness. (Adapted from Hayes and Smith 2005)

The following is a guided meditation that can be read by the financial therapist to clients in group or individual settings: "Find a comfortable position. Close your eyes, relax, and take a few deep breaths. Now, slowly bring your awareness to your fingers. Notice the tips of your fingers. Rub your fingertips together. What do they feel like? Are they silky and smooth or are they rough? Now bring your attention to your hands and arms. What do they feel like? Do they feel relaxed? Do they feel heavy? Either way it is okay. There is no need to judge, just notice. Are there any aches or pains? If there are, simply notice the pain or discomfort and move on. Now bring your attention to your toes. Wiggle them around. Are they in socks or are they bare? How do they feel? Do they feel warm or cool? Notice the sensations as you bring your awareness to your feet. Now, bring your awareness to your face. Think about your forehead. How does it feel? Is it smooth or is it wrinkled? Now, bring awareness to your nose. Breathe the air in and out. Is it easy to breathe? Does your nose feel stuffed or clear? Pay attention to the feeling of the air coming in and out of your nose. Now, bring your attention to your chest and belly. Notice how your chest rises when you breathe. Are you breathing slowly or are you breathing fast? How does it feel? Notice your belly. How does it feel? Is it full? Is it making any sounds? Now, I want you to shift gears and picture a beautiful stream. There is green grass surrounding the stream. A number of leaves are floating down the stream. Think

about some of your money beliefs and as they come up, put each thought on a leaf and watch it float down the river. As other thoughts, feelings, or body sensations come up, notice them, do not judge them, and put each thought or feeling on a leaf and watch it float down the river. Do not judge, just watch the leaves peacefully drift on the top of the water. When you are ready open your eyes."

Present Moment: Leaves on a Stream Exercise This exercise is designed to help clients practice mindfulness with difficult thoughts and emotions. Have clients identify their common thoughts and beliefs about money prior to doing the exercise (use flip chart). Then have them sit in a comfortable position. Begin by starting with the awareness exercise (above). Following the awareness exercise, have clients think about a stream with leaves floating down the river. After they can picture this scene, have them use the thoughts about money that they identified before the exercise, and as they come up, mentally place each thought on a leaf and watch it float down the river. As other thoughts, feelings, or body sensations come up, instruct clients to notice them, do not judge them, and put each thought or body sensation on another leaf and watch it float down the river. Do this for about 10 min.

Post-activity process questions include the following. What was this exercise like for you? What types of thoughts or feelings did you notice? Were you able to do the exercise without judgment? How could you use mindfulness when dealing with financial stress or limiting thoughts? As a homework exercise, encourage participants to practice mindfulness when spending time with children or other family members, in nature, eating, while paying bills, or at work. Encourage them to notice how their experience changes when they are completely present in the moment.

Theme 5: Values and Older Women and Money

The purpose of these exercises is to explore women's values and how they are related to financial security. The topic of older women will be explored as older women often have messages of regret or remorse about their past financial decisions. The concept of *values* will be demonstrated through experiential exercises and homework. With the ACT concept of *values*, clients are encouraged to explore their chosen life directions in various domains and markers, or goals, along their journey. Additionally, they are encouraged to look at the ways that choices based on experiential avoidance block the path towards these valued directions (Hayes et al. 1999).

Exercise: Visiting Your Own Funeral This exercise helps clients clarify their values and determine how financial security is a critical part of most of their important values (including relationships and caretaking). Have clients close their eyes and say: "Imagine that you are at your own funeral listening to what other people in your life are saying about you. What were some of the things you would want to hear in your eulogy? What would you want to hear from your partner? Your children? Your boss? Your co-workers? Your friends? Your community? From people in your spiritual community? What would you like them to be saying? How do you want to be remembered in terms of your relationship with money? What would your daughter

say about what you taught her about women and money? Based on what you heard what would be some of your top values? How would financial stability be associated with each of these values?"

After the exercise, ask the following questions. How is financial stability related to your values? What are the areas where financial stability is most important? What are the areas where it is least important? What was your reaction to this exercise? What financial goals would be in line with the values you identified today?

Theme 6: Committed Action and the Changing Role of Women and Finances

The purpose of this exercise is to explore the importance of *committed action* in changing women's financial futures. It is important for women to learn how to accept their limiting thoughts and uncomfortable feelings and to still take action in line with their own values. The ACT concept of *committed action* is demonstrated through an experiential exercise. *Committed action* is the ability to accept the discomfort of the mind and at the same time commit to one's own values. The promise with committed action is not that one's life will become easier, but that one will feel more alive (Hayes et al. 1999).

Climbing a Mountain The purpose of this exercise, which can be used in either individual or group settings, is to help clients prepare for their financial futures by identifying small goals and ways to commit to the goals. Have clients draw a simple picture of a mountain on a piece of paper. Then, have clients answer the following questions. How would you feel if you had to climb this mountain? What would some of your thoughts be? Next, ask clients to draw a series of steps from the base of the mountain to the peak. Then have clients answer the following questions. How would you feel if you had to climb this mountain? What would some of your thoughts be? What makes this one different? What "steps" do you need to help you reach your financial goals? Afterwards, have clients identify five small financial goals in the direction of your value.

Finally, discuss responses by utilizing the following questions. How do your thoughts and feelings change when you broke a big goal into smaller goals? What are some small goals that you could take in the area of finances? What are some of the thoughts and feelings that might come up for you when moving towards your financial goals? How will you deal with these thoughts and feelings when they come up?

Ethical Considerations

ACT is based on multiple behavioral and psychological frameworks, including DBT, CBT, and REBT. Financial planners are not typically trained in these approaches. However, many aspects of Acceptance and Commitment Financial

Therapy theory and technique do not require mental health training to be used with clients in an advisory or coaching context to improve financial health. When used in the treatment of mental disorders and money disorders such as hoarding disorder, compulsive buying disorder, or gambling disorder, practitioners would need to be qualified mental health practitioners. Financial therapists who wish to utilize the ACT model of financial therapy could educate themselves on the basic assumptions of the model and be ready to refer clients to the appropriate mental health or financial professional should their expertise be limited in the area needing client attention. Confidentiality in group settings is also an important ethical consideration. When working with groups, efforts should be made to establish guidelines around confidentiality, require client agreement to maintain the confidentiality of other group members at the onset of therapy, and discuss the possible risks associated with breaches in confidentiality by other group members and how such concerns will be addressed.

Future Directions

Readers who are interested in a more comprehensive literature review around women and money, theoretical underpinnings and techniques of ACT, and additional Acceptance and Commitment Financial Therapy exercises for women should refer to the work of Wada (2009). The theory and techniques presented herein can be used by financial planners and financial therapists alike in service of improving the financial health of clients. However, if they are going to be used in the treatment of individuals with money disorders, they should only be used by a financial therapist who is a trained and credentialed mental health professional.

It would be helpful to have more research on the most common financial beliefs for women and the types of emotional and behavioral consequences that are often associated with these financial beliefs. As mentioned previously, research has found ACT to be effective in the treatment of a variety of problems, including substance abuse, depression, anxiety, psychosis, eating disorders, fear of public speaking, chronic pain, and work-related stress (Hayes et al. 1999). While the above financial therapy exercises have been adapted from evidence-based ACT therapy techniques, it would be beneficial to have research on the effectiveness of these exercises to determine their value in helping women improve their financial health, make progress on meeting their financial goals, and reduce the frequency and intensity of unpleasant emotions around their finances.

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Chapter 17
Psychodynamic Financial Therapy

Richard Trachtman

Introduction

The Merriam-Webster online dictionary defines *psychodynamics* as "(a) the psychology of mental or emotional forces or processes developing especially in early childhood and their effects on behavior and mental states, (b) explanation or interpretation (as of behavior or mental states) in terms of mental or emotional forces or processes, or (c) motivational forces acting especially at the unconscious level" (Merriam-Webster 2014, p. 1). When applied to psychotherapy, psychodynamics generally refers to theories of development and personality that have evolved from the psychoanalytic findings of Sigmund Freud and his followers. The treatment methods Freud devised, known as classical psychoanalysis, have largely been modified and are referred to today as psychoanalytically oriented psychotherapy. Today's psychodynamic or psychoanalytic psychotherapy is not Freud's psychoanalysis, and any one psychoanalytically oriented therapist's method is often not the same as another's. Still, whatever else these therapists believe in, it does include: (a) unconscious motivation—what is known as the pleasure principle, (b) those mental structures known as id, ego, and superego, and (c) conflict among those structures. What follows has been taken from the teaching, not only of Freud but also of his many and varied professional descendants, especially this author's own teachers, and filtered or distorted through this author's own experience, perspectives, and proclivities.

Since just about everyone past infancy or toddlerhood in modern society has some dealings with money, if not credit, financial management is bound to become a necessary skill at some point in life. This chapter approaches financial management from a psychodynamic perspective. This chapter will refer to some common concepts from psychoanalysis (i.e., id, ego, and superego) as well as other concepts central to psychodynamic thinking, such as (a) repetition compulsion, (b) working through, (c) identification, (d) identity, (e) object relations, (f) transference, and (g)

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countertransference. One sociological concept will also be introduced—the money taboo—which helps explain why people have difficulty communicating and even thinking rationally about money, and why professionals may have difficulty addressing money-related problems with their clients. These concepts can help one's behavior seem understandable and enable better services to be offered to clients as illustrated through the brief vignettes throughout the chapter. At the end of this chapter, a more comprehensive case study is presented.

Theoretical Concepts

The Unconscious

In psychoanalytic thinking, the unconscious is a central tenet. A large part of motivation and behavior is considered to be based on unconscious thoughts or memories of events that have been subjected to a vigorous repression because they are traumatic or unacceptable. Some events are not available to conscious memory not because they have been repressed but because they were experienced too early to be verbalized. Truly unconscious memories are very hard to access because bringing them into consciousness would result in anxiety, or because they occurred before the child had language to describe them. The latter are simply beyond words.

> In psychoanalytic thinking … a large part of motivation and behavior is considered to be based on unconscious thoughts or memories of events that have been subjected to a vigorous repression, because they are traumatic or unacceptable.

Many memories or thoughts are preconscious rather than fully unconscious. They have been suppressed, or set aside, rather than repressed. They, too, may be painful or uncomfortable and may be kept out of conscious awareness so long as nothing jars the memory; yet they are still connected to present-day motives, which often lead to repeated maladaptive behaviors that seem to make no sense.

> A woman, whose parents had always worried about money, determined early in life that she did not want to do that. So she developed what she referred to as a cornucopia mentality; not spending lavishly but buying whatever she wanted without thinking about it. She had no thought for the future and did not save or invest for her retirement. After she retired, she realized that her assets would not last, and did begin to get depressed. But, she still could not look at her finances or create a budget because that would be too upsetting. She was still trying to avoid dealing with the uncomfortable feeling her parents worry had generated during her childhood by suppressing rather than addressing them.

During the process of psychotherapy, some of these repressed or suppressed memories can be brought to awareness, and the uncomfortable feelings associated with

them worked through so they no longer have the same powerful grip on one's present-day behavior.

> Annette repeatedly got involved with men she found ungenerous and emotionally withholding. But, aside from commenting on the stinginess of some boyfriends, she had never previously talked much about money. Then, one day, she reported that her widowed mother was giving her large gifts of cash and she was afraid she might have to pay a gift tax. (It would have been the mother who was responsible for paying a gift tax, but neither the client nor the therapist knew this at the time.) She also feared that if she did not report these gifts, she might be penalized by the IRS. Sensing that this concern suggested an important money related issue, I asked for her earliest memory involving money. She recalled an incident from when she was a little girl, in which her father held a dollar bill in his fist and told her that she could have it if she could get it away from him. She begged him to give it to her to no avail. Then, she tried to pry his fingers open. When that did not work, she bit his hand to get him to open it. He became very angry and spanked her. I responded to this story by saying: "Because you got punished for trying to get your father to open his hand to get his money, today you are afraid to accept your mother's open-handed gifts."

Annette's memory was not repressed. It was easily enough brought to mind when asked a specific question about money. Although therapy had not focused much on her past or her relations with her father, the fact that, with all of her earlier complaints about men, she had never thought to mention this event suggests that the memory and this whole area of father–daughter relationship was suppressed. Therefore, this was kept mostly in the realm of preconscious awareness, until her memory was jogged. While the therapist's suggestion that she discuss her concerns about the IRS with her accountant did allow her to accept her mother's financial gifts with less anxiety, the revelation of this memory of her father's withholding and punitive behavior did not immediately resolve her feelings of deprivation or her repeatedly dashed hopes that some man would meet her needs.

Id, Ego, and Superego

In psychoanalytic thinking, a child is born with an id: a repository of primitive impulses that can be categorized under two headings, sexual and aggressive drives. The newborn child also operates on what is known as the pleasure principle: It seeks to gratify its needs or desires and to avoid pain or discomfort. It has no ability to delay gratification. It wants what it wants when it wants it, and rages against any delay.

> A parent without money cannot provide adequate care. A parent, who is anxious, depressed, or otherwise distracted because of financial concerns, cannot give full attention to the care of a child.

The id does not take into account external reality. It does not consider money or finance. Where do money and finance come into this picture? In one sense, money

has nothing to do with the primitive needs of the child. It is not food, nor warmth. It does not relieve the discomfort of a wet bottom, nor does it soothe colic. Money is no more than an abstract idea signified by coins, bills, bank accounts, and the like. It is only a socially agreed-upon symbol for value. But, its physical manifestations can be used to buy food, diapers, or other goods or services that will provide necessities, please the individual, or relieve distress. Money may affect the emotional and physical capacity of parents to provide a good-enough environment for the infant's physical and emotional development. A parent, who is anxious, depressed, or otherwise distracted because of financial concerns, cannot give full attention to the care of a child.

In the course of development, the infant, with good-enough parenting gradually begins to take the environment into account and to develop a sense of self and mechanisms of control. These along with its perception of the external world and understanding of cause and effect constitute the ego. The ego allows the individual to manage the environment and to delay gratification until a suitable time, as well as to accept reasonable limits on the amount of gratification one can obtain. It also develops the executive function needed to respond to and exercise some control over the demands of the id and, eventually, those of the superego as well.

Along the way, the child's recognition of the external world encompasses money. At first, according to Freud (1908), the child associates money with feces. This association may explain why money is often felt to be dirty and is referred to as "filthy lucre." Fenichel went beyond Freud's linkage of money with feces "by declaring that money can symbolize anything one can give or take: milk breast, baby, sperm, penis, protection, gift, power, anger, or degradation" (as cited by Turkel 1988, p. 525). To this, Turkel added that money in our culture "is also a symbol of worth, competence, freedom, prestige, masculinity, control, and security, all of which can become areas of conflict" (p. 525).

What does this mean for the psychotherapist or financial advisor? It is not so much money itself that is important as the particular meanings that the individual's ego projects onto the abstract concept we call money; or onto its physical representations, such as dollar bills or bank accounts.

> When asked what money meant to her, Brenda immediately replied, "Freedom." As a young girl, she was stuck living with an unloving mother who wouldn't give her even a dollar to buy toys or candy. When she was still a teenager, she got a job and left home. That was a time she remembered as the happiest in her life, because she had enough money to walk down a street and buy anything she wanted. So, she had thought of money as representing freedom. But, then she reconsidered and said, "Perhaps if my mother had shown me any love, I would not have had to get a job and leave home at such an early age." Clearly, the money to buy her freedom was substituting for love.

The superego, like the ego, also develops in response to one's environment. In this case, the part of the environment that imparts social values and standards of behavior as mediated by parents and other authority, and as accepted or rejected by the individual. The prohibitive part of the superego, which contains the "shall not" imperatives, is known as the conscience. Ignoring the dictates of one's conscience leads to guilt. The part of the superego that contains the person's ideals—the "should" imperatives—is called the ego ideal. Failure to live up to one's ideals leads to shame.

An overly developed superego tends to be rigid and demanding, which leads to anxiety, depression, low self-esteem, guilt, shame, or perfectionism. Many of these emotions are commonly associated with money and financial matters. But, the individual may feel the attitude is justified and valid, and will continue striving for perfection or berating one's self for underachievement. Or, a person may project blame, becoming hypercritical towards others for not living up to his own standards, for getting in his way, or for failing to support him. Attitudes like this are not likely to motivate one to get help, though others may push him to do so. But when the source of the emotional pain is recognized as coming from within, rather than being projected onto others, it may be an impetus for an attempt to change. The case study of Goldie, toward the end of this chapter, exemplifies the kind of client who recognized her pain as coming from within and was motivated to change.

Repetition–Compulsion and Working Through

To understand repeated failure, another psychoanalytic concept, *repetition–compulsion,* is needed, while the concept of *working through* will help us understand how the tendency toward repeated failure can, over time, be overcome. Repetition–compulsion refers to a person's unconsciously motivated attempts to recreate a disappointing or traumatic event in the hopes that it will turn out differently. This fits Einstein's often-quoted definition of *insanity* as "doing the same thing over and over and expecting different results." In Annette's case, she repeatedly attached herself to men who could or would not meet her needs (financial or otherwise), hoping that this one would be different. In some cases, the men were not really so very withholding, but she expected them to be so, and searched out any evidence she could find that they would not fulfill her desires. She would then become angry at them, and they would withdraw. These relationships symbolically represented the original father–daughter relationship, which could never be retroactively undone.

> Repetition–compulsion refers to a person's unconsciously motivated attempts to recreate a disappointing or traumatic event in the hopes that it will turn out differently.

How does a therapist help a client overcome the compulsion to repeat counterproductive behaviors? By patiently and repeatedly helping her to recognize and identify the pattern, to understand it as an attempt to recreate a traumatic event in hopes that the outcome can be different, to understand and accept the futility of this attempt, and to mourn the loss of hope for what can never be. All of this takes time. Until the process is complete, the client cannot move on.

How can understanding these concepts help financial advisors? By understanding that repeating a behavior, even after the client has been provided with the cognitive tools and advice for rational money management, is very likely to be a compulsion.

Such compulsive behavior is unlikely to be overcome without therapeutic help. In a sensitive and diplomatic manner, the advisor can point out the repetition and suggest that such behavior is usually based on some unrecognized emotional concern. If the client can at least acknowledge the problem, the advisor can then suggest a referral to a therapist who is experienced in financial therapy and who might help the client to identify and work through the underlying concerns.

> …repeating a behavior which is doomed to failure—even after the client has been provided with the cognitive tools and advice for rational money management—is very likely to be a compulsion, which is unlikely to be overcome without therapeutic help.

Identification and Identity

Identity is central to who clients are and what motivates them (Trachtman 2011). How is identity formed? Both the ego and the id are central to understanding this process. One of the many kinds of conflict described in psychoanalytic theory is between the "should" imperatives of the ego ideal (the aspirations a person has for what kind of person one believes he or she should be, based on identification with the parents' values) and his or her identity (the ego's—correct or incorrect—assessment of what kind of person he or she actually is).

So, what does this have to do with money and finance? Money is one of the most important cultural forces in our society, and how we think about ourselves often reflects our attitudes about money. The term "of account" refers to how much money one has. When attitudes and beliefs about money become internalized, they become an aspect of one's identity. Thus, one may attribute worth to wealth and classify people as being "of account" or "of no account." We may also think of ourselves in other terms such as "generous," "thrifty," "responsible," "competent about money," "gambler," or "spendthrift." And the individual's sense of identity will, in turn, have a profound effect on his financial behavior. When one thinks of himself or herself in a particular way, the conviction that "This is who I am," can be more powerful and harder to change, than the idea that "This is how I am behaving." To ask a person to change behavior that is an expression of his or her identity is like asking the person to change his or her skin. The primary therapeutic task in this case is to help the client change his perception of himself rather than to change a particular behavior, although learning to change behavior may gradually shift one's perception of self.

> An artist who had doubts about his own self worth was so pessimistic about his chances of selling his work that he avoided putting in the time and effort required to market it. Yet, believing that selling his paintings would validate not only their worth but his own, he questioned why he was doing the work he loved if he could not sell it. As we explored the underlying reasons for his self doubt and passivity and as he experience being valued and cared for in treatment, both the pessimism and passivity began to abate. He began increasing his efforts to get his work shown, got it accepted into an important venue, sold one large painting to a museum and convinced a popular restaurant to hang his work where it was available for sale and could be viewed by many people each week.

Object Relations

Concepts, such as the unconscious, id, ego, and superego, were developed early in the history of psychoanalysis. Many new conceptual frameworks have followed and been superimposed on the framework of psychodynamic theory. One of the most important is the theory of object relations (or to be more precise, self-object relations). In this theory, the infant is born with need-gratifying impulses and no concept of the mother (the primary object) or others as being outside of the self. Other people exist only as an extension of the self, forming what is referred to as the self-object. Emotions are primitive—pleasure in response to gratification or rage at frustration. Pleasure comes from the "good" self-object and the rage is directed to the "bad" self-object. Only gradually does the infant begin to recognize part-objects as being outside of the self. The breast is a primary part-object, as is the mother's face. At this point, the mother is still not recognized as a whole independent person with needs and feelings of her own, but rather still as existing to serve only the needs of the self (i.e., still a part-object).

In the course of normal, healthy development, through a process of separation and individuation, the child grows to recognize the mother and other objects as individuals in their own right, with needs and feelings of their own. If all goes well, the child becomes an adult with the capacity for empathy toward others, balanced by a healthy respect for one's own needs and desires. If there is a failure in development, the individual remains stuck in a narcissistic position, in which other people are still perceived as good, need-gratifying extensions of the self or as bad, frustrating enemies.

> One seriously narcissistic client told me that, when he wasn't attending a session, he imagined that I curled up under my desk until his next session. Once, when this client asked me to attend a social function and, rather than agreeing, I frustrated him by seeking to understand the reason behind his request, he muttered under his breath, "I'll kill him." This man worked as the computer technician for a company. When he asked for a raise, which was not granted, his response was to sabotage the computer system and go away on vacation.

> Narcissistic people will be inclined to view other people's wealth, financial institutions or money itself as need-gratifying objects, which should serve their needs.

How does object relations theory relate to financial therapy? Narcissistic people will be inclined to view other people's wealth, financial institutions, or money itself as need-gratifying objects, which should serve their needs. They are likely to pursue money and material wealth even at the expense of their family members' well-being.

> Despite the fact that each of them made a reasonable salary, the parents of a teenage boy were too busy trying to make more money in the evenings and weekends, to be able to take care of him. So they sent him to live with an aged grandmother who was not providing adequate care and supervision. When the parents became aware that he was having problems,

hanging out with a questionable group of boys, but having no real friends or any interest in school, they brought him to see me. They made sure he attended his therapy sessions, but said they would be too busy to come themselves, even though I made it clear that this would be important to their son's treatment.

In one of the boy's early sessions I asked: "If you could have three magic wishes, what would you wish for?" His answer was money, a house, and an island. When asked to elaborate, he said he would want enough money never to run out and that he would live all alone in the house on the island, inviting people, mostly girls, to visit but they would not be allowed to stay. This response was understood as his own narcissistic reaction to his parents' narcissistic devaluation of his need for loving care. Money, like an ever-flowing breast, had become the primary need gratifying object, while human interaction might only fill some transitory needs. The idea of an intimate relationship with another human being was beyond his comprehension.

A severely narcissistic person may be smart and able to understand the realities of his social environment. He may act charming and seem friendly. But, there is a lacuna in his Superego. In financial dealings, he is likely to be the one who creates a Ponzi scheme, cheats his customers or his partner, and hides his assets in a divorce. Unfortunately, from the viewpoint of therapy, such a person is unlikely to want to change. However, there are many people with some narcissistic traits who may benefit from treatment. They are the ones who are motivated, partly by the desire to get their own needs met but who also recognize that, in order to do so, they must at least consider the needs of others. They may realize that they are missing out on the intimacy, which others are able to achieve, and wish to be able to have the experience of truly loving a spouse or child. In such cases, it will often be useful to help the client examine his beliefs and attitudes toward money, and how he uses money in the context of his relationship to others.

Sandy came for treatment because he was lonely and miserable. His girlfriend had left him and he had failed to keep up relationships with his friends. This was because, at a certain point, he felt he was not making enough money. So, he had become obsessed with an entrepreneurial project that he hoped would make him rich and famous. He had been spending all of his spare time—evenings and weekends—working on this scheme. He had assumed that his girlfriend would be happy to be part of his quest, never considering that she might feel ignored. When he realized what he had been doing he moaned, "How could I have become so selfish that I didn't make time for my friends and didn't even ask what my girlfriend wanted?" In treatment, he learned that his desire to be rich and famous was, in part, a revenge fantasy, in which he would become the envy of a richer cousin and richer schoolmates who had snubbed him during his childhood. He also came to realize the actual work on this venture was inherently gratifying—more so than great wealth would ever be. He started working at a more relaxed pace, making time for his old friends and paying closer attention to the desires of women he was now dating.

Transference and Countertransference

Transference is a term used to describe a common phenomenon: the transfer of one's thoughts or affects from long ago onto another person in the present day. For example, a man may transfer the uncritical assessment he had of his mother when he was a toddler onto his fiancée. Later, he might transfer some of his criticisms of

his mother, from when he was an adolescent, onto his now, not so recently married wife. While there may be some objective grounds for either or both attitudes, the theory is that the predominant reason for the present-day attitude is unconscious transference from an earlier person to a current one. Annette, mentioned above, was transferring onto the men in her present-day life the feeling of deprivation that originated with her father.

Freud made the analysis of transference central to the technique of psychoanalysis. He created conditions that would favor the development, in the neurotic client, of a strong transference (called a transference neurosis) onto the analyst. This transference neurosis could then be analyzed to uncover the origins of the client's actual neurosis and its related symptoms. Classically, the client lies on the couch facing away from the analyst. The analyst would say very little, becoming somewhat of a blank screen onto which the client projects his unconscious expectations.

Today's psychoanalytically oriented therapists do not use this technique (although psychoanalysts still do). But, depending on the therapist's style, many clients still complain that they do not talk with them enough. In either case, psychoanalytically oriented therapists do recognize the existence of transference, which is often present, in some form, in most relationships. Since transference is a common phenomenon rather than just a theoretical construct, therapists of all persuasions would do well to acknowledge its existence, be alert to its manifestations and make judicial use of these manifestations when they appear. Failure to do so may undermine the treatment.

The same is true for countertransference (the therapist's projection of his own predetermined attitudes and beliefs onto the client, which originated in his own early interpersonal experiences). We all have pre-determined attitudes toward certain clients, which are influenced by prior experience. If we do not acknowledge this and fail to examine our attitudes and feelings toward clients in order to better understand their origins, we will fail to understand the potential impact of these experiences on the treatment. As a result of unrecognized reactions to particular people based on specific early interpersonal relationships (i.e., countertransference), we will conduct therapy with blinders on, often to the detriment of the client.

> A client came to see me complaining that the family therapist who was seeing her husband and herself in couple's treatment was not being helpful. She told me that, because her husband made a lot more money than she did (she was a writer who worked at home and provided full time child care) he felt that he should control the finances and not have to explain anything to her. Asking him to discuss their finances made him angry and sparked arguments. When the client asked me to take over the treatment, I first got permission to speak with her therapist; who was a well-known feminist. When I told the therapist of the client's request, she replied, "Take her. She is a horrible woman who thinks she doesn't have to earn much money and can tell the husband how to spend what he earns."
>
> When I took over the treatment, I learned that the husband saw his wife's attempt to question his decisions as a sign that she did not trust him. She, on the other hand, had trouble understanding issues of finance. She just wanted to be included in financial decision making and helped to understand why their money should be used in the way he said it should. She especially wanted him to consider some of her ideas for how to spend their money: for example, sending their daughter to a summer camp.

> It was clear to me that the previous therapist's failure to understand was rooted in her feminist conviction that women should be financially equal to, and not reliant on men. In her view, that the client was a stay at home mom did not entitle her to equal financial decision making rights. This view was probably rooted in her own childhood experiences as well as her particular brand of feminist ideology. This countertransference resulted in a lack of neutrality and prevented the therapist from empathically exploring the reasons underlying the wife's position and why the husband was so affronted by her curiosity and wish to participate in determination of family spending.

All therapists, regardless of theoretical persuasion, can be blind to their own counter-transference problems and so need to make it a practice to question their own feelings and motives in regard to each individual client.

All therapists, regardless of theoretical persuasion, can be blind to their own countertransference problems and so need to make it a practice to question their own feelings and motives in regard to each individual client.

Even Sigmund Freud had trouble looking at his own history in terms of money and finance. He gave some very good advice to beginning analysts regarding management of the fee and elucidated the relationship of clients' relationship to money as reflected in various forms of psychopathology (Freud 1908, 1913). But, he avoided exploring his own relationship to money. With regard to his father's financial setbacks, he admitted that he preferred to suppress rather than explore their impact on him. About the "hard years" he wrote "I think nothing about them was worth remembering" (Gay 1988, p. 8). For a man to whom exploration of traumatic childhood memories was a linchpin of early psychoanalysis, this is a remarkable statement. It illustrates the difficulty we all face when dealing with money issues.

It is not just therapists who should take the phenomena of transference and countertransference into account. It is important for the financial professional to also recognize the existence of this phenomenon, not only to analyze anyone's neurosis but also to understand some of the impasses that occur with clients. Could it be that the young client who resists accepting financial advice is seeing the advisor as an overly controlling parent or that the financial advisor is, in fact, feeling overly protective to a young client who wishes to exercise some of his own independence and take his own risks when making financial decisions? Acknowledging such possibilities may, in itself, help to improve the advisor–client relationship.

…"The Money Taboo" inhibits discussion of money by psychotherapists as well as the lay public (Krueger 1986; Trachtman 1999).

The Money Taboo

Since both the ego and the superego develop in response to the environment, it is important to recognize that a cultural phenomenon, known as *the money taboo,*

inhibits discussion of money by psychotherapists as well as the lay public (Krueger 1986; Trachtman 1999). Almost any American, as well as people from many other parts of the world, if asked by a casual acquaintance or even a friend, “How much money do you make?” would find the question discomforting. This taboo does not exist in all cultures or places (personal questions about money are not taboo in places like Norway or Vietnam). When faced with such a question in the USA, or tempted to ask one, the typical reaction is; “This is inappropriate, impolite, disrespectful, an invasion of privacy.” In the case of temptation to ask such a question, the individual’s superego may respond by generating feelings of guilt or shame. In this case, the ego and superego work in tandem to keep the Id impulse to gratify curiosity in check.

One result of this taboo is that useful and important information is not discussed or shared. People often get married without knowing anything about the partner’s debt. Spouses sometimes have no idea of how much the other is spending or on what. Children may have no idea how much money their parents have. If the parents are very wealthy, the child may suddenly come into a large inheritance without having been psychologically prepared to handle the wealth. Such children may feel guilty and try to divest themselves of money they did not earn. Others, who have not developed the ego resources needed to delay gratification, may spend recklessly. Some less wealthy people may be too embarrassed to negotiate a good salary when taking a job or timid about asking for a raise later on. They may be reluctant to compare notes with others in their field to learn what a reasonable salary for their skills should be. People who are having money-related problems may be reluctant to reveal these issues even to a psychotherapist or financial advisor. Many psychotherapists, being part of the same society, are inhibited by the taboo as well, and avoid asking money-related questions for fear of seeming invasive and inappropriate. Thus, psychological help for money-related problems may be hard to find.

> …therapists tend to limit their discussion of, and writing about money, to issues concerning the fee and its management (Trachtman 2008).

This problem is compounded because therapists tend to limit their discussion of, and writing about money, to issues concerning the fee and its management (Trachtman 2008). According to the results of informal research interviews conducted by this author, social work schools, psychology graduate programs, and psychiatry internships do not teach about the relationship of money to intrapsychic and interpersonal development and adaptation. Therefore, the professional’s ego is deprived of training needed to fully understand and help with that area of his environment most central to his work: the client. Indeed, since the money taboo tends to inhibit the therapist’s ability to think about and understand his own beliefs and feelings about money, he may be unable to fully assess a crucial component of the therapeutic relationship: his countertransference.

Case Study

The following case study should give the reader a more in-depth understanding of how this author works with clients. While therapy is not kept to narrowly defined psychoanalytic methods, the approach presented in this chapter is informed by psychoanalytic developmental theory and technique. Regardless of whether the presenting problem has to do with finances or not, a variety of concerns including financial ones often need to be addressed to meet a client's needs adequately. That was true in this case.

Background Information

Goldie, a woman in her late 60s, had a variety of problems. Her initial presentation did not focus on financial issues. A divorced, bisexual woman in her mid-60s, she had always had difficulties maintaining intimate relationships from which she would, sooner or later, withdraw. This left her feeling desperately lonely, depressed, tearful, with vague thoughts of suicide, and feeling "like a kite without a tail," which caused great anxiety.

Case Conceptualization and Interventions

My stance in treating the above symptoms, as well as those to be described below which involved finances, was to maintain an interested, empathic attitude. I was analytical, enquiring about her personal and family history, as well as her dreams and current activities, relationships, thoughts, and feelings. I frequently made interpretations, which offered her insight into the underlying causes for her emotional problems and into why she saw and responded to the world in the way she did. At the same time, I also was supportive in terms of her present-day challenges, giving practical advice as to how to handle problems she encountered; such as how to build a groundhog-proof fence around her vegetable garden. In doing so, I was helping her to develop a sense of competence that was never fostered during her childhood.

During the course of treatment, Goldie developed a very strong positive transference to me. I represented the kind, caring trustworthy parents she never had. This, for a long time, was a very dependent transference. She would come into session distraught and leave feeling better. But the good feeling could not be maintained for long without my presence or the expectation that I would be there soon. All of her periods of distress seemed to her like they would never end. Repeatedly, I reminded her that her misery was transient and that she did have moments or hours and even days when she was happy or content. This was especially true when she was writing, gardening, walking, or spending time out in her kayak watching birds. Her ego

slowly absorbed this bit of her reality, her superego became less punitive, and she began reminding herself that, if she engaged in the activities she enjoyed, she would be less unhappy and less focused on her loneliness. She did have friends, and she began making a point of seeking out companionship.

We also discussed repeatedly (to help her with the process of working through) her disappointment in and resentment toward her parents. Eventually, she was able to forgive them, mourn the absence of good parenting in her childhood, and, at the same time, accept that she was not the disappointing, undeserving child she had assumed she must be. Her self-esteem improved.

The financial part of the therapy was similar to the above but addressed Goldie's relationship to money. She had a trust fund but was always reluctant to spend money on herself, even though she could afford to do so within reasonable limits. In part, this was due to the dependency that had been fostered in her during childhood. The trust fund allowed her to remain dependent and not develop a trust in her own competence. But her financial problems also were related to her feelings about the source of the money involved. The problem was so severe that, during the winter, she kept the thermostat turned way down so that she had to wear three or four sweaters and still felt miserably cold. Exploration of her history revealed that her mother was emotionally detached and super critical whenever Goldie asked for something—even to have a snack between meals—so that she never felt she was entitled to have any needs of her own.

Her father who was overly indulgent when she was a little girl later cut off funds for her pursuit of education in the performing arts, which she loved. However, he did not approve of this profession as a potential career for his daughter. As a result, she both grieved the loss of their earlier closeness and resented and felt betrayed by him.

Her father was a store owner who made a good living, but treated his Black workers poorly. Goldie identified with them as victims and disapproved of how he made his money. In reaction to her father, she developed a strong sense of social responsibility. This also contributed to her reluctance to use much fuel to heat her house because she did not want to leave a large carbon footprint.

When the father set up the trust fund for her, he told her that she could use it to take care of her needs, but it was really meant to be passed on to her children. When it came to spending what she considered "his money" on herself, she felt undeserving, ashamed for being needy, and guilty for using money that was gained at the expense of poorly treated workers. Goldie's present-day problems resulted from having developed a critical and demanding superego in conjunction with low self-esteem.

Goldie had seen other therapists before me but, as one who specializes in money and relationships, I focused on the connections between her reluctance to spend money, which was now hers, and her childhood history. Change did not happen immediately but, over time, we looked at the underlying reasons for her self-denial, and I helped her to work through the problem. I helped her to recognize her identification with her parent's expectations of her and her ongoing but fruitless attempts, through self-denial, to live up to these expectations that she express no needs of her

own. I helped her to recognize and give up her fantasy that, even after their death, she could win her parents' approval and love by self-abnegation.

I also helped her to think realistically about what she could spend on herself and still leave some inheritance for her children—thus supporting the ego function of reality testing. A referral to a good financial advisor also helped her to make this assessment and allowed her to relax her restrictions on spending for her own needs.

Consider the following description of one session, which occurred several years into Goldie's treatment. On this day, she came to therapy feeling anxious, stupid, and irresponsible. She disclosed that she had decided to bring her jewelry to be appraised and gone to her safe deposit box to get it out. She had thought she had lost two diamond rings between the time when she took them out of the safe deposit box and getting home. Until she found them, she had asked herself, "How can I be so careless as to lose something so valuable?"

I had never heard about this jewelry and asked about it. It was not just a few pieces but a sack full of gold, diamond rings, pearls, opals surrounded by diamonds, and similar items. When I pointed out that, in all of the years we had been talking about her financial worries, she had never mentioned this important part of her assets, she said that this jewelry was not really for her. It was to be passed on to her children as her grandmother had passed it on to her. I replied (knowing that she could appreciate a bit of mild sarcasm without taking it personally) "So that they will be able to keep it in a safe deposit box to give to their children who will also keep it in a safe deposit box?" She laughed at this, getting the point.

Still, there was more to understand. It sounded like what she was keeping locked up might have considerable cash value. I asked why, if she was just going to keep it in her safe deposit box, she was having it appraised? If it was for insurance purposes, it would mean she was going to take it out to use on occasion. The other purpose for appraisal would be to find out how much she could sell it for. I did suggest that, while some jewelry is hard to sell at its appraised value, I thought the price of gold might be high at the moment and, if I was correct, she might want to ask her financial advisor whether she should sell some of it to increase her cash holdings (which might—or might not—make her less prone to worry about what she could afford to spend).

She agreed that it might be a good idea to sell some of it if the price was right. But she added that she did not want to let it all go, because it had come from her grandmother and was the only gift anyone had given her just for herself with no strings attached. So she wanted to have it appraised to get a better sense of what she had been given by a generous grandmother. I replied, "It is an important part of your heritage."

The session ended with her talking about how, although she had a good figure for clothing, and did like to dress up, she often did not give any thought to how she dressed and did not have much in the way of nice clothing. If she sold some of the jewelry, she might want to buy some more attractive garments for everyday use, and might select some of the jewelry to wear with her new wardrobe. How one dresses, is often a reflection of how one feels about one's self. I thought that, if she

did start wearing attractive clothing and some of her loving grandmother's jewelry, this might be both a reflection of and an aid to increased self-esteem.

One aspect of the treatment I have not yet mentioned has financial importance, as well as symbolic significance for both the client and the therapist, is the fee and its management. In order to be able to offer my services to senior citizens, I am enrolled as a Medicare provider. This means that I must accept a small fee and cannot charge anyone on Medicare a higher fee, even for those who can afford to pay more. In Goldie's case, she had a good Medicare supplemental insurance plan, so she never had to pay anything out of pocket for her treatment.

Outcomes

Goldie's improvement over the years was gradual. When we finally started talking about termination, it had been years since she had been tearfully depressed, had thought about suicide, or felt like a kite without a tail. She was still lonely, had bouts of depression and anxiety, but understood these states were transitory, and she could manage them. At this point, I began to suggest to her that she had probably gained as much from her therapy with me as she could expect. And, I told her, I did not feel I could continue billing Medicare if her treatment was no longer medically necessary. She agreed with this position but was fearful that, without my support, she would regress. We discussed her fear of termination and agreed that she should stop for 3 months, to see how she was doing. Then, if she still felt she wanted to see me, we could talk about it. Three months later, she reported that she still had some problems but was now able to manage them on her own. She was writing well and had friends with whom she was making an effort to keep up relationships. But I had become an important person in her life, and she would also like to keep up that relationship. She asked if she could meet with me once a month, not for therapy but just to talk about whatever was on her mind. And, without my bringing it up, she volunteered to pay a considerably higher fee than I had been receiving from Medicare. Clearly, Goldie was no longer ashamed of her own needs and desires, and money had become something she could allow herself to spend to satisfy them.

Ethical Considerations

No one approach to psychotherapy is superior to others. This author was originally trained as a psychoanalytic therapist, but uses a variety of psychotherapeutic ideas and techniques—cognitive behavioral, solution oriented, family systems, etc., according to the needs of the client. Quick and easy change occurs only with very limited and generally superficial goals. When a problem is the product of one's history and personality formation, change takes a lot of time and work.

> …graduate programs seem to be lagging behind in their readiness to acknowledge and teach about the importance of money as a psychological issue.

Psychotherapists, including psychodynamic psychotherapists, have historically been reluctant to discuss with their clients anything having to do with money or finance other than their fee. Although money is one of the most powerful cultural forces shaping individuals' intrapsychic development, which, in turn, affects their emotional well-being, interpersonal relations, and behaviors, informal research by this author indicates that teaching about the importance of money in graduate programs in social work, psychology, and psychiatry is practically nonexistent. This author would hazard a guess that in training programs for financial planners there exists a similar lack of training in the understanding of the psychology of money.

Future Directions

A sea of change seems to be occurring. In the last 10 years, an increasing number of articles relating to money and psychotherapy have been published. Yet, with very few exceptions, graduate programs seem to be lagging behind in their readiness to acknowledge and teach about the importance of money as a psychological issue. At the same time, there seems to be a steady flow of articles in the popular press about the relationship of individual psychology to money and finance. Many of these are written by financial journalists or financial professionals (for an example, see Polk 2014).

What should we look forward to in the future? We should be promoting an increased awareness among mental health educators of the importance of money and finance as major environmental influences on psychological and interpersonal development and, in turn, teachers of financial advising need to increasingly instill an understanding of the impact of personal psychology and interpersonal relations on how people behave with regard to money and finance.

In graduate level teaching of future mental health professionals, courses in the areas of psychological development, psychopathology, and treatment techniques involving the application of psychodynamically oriented as well as other forms of treatment should include readings and class discussions of case studies which will illuminate how we learn about and experience money, and how we behave when issues of money and finance are involved. Eventually, evidence of such graduate-level education might be considered a prerequisite for the practice of what we call financial therapy by mental health clinicians.

We should look forward to similar change in the training of financial planners as well as other financial professionals to help them understand the impact of psychological history on financial behavior and what they can and should not do when faced with psychological roadblocks to the advising or planning process.

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Chapter 18
Financial Therapy from a Self-psychological Perspective

Maggie N. Baker and Cecile Phillips Lyons

> …the relevance of an individual's internal perceptions about money to interpersonal dynamics has not yet had a significant impact on the general practice of clinical psychology.

Introduction

While money is part of objective reality in our capitalist society, each of us has a uniquely subjective experience of it that has been shaped over time. Most often, this experience is stressful. Rich or poor, successful or not, in good times and bad, Americans report that money is their number one source of anxiety (American Psychological Association 2012).

Behavioral economics and neuropsychology show that our emotional experience of money outweighs cognitive abilities or analytical expertise when it comes to making decisions and taking action (Ariely 2008; Kahneman 2011; Zweig 2007). Not only does this experience add definition to self but also its expression in our beliefs and behaviors will ultimately influence whether we flourish or flounder.

> Research has shown strong support for the effectiveness of psychodynamically oriented treatment.

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However, the relevance of an individual's internal perceptions about money to interpersonal dynamics has not yet had a significant impact on the general practice of clinical psychology. There is speculation that many practitioners avoid this topic because it creates anxiety in them as well as in the client, and some empirical evidence shows that mental health professionals are more money avoidant than some other professionals (Klontz and Britt 2012).

By presenting a self-psychological treatment orientation applied to a particular case, we hope to provide guidance that will help both therapists and financial planners better understand their own clients, leading to better case conceptualization, stronger therapeutic alliances, and, in some cases, to be used as a catalyst for transformational intervention. The basic premise of self-psychology is to use the therapeutic relationship, self-reflection, and self-examination to help a client identify problematic relationship patterns to alleviate his or her emotional suffering (Shedler 2010).To demonstrate how self-psychology can be applied to financial therapy, a two-part case is presented immediately following the excerpt on existing treatment outcomes associated with self-psychology in other fields.

Self-psychology and Associated Treatment Outcomes

Research has shown strong support for the effectiveness of psychodynamically oriented treatment. In a review of eight meta-analyses comprising 160 studies of psychodynamic therapy and nine meta-analyses of other psychological treatments including antidepressant medications, Shedler (2010) found a

> consistent trend toward larger effect sizes at follow-up [which] suggests that psychodynamic psychotherapy sets in motion psychological processes that lead to ongoing change, even after therapy has ended…. In contrast, the benefits of other (nonpsychodynamic) empirically supported therapies tend to decay over time for the most common disorders (e.g., depression, generalized anxiety…). (p. 101–102)

In this comprehensive review of empirical research, extending as far back as 1975 to what may have been the first study of therapeutic outcomes (see Luborsky et al. 1975; Shedler 2010) demonstrated that most meta-analyses have showed support for the effectiveness of psychodynamic psychotherapy. In his review of outcome studies for cognitive-behavioral therapy (CBT), Shedler noted that many of CBT's effective factors are borrowed from psychodynamic therapy. He argued that the unique qualities of CBT—direct teaching and an authoritative orientation, as opposed to empathic understanding of the client's experience—were among the least effective interventions. In summarizing his review, Shedler (2010) outlined the fundamental elements of a psychodynamic approach: (a) focus on affect and expression of emotion; (b) exploration of attempts to avoid distressing thoughts and feelings; (c) identification of recurring themes and patterns; (d) discussion of past experience (developmental focus); (e) focus on interpersonal relationships; (f) focus on the therapeutic relationship, transference, and co-transference; and (g) exploration of fantasy life. Self-psychology incorporates all of these fundamental elements.

Shedler's (2010) findings are particularly important because health insurance cost management has placed an emphasis on "evidence-based" psychotherapy treatments. Also, academic and health insurance circles have long held the misconception that there is little empirical support for psychodynamic psychotherapy. This is simply not true.

Self-psychology "focuses on the psychological roots of emotional suffering. Its hallmarks are self-reflection and self-examination, and the use of the relationship between therapist and patient as a window into problematic relationship patterns in the patient's life. Its goal is not only to alleviate the most obvious symptoms but to help people lead healthier lives." (Shedler 2010, p. 101)

As mentioned above, self-psychology is an offshoot of psychodynamic psychotherapy, which has been shown to be effective for a wide range of mental health issues. Self- psychology "focuses on the psychological roots of emotional suffering. Its hallmarks are self-reflection and self-examination, and the use of the relationship between therapist and client's a window into problematic relationship patterns in the client's life. Its goal is not only to alleviate the most obvious symptoms but to help people lead healthier lives" (Shedler 2010, p. 101). Three studies exploring self-psychology treatment outcomes are presented below.

In a clinical trial, Stevenson and Meares (1992) studied the effectiveness of self psychology-oriented psychotherapy in the treatment of 30 clients with borderline personality disorder (BPD). A year after treatment ended, 30% of the sample no longer met the criteria for a diagnosis of BPD, arguably one of the most difficult diagnoses to treat. Furthermore, according to additional follow-up research, these clients continued to thrive 5 years later (Stevenson and Meares 1995). A significant weakness of this study was its lack of a control group.

Stevenson and Meares (1999) addressed this issue in a follow-up study. They replicated their 1992 research using a cohort of BPD clients who had waited 12 months for treatment. (In Australia at that time, the common wait for treatment was 17 months.) They then compared the wait-list group with the cohort who had been treated from a self-psychological perspective. Measures used to determine a treatment effect were objective in nature, such as the number of doctor visits, time away from work, suicidal attempts, and outbursts of rage or more extreme violence. The results clearly showed that the treated cohort were able to significantly reduce their symptoms and experienced improvement in mental health from the gains they had made in psychotherapy. A third study by Stevenson et al. (2005) found thatgains made by the 1999 cohort after a year of self-psychological treatment were sustained 5 years later at a statistically significant ($p < 0.001$) level, as measured by such objective data as frequency of drug usage, hospital admissions or visits to a doctor, missed work time, and episodes of rage, violence, or self-harm.

Case Study: Part I

Paul's Presentation to Therapist

Paul, a sales professional in his 50s, is caught in the middle—between two women who both love him, between fatherhood ties and bachelor freedom, and between financial success and self-sabotaging insecurities. The owner of an insurance agency, Paul earns an income that is midrange in his field. Although he has the potential to increase his compensation, he lacks the desire or discipline to work at cultivating relationships with his firm's clients. He is, however, passionate about making connections with new prospects and chasing deals.

When Paul and his wife Karen both worked, they were able to finance a lovely suburban home with their combined paychecks. Trouble in the marriage began as Karen devoted more and more of her attention to their two young children. A week after she quit work to look after the kids, Paul was laid off and given 5 months' pay as a severance package.

Paul spent all his severance pay to start up a new insurance business. As he struggled to make more sales, he realized that Marty, a young woman in his office, was smart, detail-oriented, and would do anything to support him and the company. Eventually, he left his wife, his 5-year-old daughter, and his toddler son to be with her.

Karen continued to offer unconditional love, believing that Paul's affair was born out of pain from his childhood. She asked him to come back. Racked with guilt about deserting his children, Paul returned home for a trial period. He loved living with the kids, but could not summon any romantic desire for Karen. Again, he retreated to live with Marty. A few months later, when his longing to be with his children became too strong, he returned home with new resolve. This time he lasted for 10 weeks. At that point, it became clear that he was trapped, unable to choose between his girlfriend and his children.

Financially, Paul was overstretched. He continued to pay the mortgage on his family's home and helped Karen as much as he could. Although Marty paid the bills at her house for both Paul and herself, his financial obligations still exceeded his income. He kept himself afloat by clinging to the lifeline of the next big deal. Unfortunately, any new income was soon consumed by past-due obligations or was siphoned into another distraction, such as his ambition to become an award-winning photographer. When he abandoned almost all of his business involvement to tend to a dying aunt, his cash flow dried up completely.

Despite living openly with Marty, Paul still considered himself a committed father. He resolved to ask for a divorce, but because of Karen's reluctance to end their marriage, he agreed to join her in marital therapy. The application of financial therapy based on a self-psychological perspective provided insight into Paul's feelings and behaviors and led to promising interventions.

Theoretical Considerations: Part I

Freud and the Poop Premise

In the case of clients like Paul, a money problem rarely stands alone. It is not a single accounting error, payment oversight, wager, or purchase that should not have been made. Money problems are more typically part of a behavior pattern, in which underlying dynamics affect many areas of a person's life. In most cases, these patterns have their roots in early childhood.

> …self-psychology provides a theoretical framework to integrate context, understand the full scope of individual money dynamics, and organize an approach to facilitate problem -solving.

Freud (1908) famously suggested that an individual's introduction to economics occurs along with his or her first product as a baby: feces. The baby's pride of craftsmanship and production, power of exchange, and rewards of discipline are part of early psychosexual development. In Freud's view, this early experience establishes the child's eventual attitude toward money.

We have found, however, that it is essential to recognize the complexity of past, present, and future experiences in financial dysfunction. In our research and financial therapy practice on the subjective experience of money, self-psychology provides a theoretical framework to integrate context, understand the full scope of individual money dynamics, and organize an approach to facilitate problem solving.

Kohut, Empathy, and Self-experience

Heinz Kohut (1977) commented on the implications of context at the time of a person's first economic exchange, placing far more emphasis on interpersonal dynamics than did Freud. Kohut's self-psychology does not outright reject Freudian drive theory and its attendant developmental tasks, such as the impact of the anal-erotic stage (withholding vs. letting go) on a growing child's relationship to money. However, he emphasized that receptivity in the caregiver's response is essential in order to form the character of a "feces producing, learning, controlling, maturing, total child" (Kohut 1977, p. 76).

According to Kohut, the important developmental question is whether this offering (feces) is met with appreciation and acceptance or with disgust and scolding. In The Analysis of Self (1971), he articulated three innate developmental needs to evolve a healthy psyche: mirroring, idealizing, and twinship. These terms are based on a caregiver's ability to be attuned to the child's needs—needs that will last a lifetime, transforming and maturing over the years.

Mirroring involves emotional attunement, conveying the caregiver's profound acceptance as well as delight in the very beingness of the child. Idealization is the response of the child to a caregiver who is reliable and provides safety, security, and support. Twinship gives the child a sense of participation by experiencing feelings of being similar to others and sharing a common purpose. As the child expands social contact outside the nuclear family into the broader human community, he or she experiments with social roles and group identifications as an expression of the twinship response. The internal experience of inclusion and belonging—whether to a sports team, church group, or street gang—is what defines twinship.

When these innate developmental needs are empathically recognized and consistently met by loving caregivers, the child is stabilized and validated. If the caregiver's response does not match the need or there is no response, the child feels bereft, deficient, and/or abandoned.

"I'm OK": The Self-object Experience

When connecting with an empathic response, a child does not experience the caregiver as an entirely separate person. The caregiver's role is primarily to satisfy the child's need for love, comfort, security, etc., without the caregiver's own needs clouding his or her response to the child. This is considered a self-object experience for the child. It is the caregiver's function in relation to the child, not the caregiver's autonomous self, that creates the self-object experience and helps build the child's internal self-structure.

This experience is more like a chord of blended tones than single notes. When the chord is harmonious, it resonates with the child's interior being and, if echoed over many measures, stimulates a reverberating capacity for self-regulation and internal motivation. On the other hand, if the caregiver's capacity to provide empathic mirroring, idealizing, and opportunities for twinship is diminished or nonexistent, the growing child may well respond by feeling bad, insufficient, or unlovable.

Kohut's theory suggests that in this kind of situation, the child will attempt to compensate for an unconsciously experienced lack of affirmation by trying to be perfect, cute, and bright, or defiant and bad. This attempt to "fix" the insult reflects the child's perception that something is wrong with him or her. The child unconsciously believes that the lack of mirroring, idealizing, or twinship responses is caused by his or her inadequacy.

However, the defensive effort involved in this "fix" may intensify and/or cement the growing child's grandiose, exhibitionistic self (Kohut's technical term for the unbridled, immature self), derailing the healthy maturational processes. The child may lose his or her healthy potential to develop an authenticity that balances self-assertive goals, purposes, and ambitions with certain idealized values expressed within the human community. Each of us develops one or more of these idealized values, some of them considered healthy (e.g., integrity, dedication, loyalty) and others considered unhealthy and unproductive (e.g., exploitation, authoritarianism,

adultery) since they lead to destructive consequences for both the individual and society. Balancing these values against our self-assertive goals will determine, for example, whether we buy votes if we run for office, or whether we overindulge in material desires without feeling we ever have enough.

Developing a Sense of Self

When empathic attunement is "good enough" (there is no such thing as perfect attunement), the child's need for self-objects diminishes as he or she develops the ability to sustain well-being, maintain resilience, and stimulate growth. A healthily maturing child creates ways to calm the self when upset or overstimulated, and grows from unrealistic demands for perfection and constant attention into self-confidence and a desire for occasional, thoughtful appreciation and praise. The need for self-objects never completely disappears.

In self-psychological theory, evolving and maintaining a sense of self is viewed as an innate motivational need that functions to create the internal psychological structures needed to preserve personal identity and constructive striving. This need is not just primary but superordinate, meaning it is a more powerful motivator than the sexual and aggressive drives as postulated by Freud. A sense of self is what we mean by "I" when we say, "I feel such and such," or "I do so and so." It is what we recognize and identify as who and what we are that gives joy, cohesion, and vitality.

After Kohut's death in 1971, self-psychology continued to develop with Stolorow, Atwood, and Brandchaft's work on intersubjectivity—the sharing of subjective states between individuals and the psychological energy moving between them (Stolorow et al. 1994). Their theoretical constructs are derived from clinical practice, working directly with clients. This clinical work has been substantiated and expanded by the research of Beebe and Lachmann (2002); Lichtenberg (1983); Stern (1985); Ainsworth (1989); Schore (2002). To consider how Paul's upbringing may have affected his developmental needs and maturational process from a self-psychological perspective, it is interesting to review how he described his background to the therapist.

Case Study: Part II

Paul's Background

Paul grew up as the only child in a stressed household. Looking back on his youth, he does not recall any experiences that helped him build a bond with his father or reflected physical or emotional nurturing from his mother. In fact, he rarely received direct attention from his parents, who regarded him at best as a nuisance. As a 2-year-old, he was once found wandering the neighborhood dressed only in

underwear, cowboy hat, and holster. A neighbor returned him to his apparently unconcerned mother. Fights about money became the central family dynamic. When he was 14 years old, his parents finally divorced.

Paul describes his father, Richard, as irresponsible, amoral, and unprincipled enough to lay claim to and take the money Paul had been given for his Bar Mitzvah. Working at Richard's advertising firm during his adolescent years, he experienced his father as intensely competitive and critical of Paul's growing sense of competency. For example, Richard discouraged his son's desire to pursue a career in art, despite Paul's artistic talent. Paul also complains that his father deducted US$ 50 from his US$ 200 weekly salary, but never paid the payroll taxes for which the deduction was intended.

Paul views himself as the victim of these miserly family dynamics. He says he feels resentment, but it is hard for him to experience his negative emotional states without shutting down or numbing himself to avoid emotional pain. Instead, he is prone to expressing negative feeling by getting into his car and driving nowhere for hours, or holding an unloaded gun and staring at a blank wall. His tendency to numb his feelings makes it difficult for him to process and work through emotional difficulties, particularly his money issues.

Early in his individual therapy, it became clear that Paul's behaviors and attitudes toward money needed to become a critical part of the therapeutic dialogue. During good times, his impulsivity and lack of financial planning put him at risk. During bad times, his stress was compounded by worry about his growing indebtedness and the consequent feeling that "people own me." In fact, paying for therapy became a therapeutic issue. The therapist agreed to accept partial payment for individual sessions. After a year of individual sessions, Paul joined a therapy group, in part to minimize his growing therapy bill.

In self-psychology, a therapist's personality and presence are key to the therapeutic process (Kohut 1971).

Theoretical Considerations: Part II

The Therapist's Vital Role

In self-psychology, a therapist's personality and presence are key to the therapeutic process (Kohut 1971). Kohut maintained that the therapist has three main functions: (a) to understand clients' emotional experience of themselves within the intersubjective field (i.e., how the client reacts to the therapist and how the therapist responds to the client), (b) to clarify the client–therapist communication, and (c) to interpret the meaning of this communication in a way Kohut called "experience-near" (in contrast to the objective, detached stance originally dictated by Freudian theory).

Stolorow et al. (1994) and the "intersubjectivists" go even farther than Kohut, asserting that individuals in the intersubjective surround are constantly influencing each other and cocreating their experience of each other. The child influences the caregiver, just as the caregiver influences the child. Stolorow et al. believes that along with processing a client's self-object needs, therapists should be prepared to analyze repetitive and conflictual elements of the intersubjective experience. In Paul's case, his father repeatedly undermined his competency and devalued his achievements when Paul was younger, instead of being empathic and encouraging. Paul has internalized this childhood pattern and it is manifest now in his behavior as an adult. Unconsciously "hearing" his father's response to him, he sabotages his own opportunities for success.

As the Twig is Bent…

When certain behaviors keep repeating themselves because the tie with an early caregiver still grips the client's psyche and behavior, therapy must address what Stolorow calls invariant organizing principles (Stolorow et al. 1994). These organizing principles are embedded in early childhood when the self is being formed. Over time, ideas about oneself that are unconsciously absorbed in childhood evolve into self-perceptions like "I 'm good, strong and healthy" or "I can't do anything right; I 'm worthless" and become the content of the invariant organizing principles.

For example, suppose you go to a meeting and the person next to you starts talking to someone else. You might think, "Oh, he chose not to talk to me because he saw I wasn't worth speaking to." Or you could think, "Thank God he didn't talk to me; I'd be bored out of my mind." Or you might not even notice that the person chose to talk to someone else.

In the first instance, your underlying belief might be something like "I'm worthless, stupid, and invisible." In the second, the unconscious organizing principle might be "I'm special, superior, and above needing anything from other people." The third type of response might indicate a positive belief or principle like "I'm a good, valuable person and feel comfortable in my own skin." In this self-talk, you will have not just experienced your invariant organizing principles, you will have reinforced and strengthened them, which could be viewed as a way of being in the world. These principles may be completely unconscious and hidden from awareness, but often they are merely pre-reflective, in that we can become aware of them if we take time to reflect.

Whether unconscious or pre-reflective, the client's invariant organizing principles must be brought to consciousness before any change in feelings or behavior can be expected.

As we have discussed, in a therapeutic dyad, the client and therapist become an intersubjective system with both members influencing their cocreated, unique context. Growth occurs when dialogue between the two succeeds in resolving the patterns that derive from the client's self-object needs (mirroring, idealizing, and twinship) and repetitive conflictual experiences (for example, Paul's pattern of self-sabotage derived from his unempathic childhood experiences with his father). The effectiveness of these dialogues is determined not only by what the client brings to the sessions but also by how the therapist reacts to the content and the nonverbal messages that surround it. Whether unconscious or pre-reflective, the client's invariant organizing principles must be brought to consciousness before any change in feelings or behavior can be expected.

The "Self-righting" Self

When an individual's sense of self is healthy and there is consistency and clarity in formative patterns of experience and behavior, a person can internally regulate self-esteem, calm or invigorate his or herself, and feel connected to and part of the human community even in circumstances of extreme stress. As a consequence of these effective internal structures, others may be needed to serve as self-objects in only a mature, limited way. On the other hand, a person whose sense of self is weak or poorly integrated will rely heavily on responses from others in attempts to avoid the unbearable experience of fragmentation, depletion, and depression.

Paul, for example, appears to have an engaging, outgoing personality. Inclusive and collaborative, he creates enthusiasm and fun when he interacts with others. Yet, when it was suggested that he take some time to himself to think through his past experiences and current options, he refused. Being alone, he said, makes him feel depressed, overwhelmed, and unable to cope. When he experiences his good qualities through the eyes of Marty, his girlfriend, she becomes a "good mirror"; when he experiences his negative qualities through the eyes of Karen, his wife, she becomes a "bad mirror." By keeping persistent tension between these good and bad mirrors, he lives in constant psychic turmoil that helps him avoid underlying feelings of depletion, depression, and self-loathing that surface when he is alone. From Paul's perspective, he is doing the best he can with what he has, though he is clearly not in healthy balance with himself.

Damage to the Sense of Self

Healthy narcissism is an important concept Kohut developed relatively late in building the foundation of self-psychology. He argued that wisdom, humor, and creativity emerge from the tension of maintaining balance between intact immature narcissism (such as overreliance on affirmation from others, entitlement, diminished empathy for others) and chosen idealized values that are affirming and

constructive for the self and others (Kohut 1985). In the best of cases, both poles contribute to a coherent sense of self even when apparent contradictions increase the tension between them. However, when early development has been disrupted by trauma or parental and environmental self-object failure, Kohut maintains that individuals are more vulnerable to losing a cohesive sense of self, and consequently may compromise their efforts to achieve a more mature sense of self.

> …when early development has been disrupted by trauma … individuals are more vulnerable to losing a cohesive sense of self…

In self-psychological, the symptoms of a poorly integrated sense of self are viewed as a best effort to maintain or restore internal cohesion and harmony, in line with the belief that all of us have an innate “self-righting” tendency to strive for health. Behaviors that appear to be shortsighted or even overtly self-destructive are seen as a client’s persistent efforts to achieve stabilization until genuine nondefensive repair can occur (Baker and Baker 1987). For example, Paul’s striving for money and the power he ascribes to it, his efforts to build a profitable business, and his search for sustaining affirmation from Karen, Marty, and his children are efforts to find internal cohesion, balance, and growth. These efforts misfire, however, because he is unable to adequately reflect upon and regulate his confused and often contradictory internal affect states, beliefs, and cognitions.

As we strive to build a cohesive sense of self over time, certain desires or behaviors may be unconsciously censored because we never received an empathic and attuned response to them from important others. Consider, for example, a 5-year-old girl excitedly telling her father that the candy she bought for 10 cents and sold to her friends for 5 cents made her a good businessperson, “just like you, Dad.” The father looks at her with a frown and says in a tone of disgust, “You’ve got a lot to learn, kiddo!” The father’s lack of mirroring makes it difficult for the daughter to feel proud of herself.

> Psychotherapy within a self-psychological theoretical framework has three defined objectives (Kohut 1984; Stolorow et al. 1994): (a) to develop understanding of early failures in meeting developmental needs, (b) to recognize and respect the individual’s efforts toward self-protection, and (c) to provide a secure alliance that facilitates growth of an authentic self.

With such negative, deflating responses lodged in this child’s unconscious, her later entrepreneurial strivings may well be repressed as she strives for what Stolorow et al. (1994) terms self-delineation. In her efforts to find a meaningful path in life and further define herself, she may exclude a career in entrepreneurism because it will be a path that remains unconscious. If she gains more insight into her past, she may be able to revive her entrepreneurial wishes and “re-delineate” her growing sense of self.

Theoretical Considerations: Part III

How Therapy Can Help Heal the Self

Clearly, Paul's picture is a complicated one, combining external financial dysfunction with many conflicting emotions. Simple money coaching will not be enough to lead to healing.

By focusing on the unconscious and the complexity of childhood development gone awry, the self- psychology approach offers the potential for healing. Psychotherapy within a self-psychological theoretical framework has three defined objectives (Kohut 1984; Stolorow et al. 1994): (a) to develop understanding of early failures in meeting developmental needs, (b) to recognize and respect the individual's efforts toward self-protection, and (c) to provide a secure alliance that facilitates growth of an authentic self.

In conjunction with the specialized nature of therapy, the skills, talents, and knowledge of the clinician present a unique opportunity—one rarely available in other relationships and settings—to explore both intrapsychic and interpersonal dynamics as they become identifiable in the therapeutic dialogue ("intrapsychic" dynamics pertain to a person's internal psychological processes; "interpersonal" refers to behavioral patterns and emotional interdependence between and among people). The therapist serves as a self-object with the goal of resuming the thwarted developmental process by providing empathy, safety, attunement, clarification, interpretation, and mutually experienced insight and growth.

Inevitably, the therapist at times will fail to be sufficiently attuned and empathic. The client may perceive these failures as seriously disrupting the developmentally essential self-object tie to the therapist. But, if the disruptions are discussed and understood by both individuals, the self-object relationship will be restored and the therapeutic engagement continued. This process of clarification, disruption, and repair ends in transmuting internalization—Kohut's term for absorbing what a person psychically needs (in this case, from the therapist), just as our body absorbs necessary nutrients from food and discards what it doesn't need. In this dialectic lies our potential to change our invariant organizing principles, promoting growth toward authenticity, and emotional maturity.

The Importance of Organizing Principles

Paul is organized around the idea that he is worthless and bad. When stressed, he falls back into this way of thinking. It has become his way of making meaning out of his world.

Meaning-making systems, according to self-psychology, are based on the organizing principles that can be identified in our self-talk about the kind of person each of us imagines our self to be and our expectations of what we will experience in the

world. These assumptions serve as shortcuts to establish our expectations for ourselves as well as others, and to interpret our "here and now" perceptions. According to self- psychology, we do not treat these organizing principles as hypotheses to be proven or disproven, but rather operate with them as our reality. In this way our organizing structure influences, if not creates, our reality.

While everyone's ways of coming to terms with life have roots in the earliest interactions of their infancy, organizing principles are regularly reformulated in response to new intersubjective experiences. The ways we understand the past also change because of opportunities offered by cognitive development. This is part of normal life. Some elements of the past, particularly when they are traumatic, seem impervious to change. In essence, they are so powerful that they prevent people from even noticing that life offers new possibilities, as in Paul's case. In some circumstances, of course, life is filled with ongoing trauma, allowing few opportunities to restructure one's organizing principles.

> Some organizing principles can be shortsighted, rigidly held, and counterproductive, producing actions and beliefs that lead to unwanted consequences.

The point is that while we think we perceive the world as it is, we have no way to structure our internal experience other than by using our many organizing principles—principles we have formulated over the years that combine our biology with what we have already learned, our current relationships, and events we immediately observe. "The measuring device has been constructed by the observer," as Werner Heisenberg (1985, p. 58), the father of quantum mechanics put it, "… and we have to remember that what we observe is not nature in itself but nature exposed to our method of questioning."

Some organizing principles can be shortsighted, rigidly held, and counterproductive, producing actions and beliefs that lead to unwanted consequences. This was certainly the case with Paul. While we may perceive these nongrowthful patterns as primitive or immature, they are usually the person's best effort to maintain, restore, or repair their self-structure. When the therapist empathically recognizes this best effort as a first step, clients often come to reflect and then experience (because they feel understood and supported) that their way isn't working effectively. This awareness facilitates their active search for new ways to organize their experience. In other words, they begin to develop flexibility and thus the potential for generating new organizing principles that will lead to more effective ways of interacting with others and viewing themselves. For Paul, an understanding of his apparent need to try to please his children, ignore his wife's needs, and bask in Marty's affirmations helps him begin to process how untenable his situation is in the long term.

Now that we have reviewed the core elements of self-psychology,we return to Paul to see how self-psychology can illuminate the dynamics underlying his financial behaviors.

Case Study: Part III

The Therapist's Analysis

Paul's profligate spending and financial reality, combined with his difficulty in reflecting on the motivations behind it and other unhealthy behavior, made him a promising candidate for group therapy. In a group, he could be supported and challenged directly, while maintaining a therapeutic alliance with his therapist (Baker 1993). Paul's personal charm and intelligence contributed to a warm reception by the group, and he responded well to other members who both supported and challenged him.

In beginning Paul's financial therapy, the therapist's approach was to "follow the money trail," exploring how Paul experiences his relationship to money ("I'm a victim"; "I'm owned by whom I owe"), what he actually does with it, and the emotions, attitudes, and beliefs that are woven into his subjective and objective experience of money. For instance, Paul's therapist asked him to write down his monthly expenses and income. When they went over the list together, he became defensive, angry, and overwhelmed. The emotions and associations generated by the list became fodder for the several therapy sessions.

As mentioned earlier, Paul had become gravely overextended in his financial life. Although he has many qualities that could lead to conventional success, he is so prone to self-sabotage that his prospects for breaking even (much less coming out ahead) seem remote. Research suggests that a person's relationship to money is usually established in early childhood (Matthews 1991; Mumford and Weeks 2003). Paul is no exception, though his vivid memories around money begin in early adolescence. He describes himself as an industrious boy who was capable of providing for his own basic needs. There is no indication in his story that this resourcefulness brought him satisfaction or validation. Rather, there is an undercurrent of resentment that neither parent took an interest in him, so he had to fend for himself.

The narrative of his upbringing indicates later aspirational conflicts. He portrays his father as unscrupulous, competitive with his own son, and interested in money to ensure his personal freedom of choice, not his family's security. Paul's characterization of his mother is sympathetic, although this sympathy diminishes as he describes her dependency and seductiveness, rancor, and recriminations. He does say that he emulates her "pride in earning money," but he does not reflect on the source of her pride or consider how she used the money. Apparently no external influence, whether parental or outside the family, has given Paul a sense of conscientious money management. In other words, he is locked into and "owned" by the unprocessed repetitive conflicts of his childhood and the old negative organizing principles that tell him he is worthless, inept, and needy.

> …self-psychology theorizes that mirroring, idealization, and twinship are essential components of development.

Part of Paul's internalized image of his parents is derived from envying his father's freewheeling autonomy and resisting his mother's dependency, which encourage him to aim for freedom from responsibility and to settle for power without respect or accountability. Antithetically, he also aspires to be the parent for his children that he himself never had.

As mentioned, self-psychology theorizes that mirroring, idealization, and twinship are essential components of development. Although these processes work together, mirroring is particularly important in the development of resilience, efficacy, and fortitude, while idealization gives shape to a person's character, evidenced in the best of circumstances by such personal virtues as authenticity, self-discipline, and gratitude. The lack of mirroring (expressed appreciation for his talents) and negative process of idealization in his formative years have left Paul, even in his 50s, feeling as if he is not "enough" and will never have "enough." Consequently, he has created a vicious cycle around money in the unconscious assumption that it will validate his worth and solve his problems. In other words, money is expected to be the self-object that neither of his parents adequately provided. Although he is angered by perceived deficiencies in his childhood and wants to be different from his parents, he is vulnerable to reenacting those early experiences because of his conviction that he is incompetent, undeserving, and an "owned victim," coupled with a belief that money will transform him into a man worthy of admiration and respect.

Paul's children, whom he wishes to protect and parent, are also adversely impacted. They benefit from their father's appreciation (mirroring) only when Paul engages with them in carefree play. They suffer from his inability to give them an opportunity for constructive idealization, since the values Paul espouses are directly opposed to those embedded in his life. It's the classic contradiction: "Do as I say, not as I do."

Effective intervention is, of course, multifaceted. There is certainly restorative potential in a therapeutic relationship that involves the crucial caregiving elements highlighted in our earlier discussion of self-psychology, which were missing in Paul's development. Helping him reenvision his dysfunctional subjective experiences of money can deepen and accelerate the therapeutic process, potentially bringing more productivity and less stress into his financial life.

Lyons' (2013) qualitative research study identified coping strategies commonly adopted in response to discomfort generated by money issues. Two of the unproductive responses are avoidance and intensification of characteristic attitudes and behaviors. Avoidance is likely based on the hope that evolving circumstances will alter the financial facts. Continued intensification is an attempt to resolve problems and salve the distressed emotional state by emphasizing esteem-building values.

Paul's behavior incorporates both of these strategies, which predictably only exacerbate his existing problems. His avoidance of money issues is evident in the distractions of an extramarital affair, his pursuit of photography, and his literal abandonment of income-producing opportunities while tending to his aunt. Although these behaviors help Paul feel appreciated, any potential financial satisfaction is compromised by his conflicting motivations.

His behavior also exemplifies the second ineffective strategy identified by Lyons (2013): exaggerating characteristic attitudes and behaviors in order to cope with financial pain. Paul increases his natural ability to charm and impress others by making himself look good; attended by an adoring and very attractive younger woman as well as a faithful wife, and showing devotion to his aging aunt. Similarly, he escalates his deal-chasing behavior in business, concentrating on widening his circle of associates instead of following up on the deals he makes or managing his cash flow. His ability to wheel and deal, and generate income is his greatest source of pride.

The viciousness of this cycle is reinforced by Paul's conviction that the ability to charm and impress others constitutes his full worth. He needs both money and adulation, but he never gets enough of either because of his internal dysregulation and consequent external mismanagement. For example, he has little internal ability to soothe himself when frustrated or to exercise self-discipline when faced with onerous tasks. Externally, we see him pursuing impulsive, short-term solutions that create more stress and problems, relying on avoidance and an escalation of his existing dysfunctional behaviors.

Using the theory of invariant organizing principles developed by Stolorow et al. (1994), we can surmise from this glimpse into Paul's life that his focus on money as a vehicle for security, status, and success gives him periodic reprieves from despair. His repeated plunges into gloom as the financial and psychic "high" of a new deal ebbs merely reinforce his conviction that each succeeding deal will turn the tide.

Interestingly, Paul reflects on any influx of cash as his only fleeting moment of peace. "Money [as] the root of happiness is not a myth," he wrote, "because if I owed money to myself instead of others, I would be whole." While we can rationally categorize his coping strategies as bogus and perceive the flawed assumptions underlying his organizing principles, these are essential survival mechanisms for Paul's "immature child within."

Lyons (2013) substantiated core values attributed to money, some of which have been commonly assumed, such as money-symbolizing power, security, love, or freedom. Other operant values supported by her research were competence, honor, and transformation. Each of these symbols is understood to incorporate positive and negative interpretation as well as functional and dysfunctional utility. Paul's case demonstrates how people generally attribute some combination of these values to money but specifically experience one above the others as the defining symbol. Paul has stated in his therapy, "It [money] is the freedom … makes me feel powerful … like I am in control. It is also a measure of success." His distorted belief that money is a transformative force is ultimately the defining value that establishes his relationship to it.

Each of the core values identified by Lyons (2013) has an inherent continuum ranging from destructive to constructive. At the dysfunctional end of the trans formational spectrum, money is viewed as either malevolent (likely to corrupt and bring unhappiness) or, as in Paul's belief system, redemptive (able to liberate, glorify, and create happiness). Paul claims that money represents freedom and power, and alludes to a perceived connection with competency or, in his words, with "success." However, his behaviors are animated by an underlying belief that

money is inherently magical and will change his life, solve all problems, and prove his worth, when in fact his experience is just the opposite. His conviction that he will never have quite "enough" renders him powerless, confused, and deflated in the pursuit of success.

On the positive end of the transformational spectrum, legitimate hope, opportunity, and relief can be realized. This phenomenon has been identified as regenerative engagement with a person's relationship to money (Lyons 2013). Pain and fear in the relationship to money, as Paul has been experiencing, were shown to occur when a person's orientation to money resulted in a perception of insufficiency or a dissonance between needs and desires, aspirations and ambitions. This is the dialectic described by Kohut (1977) in his exposition of mature narcissism.

Although Paul's ability to charm others inflates his sense of self, it is never enough to fill his hidden abyss of self-perceived inadequacy or unworthiness. He rejects the model of his disreputable father and aspires to be a man of substance, yet he repeatedly succumbs to self-indulgence, evades responsibility, and seeks immediate gratification. His behavior is that of a man stuck in adolescent self-absorption, unwilling to fully confront life's challenges and therefore unable to grow beyond childhood pain and want.

These painful circumstances could propel Paul into the discomfort of his interior dissonance where, with the support of validating psychotherapy, he may find the courage to grapple with the polarities that are tearing apart his life. Only by delving into the dissonance and meeting the challenge of seeking resolution will he find relief, gain self-mastery, reduce his shame and desperation, and discover new opportunities.

His decision to get a divorce, rather than passively forcing either Karen or Marty to leave him, is a huge step forward in being accountable for himself. He has also taken steps to grapple with his financial mismanagement and indebtedness. As a work partner, Marty complements his strengths, unlike Karen who has many of the same weaknesses that he has. Finally, Paul has accepted that going back home "for the children's sake" will only continue to create pain for them and for Karen, and will prevent her from moving on with her life.

Outcomes

As identified above, psychotherapy from a self-psychological perspective has three objectives (Kohut 1984; Stolorow et al. 1994): (a) to develop an understanding of early failures in meeting developmental needs, (b) to recognize and respect the individual's efforts towards self-protection, and (c) to provide a secure alliance that facilitates growth of an authentic self.

Were these objectives met in Paul's case? Certainly Paul has an understanding of where and how his needs were not met early in life. However, this understanding has just begun to help him reflect and thus change the content of his organizing principles from a worthless, neglected "owned" victim to a sense of himself as worthy, capable, and responsible.

> Financial therapy is an emerging field integrating therapeutic technique with an understanding of the role and meaning of money.

Second, the group therapy intervention and his therapeutic alliance in the group has challenged his self-sabotaging behavior while providing the support he needed, allowing him to relax his need for self-protection and, by growing more vulnerable, to become more open to change.

Third, a deeply felt alliance with the group members and his therapist helped Paul decide to make his life with a woman who helped him feel safe and understood while complementing his own business skills. This choice did not rid him of guilt in hurting his wife and children, but gave him the fortitude to bear it without paralysis.

Paul's progress toward a positive sense of self and authenticity is clearly not finished. Unlike the precise, static world of numbers and facts, human development and growth is a multi-layered, messy, and ongoing dynamic process. It is our belief that with sustained effort and continued engagement in treatment, Paul will become not only a more responsible money manager but also a fuller and more self-confident human being.

Ethical Considerations

Financial therapy is an emerging field integrating therapeutic technique with an understanding of the role and meaning of money. Competence in self-psychological theory and technique as well as familiarity with the workings of money—both external (investing, budgets, saving) and internal (beliefs, attitudes, emotions, and personal meaning)—are the basic ethical foundation to which practitioners must adhere. Since there is as of yet no standard licensing criteria for the designation of financial therapist, we early practitioners must be particularly conscious about self-monitoring and vigilance in our practice, and seek supervision when we lose focus or become personally reactive to a client.

Self-psychology's approach is based on empathy and its communication to the client, and a working-through of intense, affective reactions within the client and between the client and therapist. With money as a stated core issue to resolve, the opportunity to be exposed to great ideas, great ambition and entrepreneurial enterprises may make it easy for a therapist to be seduced by a client's grand designs. It is also easy for a client to interpret a therapist's empathic response as agreement. Staying within the bounds of the therapist's value system and training, and having the therapeutic skill to track the impact of empathic responses on the client, are critical ethical standards.

It is also ethically important for the therapist to recognize his or her own professional limitations. Some, but by no means all, financial therapists are also trained

financial planners. In this case, the problems of dual relationships and responsibilities may become acute. While this can enable the therapist to make more suitable financial suggestions, the client's goals may become inappropriately entangled with the therapist's financial biases. Additionally, the therapist may become privy to specific business information and be tempted to use it in making personal investments, which is both unethical and illegal.

Dual or multiple relationship issues are also an ethical concern. Paul met his therapist at a networking event. By the time he entered therapy, the therapist was no longer a member of the networking group. Had the therapist stayed in the group, it would have constituted a dual relationship that could easily become destructive to both Paul and the rest of the group. In addition, Paul had some couples sessions with his wife while in group psychotherapy, which also created a dual relationship. The therapist judged that being in couples therapy and group at the same time was productive (Bleiberg and Baker 2008).

…self -psychology, with its emphasis on understanding and creating a therapeutic bond, is particularly suited to working with money issues.

Finally, getting written permission from clients to publish their material and disguising it sufficiently is an ethical responsibility for all practitioners. In Paul's case, he was delighted to be used as a case study because it made him feel special and important. It is the therapist's responsibility to protect a client like this from his own eagerness.

Future Directions

Financial therapy often involves dealing with deeply embedded shame-based, self-destructive behavior. For that reason, self-psychology, with its emphasis on understanding and creating a therapeutic bond, is particularly suited to working with money issues. Furthermore, it is a premise of self-psychology—as well as other psychodynamic approaches to psychotherapy—that understanding, reflection, and insight are essential keys to transformational and lasting change. Could Paul or others emerge from entrenched dysfunction or complex emotionality around money simply by being coached toward improved financial practices? Would following a focused intervention strategy of addressing a person's thoughts and behaviors around money alone be enough to positively infuse other areas of life? Will Paul's increasing consciousness and the resulting correction of his money-related dynamics translate into improving his capacity for wholeness in relationships as well? These are questions that research could help explicate.

Because communication about money is such a charged topic, particularly when there is money dysfunction, it can be fraught with emotional difficulties. Since most

people have to deal with financial matters in a marriage or partner relationship, understanding and developing strategies to enhance clear, accurate, and meaningful communication about money within the couple is an important area of research.

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Chapter 19
Humanistic Approaches to Financial Therapy

L. Martin Johnson and Kelly H. Takasawan

Introduction

Money disorders are a relatively new set of behavioral disturbances to be considered for psychological treatment. The Diagnostic and Statistical Manual of Mental Disorders (DSM) has never had a section dedicated to money disorders, and with the exceptions of gambling disorder and hoarding disorder, none of them are included as formal diagnoses. Recent research has attempted to classify and differentiate different money disorders (Klontz et al. 2012; Klontz and Britt 2012), and psychotherapy outcome research suggests that money disorders may be amenable to treatment (Klontz et al. 2008). Although the conceptualization of money disorders as being a result of "money scripts" (Klontz and Britt 2012) may lend to a more cognitive approach to therapy, they can also be viewed more holistically as a personal incongruence. In humanistic psychotherapy, mental disorders are viewed as an incongruence within the person. This incongruence can be cognitive, behavioral, or emotional, and may involve all three aspects. While a humanistic psychotherapist may view the incongruence in a wider context, it is a useful construct for conceptualizing a humanistic approach to understanding and treating money disorders. Consider the following case example:

Jennifer is a 23-year-old single female who recently started as an assistant account executive in a prominent advertising agency, a high status position with a low pay scale. She is intelligent, attractive, has a college degree, and is looking forward to a bright career in marketing. She recently started dating Mitch, and as the relationship is becoming more serious, she is nervous about telling Mitch about her US$ 8400 credit card debt. Most of this debt is the result of her buying new clothing and jewelry and putting a down payment on a nice car, all of which she views as a necessary part of being a young ad executive. However, if Jennifer were to take

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an objective view of her financial situation, she would find that she is consistently spending beyond her means.

Humanistic psychology has been called the “Third Force” in psychology and was developed in the 1950s and 1960s as an alternative to the prevailing therapeutic schools of Freudian psychodynamics and Watson’s behaviorism.

Jennifer grew up in a relatively affluent family and became accustomed to getting whatever she desired. As part of their jobs, both parents frequently went on business trips, and would bring home expensive gifts for Jennifer.

Jennifer arrived for therapy after an argument she had with Mitch about cheap tickets he purchased to a concert she had been looking forward to. The tickets were a surprise gift for Jennifer’s birthday and she was disappointed and hurt by what she perceived to be his lack of caring. When she voiced this, he became angry and defensive stating that she was unappreciative. Jennifer was completely shocked and confused by the intensity of the argument that ensued. After the argument, she went out and bought a new pair of boots, two pairs of pants, and US$ 250 worth of makeup on her credit card, which she periodically does to make herself feel better.

After a brief interview, it was obvious to the therapist that part of Jennifer’s problem was her compulsive buying behavior. Jennifer and her therapy will be revisited as different aspects of humanistic psychotherapy are explored throughout the chapter. First, a brief overview of the humanistic approach to psychotherapy and its evidence base will be provided. Then the most common humanistic therapies will be presented with a discussion on how each might be applied to financial therapy and Jennifer’s case.

For the humanist, therapy entails self-exploration, self-expression, and self-mastery and seeks to enable clients to move towards independence, greater self-trust, and greater trust in one’s relationship to others and the environment.

Overview and Definition of Humanistic Psychotherapy

Humanistic psychology has been called the “third force” in psychology and was developed in the 1950s and 1960s as an alternative to the prevailing therapeutic schools of Freudian psychodynamics and Watson’s behaviorism. While there were many contributors to the development of humanistic theory, the development of humanistic psychotherapy itself is largely credited to Carl Rogers (1946, 1951) and Abraham Maslow (1954, 1971). The humanistic approach asserts that human beings are intrinsically good, are innately prone towards growth, and are best understood

when viewed as a dynamic whole instead of the sum of reductionistic parts. Rather than focusing on psychopathology, humanistic psychotherapies focus on the health and potential of the individual, as well as whatever incongruence may exist that thwarts the person's natural growth tendency. Individuals are viewed as resilient and self-determining with the very human need to make sense of their experiences, while seeking meaning, purpose, and a sense of belonging. As such, humanistic psychology recognizes the uniqueness of each person and the manner in which each individual constructs his/her reality. This approach acknowledges that people build meaning based on these constructs as they strive towards a greater understanding of who they are in the world.

The foundational premise of the humanistic approach is that people are self-actualizing and have an inherent tendency towards growth, even in the most adverse situations. We have a powerfully innate impulse to maintain our sense of self and fully develop our potential. We have the capacity to utilize our internal experiences and external resources to grow, and it is the therapist's job to have faith in this inherent growth potential and to assist in removing obstacles of incongruence that impede such growth. The famous psychoanalyst Karen Horney understood this process and wrote that like the acorn that cannot help but grow into the mighty oak tree, human beings have intrinsic potentialities that they cannot help but grow into (Horney 1950). Once obstacles are removed, this built-in propensity towards growth and self-realization results in a mature, fully realized individual, otherwise known as an emotionally well-balanced person.

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For the humanist, therapy entails self-exploration, self-expression, and self-mastery and seeks to enable clients to move towards independence, greater self-trust, and greater trust in one's relationship to others and the environment. Through this process, the individual learns to depend on their personal abilities and their own sense of agency, or capacity to create change in their own lives, and subsequently moves through boundaries that previously blocked the natural growth tendency.

The heart of humanistic therapy is providing an environment that is defined by having empathy, authenticity, and positive regard for the client. These are the necessary and sufficient conditions for therapeutic change and growth. Maintaining these conditions within the therapeutic relationship results in a safe environment that provides the climate in which a client is able to move toward self-understanding and growth. A humanistic therapist is confident in the knowledge that, provided with these necessary and sufficient conditions, the person in their care will naturally begin to surface whatever incongruence may exist within them. As these areas of personal incongruence arise, the therapist and client work together to explore and work through the issue until it is resolved into a greater sense of wholeness.

According to Cain (2006), “People promote growth in others by the manner of their relating” (p. 5). In this process, the therapist attempts to understand the client’s world and their experiencing of it from the client’s point of view. The therapist then communicates these experiences back to the client. This process allows the client to “decipher the unclear aspects of their feeling states,” leading to clarity in their motivations, desires, and needs (Cain 2006, p. 9). The experience of feeling acknowledged, valued, and supported, allows for further personal exploration and understanding that is a necessary component of the growth process. The goals of humanistic therapy are to understand how individuals perceive themselves in the here and now and to move towards self-actualization through developing internal congruence (i.e., harmony or agreement).

Humanistic Psychotherapy Outcome Research

Carl Rogers, a humanist and the father of person-centered therapy (PCT), was one of the first to study the process and outcome of psychotherapy. He was interested in finding out what worked in therapy—in other words, what made for successful therapeutic outcomes. He created some of the earliest controlled studies of therapy outcome and helped begin a tradition of therapy outcome research in psychology (Rogers 1942; Rogers and Dymond 1954; Rogers 1957).

Meta-analyses of 127 studies from different countries and across a variety of medical settings found that all experiential therapies, including client-centered therapy, are effective and that when compared, all therapies are equivalent in effectiveness (Greenberg et al. 1994). Furthermore, outcome research overwhelmingly suggests that therapeutic technique does not determine treatment success. More important than technique, is the therapeutic relationship, and the therapist’s ability to stimulate client resources and the self-healing process (Hubble et al. 1999; Lambert and Barley 2001). In their research summary of 100 psychotherapy outcome studies, Lambert and Barley (2001) state that the “…development and maintenance of the therapeutic relationship is a primary curative component of therapy and that the relationship provides the context in which specific techniques exert their influence” (p. 359).

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In terms of humanistic-oriented financial therapy, only one study is available in the literature. In a clinical trial, Klontz et al. (2008) observed positive psychological

and financial outcomes in 33 clients who participated in a financial therapy approach they described as "an integration of experiential therapy and financial planning concepts" (p. 298). Experiential therapy was "the core treatment modality" in the Klontz et al. study (2008, p. 298), and experiential therapy is grounded in humanistic-existential theory (Mahrer 1983; Klontz et al. 2001). While much more research needs to be done in the area of humanistic financial therapies, clearly, there is a significant body of research that establishes humanistic psychotherapy as an evidence-based treatment.

Common Factors

In an attempt to determine what makes for effective psychotherapy and whether one modality of therapy reigns supreme, many quantitative studies have been conducted (Cooper 2008). The majority of these studies yield the puzzling finding known as the equivalence paradox—finding that different therapeutic modalities are, as an approximation, equally effective. What has, instead, been found in the growing body of evidence-based research on therapeutic outcome is that there are common factors across treatment modalities that account for successful therapy. In order of impact, these common factors include client or extratherapeutic factors, therapeutic alliance, hope and expectancy, and models and techniques (Hubble et al. 1999).

Originated by Rosenzweig in 1936, the common factors notion has most recently been further elaborated upon by Hubble et al. (1999), and Wampold (2010). The purpose behind the finding of these common factors is the importance of determining what works in psychotherapy. What was found along the way is that there are some therapists who are more effective than others (Lutz et al. 2007; Wampold and Brown 2005). Therapists who form better alliances have better treatment outcomes and variability in therapist effectiveness is due to variability in the therapeutic alliance (Baldwin et al. 2007). In pursuit of determining the characteristics and actions of these effective therapists, it was found that there were a set of factors common to these effective therapists, and the therapy they provided. First and foremost, it was found that client or extratherapeutic factors are of primary importance. These include the client's focus on change, the importance of viewing the client as the primary agent of such a change, and having an understanding of the client's strengths and resources. Second only to these factors is the therapeutic relationship. Clients who rate the therapeutic alliance highly are more likely to be successful in therapy. Meta-analyses show that the client–therapist relationship is strongly associated with outcomes (Horvath and Bedi 2002; Horvath and Symonds 1991; Martin et al. 2000). The therapeutic alliance is a robust common factor and appears across various therapeutic orientations (Wampold 2010). It is important for the therapist to meet the client where they are at, as discussed in Prochaska and Diclemente's (1982) stages of change, and to partner with them to work towards this change.

However, it is not just the alliance alone that determines therapeutic success. The alliance is dependent on the delivery of a particular treatment. In other words, it is important for the therapist to understand and skillfully utilize the "techniques" of

their orientation in order to elicit change and the stronger the therapeutic relationship as experienced by the client, the greater the degree of therapeutic success.

Specific Humanistic Approaches to Therapy

Within the "family" of humanistic psychotherapy are several specific approaches. Each of these approaches can be adapted for use in financial therapy. Let us briefly list some of the major approaches and explore each of them in more depth below, followed by how they can be applied in the context of financial therapy with Jennifer.

- *PCT* was developed by Carl Rogers (1946, 1951, 1959) and emphasizes providing the proper therapeutic environment in which personal growth will result.
- Gestalt psychotherapy has grown out of the work of Fritz Perls (1969) and emphasizes increased awareness of the client's experience of the present moment as an entry point to insight and therapeutic change.
- The *focusing-oriented psychotherapy* approach is an experiential process developed by Eugene Gendlin (1996) that works with the individual's felt sense as a way of accessing and working with the body–mind connection.
- *Existential psychotherapy* refers to a variety of psychotherapies, which originated in the French philosophical tradition of existentialism. Focus of therapy is upon finding meaning in one's life, pain, existence, and mortality. *Emotion-focused therapy* (EFT) is by far the most securely evidence-based approach thanks to the research of its founder, Leslie Greenberg (Greenberg et al. 1993). EFT, as the name implies, works directly with emotions by identifying "process markers" or incomplete emotional processes, and uses specific techniques for working these emotional processes through to resolution.

> Person-centered therapy holds that human beings have an innate tendency towards growth and developing their full potential.

Person-centered Therapy

PCT holds that human beings have an innate tendency towards growth and developing their full potential. However, life experiences can block and distort this natural tendency, particularly as a result of incongruence that occurs between the ideal self, the perceived self, and the real self: The ideal self, the way we think we are supposed to be; the perceived self, the way we believe we are; and the real self, the way we actually are (Rogers 1959). The end of goal of therapy is to move towards internal congruence. More specifically, as these three aspects of self-converge, the person tends to have decreased anxiety, congruent behavior, and a more balanced sense of wholeness.

Carl Rogers had no intention of developing a new theory of psychology. Instead, it was his desire to better understand the process of psychotherapy in a manner that could be scientifically validated. He sought to develop and work from objective empirical evidence of effective therapy and believed in the "persistent, disciplined effort to make sense and order out of the phenomena of subjective experience" (Rogers 1959, p. 188). It was in this spirit that Rogers promoted the progress of research in the field of psychology through the investigation of psychotherapy. The origins of Rogers' PCT date back to his earliest works in the 1920s in which he proposed a theory focused on the client as the agent of change. His theory introduced a major shift from an emphasis on the problem expressed by the client, to a focus on the actual person of the client and their experienced feelings. No longer were thoughts and behaviors the primary focus of therapy.

Rogers suggested that the therapist's attitudes of respect for and belief in the client's capacity for self-directed growth was imperative, and subsequently provided an environment of safety in which the client is able to fully explore and understand who they are. The therapist is not the expert in the content of the client's life material directing the course of discussion in session, but rather an expert in process, an understanding listener who provides acceptance of the client and communicates their experiencing back to them. It is important to realize that the purpose of this reflection is not to simply parrot the client's content back to them, but rather to both demonstrate the therapist's understanding and empathy while allowing the client the ability to either affirm or correct the therapist's understanding. In this way, both therapist and client become increasingly clear in their understanding of the client's phenomenology.

…Rogers found that there were three consistent qualities of the therapist (therapeutic conditions) in successful psychotherapy: (a) congruence; (b) unconditional positive regard; and (c) empathic understanding.

Rogers emphasized the attitude of the therapist over technique and placed primary focus on the therapeutic relationship. Unlike the technique-focused behavioral and psychoanalytic approaches, Rogers' (1957) formulation showed that the therapeutic relationship was of primary importance to the process of change. Psychotherapy outcome studies across orientations have repeatedly confirmed this belief. Research has consistently shown that clients' perceptions of the quality of the therapeutic relationship are positively and significantly correlated with positive clinical outcomes (Bergin and Garfield 1994). Through his personal research and review of the empirical data of others, Rogers found that there were three consistent qualities of the therapist (therapeutic conditions) in successful psychotherapy: (a) congruence, (b) unconditional positive regard, and (c) empathic understanding.

Congruence It is imperative for the therapist to be congruent, in other words, to be exactly who she is and what she is in relationship with the client. She must not play a role or put on a facçade. In order to do so, the therapist should be fully and accurately aware of her

moment-by-moment experiencing in the relationship. This availability of feelings and the ability to listen to and accept what is going on within the self without judgment or fear, allows the therapist to be even more present and empathically connected with the client (Rogers 1961). This is a trusting of one's own personal understanding and experiencing without need for analysis or judgment. Rogers believed that unless the therapist remains congruent with herself in the therapeutic relationship, significant learning and growth may not occur within the client. The more genuine and congruent the therapist is in the therapeutic relationship, the more she is able to empower the client in moving towards their own congruence.

…in being a congruent therapist who provides unconditional positive regard and empathic understanding, a strong therapeutic alliance develops which potentiates the client's natural growth tendency and movement towards self-actualization.

Unconditional Positive Regard In addition to the therapist's own congruence, it is important for her to also develop and maintain a warm, positive, and accepting attitude toward the client. This type of caring for the client is not possessive or judgmental and has no conditions of worth attached to it. Unconditional positive regard is an acceptance and unconditional prizing of the whole client. This does not necessarily mean agreeing with or condoning the behaviors or actions of a client, but instead, it is accepting the client as they are. Ironically, this acceptance of the person as they are creates the freedom necessary for the growth process to occur, as the client moves towards greater internal congruence.

Empathic Understanding Empathic understanding speaks to the ability of the therapist to sense and feel the personal moment-to-moment meanings and experiences of the client. This is a sensing and understanding of the client's internal world as if it were one's own, but without ever losing the quality of the client as separate from the therapist. It is important for the therapist to maintain the separateness of their own identity while empathically connecting with the client's lived experiences. When the therapist is able to empathically experience the client's inner world, it is then important to successfully communicate this understanding to the client. This type of penetrating empathy, one in which the therapist empathically understands how it feels and seems to the client without analysis or judgment, is a condition that allows for client growth towards their own congruence and actualization. As the therapist gains an increasing understanding of the client's experience of life and accurately reflects that understanding, the client has the opportunity to more clearly and deeply understand themselves as they alternately accept or reject the accuracy of the therapist's understanding.

Rogers held that in being a congruent therapist who provides unconditional positive regard and empathic understanding, a strong therapeutic alliance develops which potentiates the client's natural growth tendency and movement towards self-actu-

alization. Returning to the case of Jennifer and the application of PCT to financial therapy:

If Jennifer were to seek financial therapy with a PCT, the therapist begins with a focus on creating a safe therapeutic environment by empathically attuning to Jennifer's distress. As Jennifer experiences the safety created by the therapist's empathy, acceptance, and authentic interest, she finds herself speaking more openly about a variety of life experiences which have caused her distress. As she and the therapist seek to understand her experiences, she realizes a pattern of equating her perceived worth as a person with the material possessions she acquires from self and others.

Jennifer's idealized self is wealthy, sought- after, and the object of largess. Her real self is a young woman who is starting a career and relationship and is dealing with the insecurities and uncertainties of early adulthood. Her perceived self is that she is a fake who no one appreciates and that she is ultimately unworthy, desperate to avoid anyone discovering that she is an imposter—a scared little girl dressed up as a sophisticated ad executive. In order to avoid the anxiety and pain of this internal incongruence, Jennifer acts out by either being demanding and unappreciative of others, or buying things she cannot afford in order to reinforce her sense of idealized self.

For the Gestalt therapist, the focus of therapy is in the "here and now" and specifically on the client's awareness of her contact with self and other.

Over time, as she becomes more acquainted with her real self, she recognizes how unrealistic the demands of her idealized sense of self have become and readjusts to a more realistic standard. As she does so, she finds herself less anxious, less likely to indulge in retail therapy, and less demanding of others to reinforce this inflated sense of idealized self through material gifts.

It is worth noting that in the person-centered approach, the therapist is not likely to direct the content of the therapy towards the overspending or in any other particular direction. Instead, the therapist trusts that the therapeutic process will empower the person to confront their incongruence. In working towards a more congruent stance, the person will experience less anxiety and distress, as well as a greater sense of wholeness and congruence. As this growth process proceeds, the presenting symptoms will resolve.

Gestalt Therapy

Gestalt therapy is a phenomenological and process-oriented approach that was developed from the works of the German-born psychiatrist and psychotherapist, Frederick "Fritz" Perls, his wife, Laura Perls, and the American writer and philosopher, Paul Goodman. The term "Gestalt" is defined as an integration and unification of the parts or elements of the whole that cannot be understood when separated and

differentiated. It is only as the complete whole that one comes into health and well-being. Gestalt therapy, with its unitary outlook, speaks to the wisdom of the whole human organism and focuses primarily on the client's awareness in the here and now. The approach holds that we *are* aware rather than *have* awareness. Therefore, as one becomes aware of what they are experiencing in the present moment, they come into contact with their own existence.

For the Gestalt therapist, the focus of therapy is in the "here and now" and specifically on the client's awareness of her contact with self and other. Contact in the interpersonal sense, is the experience of the boundary and differentiation between self and other. Intrapersonal contact refers to the interaction of different aspects of self or as Greenberg et al. (1993) conceptualize, the liveliness of the interaction between parts of self and the felt experience of these interactions in the present moment.

Gestalt therapy promotes the growth process and the development of human potential. This is done by acknowledging and investing in the experiencing self, while remaining consciously aware of and connected to the present. It is through this awareness and being in the here and now that a change takes place. "Change occurs when one becomes what he is, not when he tries to become what he is not" (Beisser 1970, p. 77). In other words, the more one tries to be what one is not, the more one stays the same. It follows, then, that psychological health results from identification with the whole self and maximum use of the whole self for interacting within the environment.

Awareness of what happens in the here and now is of primary relevance to Gestalt therapy. This includes one's thoughts, feelings, gestures, beliefs, and memories. Awareness is curative "because with full awareness, you become aware of this organismic self-regulation, you can let the organism take over without interfering, without interrupting; we can rely on the wisdom of the organism" (Perls 1969, p. 17). Perls (1969) refers to this organismic self-regulation as "…important in therapy, because the emergent, unfinished situation will come to the surface. We don't have to dig: it's all there" (p. 23). In other words, as the individual moves towards wholeness and acceptance of self, there is a natural tendency towards awareness, confrontation, and resolution of issues. One of the classic Gestalt approaches for expanding awareness involves the concept of shifting what is figure and background in one's awareness. That is, things that are just out of awareness are brought to the focus of attention, explored, and integrated. Once integration has been achieved, the organism can take care of itself. Control no longer becomes a factor, either internally or externally, as a trust in the true self and awareness of the here and now results in health, resilience, and growth.

One of the primary aims of Gestalt therapy is for the individual to mature and transcend above environmental support to self-support. This is where we really see growth occurring.

Problems, then, come from attempts to actualize a concept of who one should be rather than actualize who one truly is—self-actualizing versus self-image actualizing. This usually comes in the form of an impasse or a point where environmental support or inner support is not forthcoming and authentic self-support has not yet been achieved. Thinking, computing, planning, and focusing on "shoulds" leads one away from experiencing and ultimately to exhaustion and confusion. Instead, if one can become aware of the confusion, anger, anxiety, or whatever other experience that arises for the individual, and is able to stay in that experience, nature, in the form of self-regulation, takes over and it all sorts itself out. On the other hand, attempting to sort out a dilemma or "stuck point" through computing and planning only adds to the confusion, frustration, and "stuckness." Allowing the experience to guide the self leads to learning, which moves into discovery, and evolves into trust in oneself.

The therapeutic relationship is one of authenticity, where the therapist must be present, and bring the self into the therapeutic encounter (Woldt and Toman 2005). The therapist establishes contact as a whole person with the whole person of the client. Out of this meeting evolves awareness and growth.

One of the primary aims of Gestalt therapy is for the individual to mature and transcend environmental support to self-support. This is where we really see growth occurring. When one is able to reside in the true self, letting the masks and the facades fall away, attaining freedom from the "shoulds" of the environment, then one cannot help but grow. No natural animal or plant will prevent its own growing; so too is this true for the human being. From this vantage point, pathology is seen as a growth disorder. Once this natural process is allowed to proceed, the individual then will own their experiences and choices made.

Approaching financial therapy from a Gestalt perspective:

As Jennifer sits with her Gestalt therapist, the focus is on her here-and-now immediate experience. She gets in touch with how angry she is at Mitch. As she expresses her anger, feelings of sadness and pain emerge around her perception that Mitch does not love her as ardently as she imagined. The therapist facilitates her, examining her moment-by-moment experience of these feelings, and what emerges into awareness is Jennifer's belief that she is not worthy of the love and adoration that she seeks. As she begins to explore her sense of inadequacy, her therapist notices that she is absent-mindedly fondling her pendant, a gem encrusted gold necklace that she had purchased for herself in the aftermath of her fight with Mitch. The therapist brings this to her attention, asking her to continue stroking the pendant and to examine what the experience of stroking the pendant is like for her.

At first, Jennifer is puzzled, but as she brings the absent-minded behavior to the foreground, she becomes increasingly aware of how it serves to soothe her and in fact functions like a child's security blanket or teddy bear. This leads to an awareness of how she uses objects to soothe the pain of her felt inadequacy and to prop up her sense of self-worth. Over the course of several sessions, Jennifer comes to recognize that this pattern transcends her relationship with Mitch and serves as a general pattern in her life. Working with her Gestalt-oriented financial therapist, she is able to expand her awareness to include the pain she still feels from her parent's

emotional absence, and the importance she places on their gifts as evidence of their love for her and her worth as an individual. As these difficult and long-suppressed feelings are brought to awareness and worked through to acceptance, Jennifer's sense of inadequacy begins to be replaced by a new sense of self-worth and acceptance.

As she feels more worthy of love, she experiences Mitch's attention and appreciation of her more directly and completely, and places less emphasis on how much money is spent. Her primary symptom of overspending lessens in intensity and frequency. Eventually, Jennifer shares with her therapist that she is proud of herself for meeting with a financial planner. She now sees this as a congruent part of her identity as a young professional.

Notice how the Gestalt financial therapist focuses on the here-and-now experience and may direct the focus of therapy to bring feelings, thoughts, or behaviors to the foreground, thereby increasing Jennifer's self-awareness.

Focusing-oriented/Experiential Psychotherapy

The focusing-oriented psychotherapeutic approach is an experiential process developed by Eugene Gendlin (1964) that works with felt concreteness and focuses on the experiencing that occurs at the body–mind interface. Focusing involves inward bodily attention and personal attunement to one's felt sense. Felt sense refers to meanings felt in the body. This bodily experiencing is neither thoughts nor emotions, but a distinct bodily sensation before it is attached to thoughts or words. For example, take a moment here and imagine your dearest friend. Now, notice the bodily sensations that have arisen from this. Perhaps a feeling of warmth within, a lightness, or the tensing of facial muscles into a gentle smile. Now, imagine an individual with whom you have a contentious or conflicted relationship and again notice the bodily experience arising there. This is an example of felt sense. It is the inward experiencing of the complexity of situations that cannot be fully described by thoughts, emotions, or words. The healthy individual is consciously aware of the felt sense of life situations as they occur in the moment, and subsequently responds to what is vague, unclear, and on the edge of consciousness. The client's self-concepts and constructs become partially unstructured and their felt experiencing may exceed their intellectual understanding (Gendlin 1964). Experience is considered as a felt process of inwardly sensed, bodily felt events.

The focusing-oriented psychotherapeutic approach … works with felt concreteness and focuses on the experiencing that occurs at the body–mind interface.

The theory holds that blocked experiencing results in a sense of constriction and pain that is resolved through attending to one's felt sense. As such, in therapy, the

client develops an awareness of their felt sense of empathy, but with the added awareness of not-yet-articulated, but client-sensed experiences. Therapy shifts the client from content (information shared by the client) to the manner of process (how the client relates to their experience). The client learns to attend to their bodily experiencing in the here and now.

In focusing, the client–therapist relationship is given priority over all else. The therapist adopts an empathic, listening attitude akin to the Rogerian approach, then symbolizes this experience, and checks to see if there is a bodily response to the symbolization. This process allows words, images, gestures, or new actions to arise and subsequently moves one forward through process blockages. Finally, the client receives all of this information without judgment, which results in a felt shift—an easing in the body that follows the processing of one's felt sense. Change and growth develop out of multiple small felt shifts in one's self-understanding and experiencing. Returning to the financial therapy case from a focusing perspective:

The therapist empathically listens to Jennifer's experience as she talks about the concert-ticket situation she had with Mitch. She begins by primarily focusing on content (i.e., what he did, how she responded, the argument that ensued), but she also talks about her feelings of hurt and confusion. Her processing has been blocked, which has resulted in this experience of constriction and pain. The focusing financial therapist directs Jennifer's attention to her felt sense by asking her focused questions that begin to turn Jennifer's attention internally to her bodily sensation (i.e., "How does that whole situation feel in your body?"). She identifies the words, "deep emptiness in my stomach" and "a tightness in my throat as if I'm holding back tears" to verbally describe her felt experience. Jennifer begins to make direct contact with her experiencing. She has shifted from focusing on content to how she is relating to the experience. She attends to what she feels.

As the therapy continues, Jennifer becomes increasingly able to make contact with her bodily-felt experience and in doing so, she is more aware of what is happening at the edge of her consciousness. She is able to focus on the vague, implicitly meaningful aspects of her present, emergent experiencing and is able to utilize this expanded awareness to create meaningful resolution.

Through this process of unfolding, Jennifer comes to understand and experience herself and her relationship with money in a new way. She has greater trust in her experiential perspective and has a self-awareness that she allows to guide her thoughts and actions.

> …existentialism focuses on the experience of becoming, of growing and changing, and of redefining the self by taking responsibility and making choices towards one's destiny and ultimately, freedom.

It is worth noting the importance of expanding awareness by focusing on the felt sense of the person's immediate experience. As that awareness is expanded, the person experiences a larger sense of meaning and a greater integration of self and experience.

Existential Psychotherapy

Existential psychotherapy seeks to assist the individual in growing to their fullest possible potential by helping the client move towards greater clarity and understanding of their lived experience in the world and connecting with life and experiences beyond the self. The therapist is curious and respectful, and provides an invitation for exploration and reflection on the client's existence. This approach is not symptom-focused, but is instead more intent upon explicating the latent meanings of symptoms with a goal of obtaining illumination to full openness and experiencing (Walsh and McElwain 2006).

Existential psychotherapy was primarily influenced by the writings of the Danish philosopher and theologian, Soren Kierkegaard, who focused on subjective human experiences rather than the objective truths of science in an attempt to understand the self and the meaning of life. Kierkegaard was concerned with society's growing tendency towards dehumanizing the individual and opposed any attempt to see humans as mere objects; however, he also opposed the view that subjective perceptions alone comprise one's reality. Instead, he believed in the importance of both the experiencing person, as well as the person's experience.

Existentialism focuses on the conditions of existence in regard to the individual person, and their emotions, actions, responsibilities, and thoughts. People are in search of who and what they are throughout their life and make choices based on their personal experiences, beliefs, and understanding of themselves, others, and the world around them. Moreover, existentialism focuses on the experience of becoming, of growing and changing, and of redefining the self by taking responsibility and making choices towards one's destiny and ultimately, freedom. Unity between the person and the world leads towards integration, health, and function. In contrast, being out of touch with self and world leads towards alienation, isolation, and anxiety.

It is from the fount of this philosophy that existential psychotherapy came into being. The most prominent forefathers of existential psychotherapy were also European and include Karl Jaspers (1883–1969), Ludwig Binswanger (1881–1966), Meddard Boss (1903–1990), and Victor Frankl (1905–1997). From this early existential approach, came the acknowledgement of the significance, and primacy of the search for the authentic self. Through encounter, reflection, and subsequent self-awareness, the individual is able to become one's true self, transcending the crises of life. Growth comes from living authentically as an individual and engaging in authentic encounters with others. In therapy, mutuality and openness surmount technique, and each client's individual experiences serve as the primary source of information about reality (Cain 2006).

While Rollo May introduced the European existential analytic trend to America, Irvin Yalom, psychiatrist, psychotherapist, and professor, has brought a coherent structure to this school of psychotherapy. Existential psychotherapy proposes that inner conflict is the result of the individual's confrontation with existence. More specifically, Yalom (1980) believes that there are four major existential concerns central to the human experience, that are at the root of the majority of psychological problems. These include death, freedom, isolation, and meaninglessness. These

forces are often in conflict within the individual and can result in adaptive or maladaptive thought, emotion, and behavior.

As it pertains to financial therapy, existential approaches may be very helpful in explicating the client's interpretation of the meaning of money, wealth, or poverty as it pertains to their sense of themselves in the world. Applying the existential financial therapy approach to the case:

In working with an existential financial therapist, Jennifer's therapy is likely to begin similar to a PCT approach. However, the therapist will tend to be curious about, and consequently the work will focus on, her anxiety and perhaps her sense of what it means to spend, to have, or conversely, to want. The therapist might ask her what it means that Mitch bought the cheaper tickets and what it would have meant had he paid more. Together, they may explore her fears and anxieties of being a young professional, and how that relates to her sense of belonging. They might also explore the meaning and experience of being in debt, and how this relates to her sense of freedom and empowerment. Through this exploration of anxiety and meaning, Jennifer is likely to come to a new understanding, not only of her relationship to money and spending but also to her innate sense of self-worth and belonging. As this new understanding takes hold, her symptoms are likely to remit.

In approach, existential therapy may take a similar form to many of its sister therapies. The hallmark of existentialism is the engagement of anxiety in the pursuit of examining and creating a deeper context and meaning to the person's life experience.

> The goal of EFT is for the client to return to and trust the innately adaptive potential of their primary emotions. However, the client must first arrive at their feelings of hurt, sadness, anger, or whatever emotion may be presenting itself as a stuck point before one can leave it and move forward.

Emotion-focused Therapy

EFT views emotion as both the primary target *and* the agent of change. An integration of PCT, Gestalt, and experiential therapies, EFT focuses on the empathic attunement and prizing of the therapeutic relationship, combined with the task-focused, process-directive style of Gestalt therapy (Greenberg et al. 1993), and the bodily felt sense. An empirically supported approach based on a 25-year program of psychotherapy research (Elliott et al. 2003; Watson et al. 2003; Elliott and Greenberg 2006; Greenberg et al. 2001; Greenberg and Watson 1998; Greenberg et al. 1994; Elliott 1999; Rice and Greenberg 1984), EFT weaves together the humanistic values of self-determination, experiencing, growth, holism, and authenticity with emotion theory's regard for the fundamental adaptive nature of emotions.

Healthy functioning occurs when individuals emotionally process their internal and external experiences thoroughly so that the meaning derived from them can adaptively guide them. Emotions provide information about what is important in a

situation, reveal what one wants or needs, and then help determine what appropriate actions one should take in order to meet that need. In other words, emotion is seen as the central source of meaning, direction, and growth. The goal of EFT is for the client to return to and trust the innately adaptive potential of their primary emotions. However, the client must first arrive at their feelings of hurt, sadness, anger, or whatever emotion may be presenting itself as a stuck point before one can leave it and move forward. This is done by eliciting and attending to the here-and-now experiencing of emotion so as to understand, process, and transform it from dysfunctional emotion responses into a primary adaptive emotion to be fully processed.

EFT is characterized by its recognition of in-session therapeutic markers, and tasks that signal the client's readiness to work on a particular problem. Main markers include, but are not

limited to problematic reactions expressed through confusion about emotional or behavioral responses to a particular situation; an unclear felt sense; conflict splits in which one aspect of the self is critical towards another aspect of self; self-interruptive splits in which one aspect of self interrupts emotional expression; unfinished business in which there are unresolved feelings towards a significant other; and vulnerability, a state in which one feels emotionally fragile and insecure. Each marker indicates the specific type of intervention to use. Specifically, problematic reactions are addressed through the use of evocation of experience to allow the client to re-experience the situation and reaction in order to finally arrive at the meaning of the situation. This provides a greater understanding as to the reaction and a subsequent new view of self-functioning. An unclear felt sense is addressed through the use of experiential focusing, in which the client becomes mindful and turns his attention inward, and is allowed to sit with the bodily experience he is having in the moment in order to move towards a shift in this bodily-felt sense. This shift in experience results in the creation of new meaning. Conflict splits are resolved through two-chair work in which two aspects of self are put into live contact by dialoguing with one another in order to move towards integration and self-acceptance. Self-interruptive splits are addressed through two-chair enactment in which the client is invited to physically, metaphorically, or verbally enact the ways in which he interrupts his process. He is then called to react to and challenge the interruptive aspect of self in order to allow for full expression of the previously blocked experience. Unfinished business calls for an empty-chair intervention in which the client activates his view of a significant other and both experiences, then expresses their unresolved feelings and needs. This leads to a shift in view of both self and other which results in the client either holding the other accountable, developing understanding, or forgiving the other. Vulnerability requires affirming empathic validation in which the therapist empathically attunes to the client's feelings of deep shame or insecurity about some aspect of their experience. Through validation and normalizing the experience of vulnerability, the client develops a stronger sense of self.

The EFT therapist integrates a person-centered, marker-guided, and process-directive relational stance that alternates between following the client's content and the therapist leading the process. As the process consultant, the therapist directs the client toward self-reflection, personal understanding, and reevaluation of his/

her emotion schemes—complex organizing structures that integrate feelings, bodily sensations, cognitions, and behaviors that help us understand ourselves, others, and the world around us (Greenberg and Paivio 1997; Greenberg et al. 1993; Elliott and Greenberg 2006). Sometimes described as internal voices, these emotion schemes automatically influence one's behaviors and are not directly available to awareness. Therapy primarily involves helping clients access their emotion schemes under the therapeutic conditions of safety and prizing which facilitates more complete processing. Change occurs when clients make sense of their emotions through awareness, emotional expression, regulation, and reflection, which results in transformation and a corrective experience of emotion. Looking at the case through an EFT financial therapy lens:

The emotion-focused financial therapist will likely enter into therapy with Jennifer in much the same nondirective style as the person-centered therapist. However, as she begins to explore her distress, the therapist will be looking for various process markers which are indicative of opportunities to work through unresolved emotional material. In this case, Jennifer's parents were often away on business throughout her childhood and adolescence. They rarely verbally expressed their love to Jennifer and would instead purchase expensive gifts for her on their travels. As such, she developed an emotion scheme in which she was sad and lonely; however, her parents' gifts would temporarily make Jennifer happy. She did not feel safe expressing her primary adaptive emotion of sadness to her parents, as she feared that they would disapprove of her, and push away from her even further. As such, she never expressed or processed these feelings. Instead, Jennifer would put on a happy face for her parents, so as to gain their approval, and would suppress her primary adaptive emotion.

Through these early experiences, Jennifer learned that her feelings of sadness were unacceptable. As an adult, she continues to block her emotional processing by purchasing material items for herself in an attempt to alleviate her sadness. This behavior results in a momentary rush of happiness that has snowballed into a repeated pattern of spending beyond her means. As Jennifer has never allowed herself to arrive at her sadness, she finds herself in a repeating pattern of spending sprees that has begun to feel out of control. Furthermore, Jennifer realizes she does not feel loved unless gifts of value are presented to her.

Initially in therapy, Jennifer has a problematic reaction, in that she had minimal insight and was puzzled by her spending behaviors. Through the use of vivid evocation of this experience, the therapist helps Jennifer explore this area of challenge, and evokes and intensifies her emotional experiencing prior to and during her spending sprees. As she becomes aware of the "sad, empty feeling" in her gut prior to her excessive spending, she realizes this was a familiar bodily experience that dates back to her childhood. Primarily, she experienced this "empty feeling" whenever her parents would be away, as well as when she worried about their feelings towards her; however, these feelings would temporarily remit when they came home with new and exotic gifts for her. Through increased awareness of this bodily-felt sense, Jennifer realizes that this feeling in her gut was and is directly connected with a deep sadness and loneliness that she has never allowed herself to express, but has instead repeatedly immediately blocked by acquiring new material possessions.

Through continued work together, Jennifer begins to allow herself to experience this “empty feeling” and its associated primary emotions of sadness and loneliness. She begins to explore and express what this sadness and longing means to her and has found adaptive ways to meet her need for connection. She has also developed healthy means of regulating these feelings of sadness through self-soothing (i.e., running, talking with close friends, spending time in prayer) while she allows herself to experience this emotional pain. Through this emotional processing, Jennifer’s formerly unclear felt sense transforms into a complete and adaptive emotion scheme in which she experiences greater compassion towards self and is able to meet her needs in a more adaptive and healthy way.

Ethical Considerations

It is important to note that EFT, like other humanistic approaches, values and prioritizes the authentic relationship and empathic support of the therapeutic alliance. However, more than any other humanistic stance, EFT will, from time to time, take a firm lead in moving the person through various emotional processes. Financial therapists applying this approach should be prepared to deal with such emotions. If financial therapists are not trained or prepared to lead clients through intense emotional processes, a different approach should be utilized.

Future Directions

There are core elements of humanistic approaches to psychotherapy that differentiate them from the other major modalities of therapy and have direct application to financial therapy and the treatment of money disorders. First, there is a tendency to take a holistic approach to the person, their life situation, and their problems. While other approaches lean towards a more reductionistic approach, examining cognitive schema, discreet behaviors, and relationship patterns or scripts, humanistic approaches focus on the quality of the authentic encounter between the therapist and the person. In keeping with the holism, the focus of therapy tends to be on the person rather than the symptom. The therapeutic process is, in fact, a facilitation of the person moving towards a greater state of wholeness in which symptom resolution is basically an inevitable byproduct of the process.

The therapeutic process is, in fact, a facilitation of the person moving towards a greater state of wholeness in which symptom resolution is basically an inevitable by-product of the process.

Another hallmark of humanistic approaches is that they tend to be more focused upon and integrative of emotions and emotional process. The primacy of emotion varies among the specific approaches, but is an integral part of each of them. And finally, the actual process of therapy often has a less linear and more organic feel and process than many other approaches. This tendency may be particularly disturbing or difficult for the novice therapist, but is an inherent aspect of the wholistic and emotionally centric therapy.

In terms of applicability to financial therapy, the wholistic nature of the humanistic approach lends itself to the inevitable view that while humanistic approaches have been found to be effective therapeutic approaches in general, and a promising approach in the treatment of disordered money behaviors, their application in financial therapy and the treatment of money disorders warrants further research and scholarly attention.

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Chapter 20
Stages of Change and Motivational Interviewing in Financial Therapy

Bradley T. Klontz, Edward J. Horwitz and Paul T. Klontz

Introduction

How many times have you sat with a client and given your best advice, only to have the client sigh, argue, respond with a "Yes, but," make excuses, or agree with you only to find out later that he or she did not follow through? The most experienced professionals recognize that getting clients to take positive action, even when they are asking for help, can be challenging. Even some of our favorite clients hesitate, fail to act, or simply do not take the agreed upon action to implement our recommendations. The fact is changing entrenched financial beliefs and behaviors is not easy.

Financial therapists routinely experience resistance from clients in implementing recommendations. Whether it is agreeing to reduce spending or delaying setting up a will, resistance to change can reflect a client's apprehension, belief that the change is not important, or a lack of confidence in his or her ability to make the change. A typical response to a client's resistance to a recommended action is for the financial therapist to provide additional rationale for the recommendation, remind the client of the problem, or discuss the likely consequences of not changing. Sometimes these techniques meet with success, but most of the time they do not, and serve to reinforce resistance to change.

> Resistance to change is a normal and expected part of the behavioral change process. (Miller and Rollnick 2002).

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Resistance to change is a normal and expected part of the behavioral change process. Research has found that failure to recognize client resistance and shift tactics when faced with client resistance can actually result in a deeper entrenchment of the status quo (Miller and Rollnick 2002). In other words, a financial therapist's natural response in the face of client resistance to changing financial belief and behavior patterns is likely to backfire and make the client even less likely to change. To be more effective in working with clients on financial matters, understanding proper techniques for helping deal with change and resistance to change is critical (Horwitz and Klontz 2013; Klontz et al. 2008). This chapter explores the change process, ambivalence towards change, resistance towards change; introduces evidenced-based techniques to help clients change; and provides a case study to show these techniques in action with a financial therapy client.

The Process of Change

Prochaska et al. (1994) identified a six-stage process of change, which financial therapists can conceptualize during client interactions including: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, (e) maintenance, and (f) termination. Previous authors have argued that the stages of change model have applicability to financial planning and financial therapy (Grubman et al. 2011; Klontz et al. 2008). What follows is a brief description of the stages of change model as applied to financial therapy.

> When a client is precontemplative, they are often said to be "in denial" about their problem.

Stage 1: Precontemplation

In the precontemplation stage, clients are unaware that they have a problem. Precontemplative clients downplay the extent of their problem, make excuses for their behaviors, and blame others. Precontemplative clients may be spending down retirement savings, financially enabling adult children, or maxing out credit cards. Precontemplation around financial problems comes at a cost. Those suffering from financial denial (see Chapter 3) are in the precontemplative stage as indicated by their avoidance of money, trying to forget about financial situations, and ignoring bank statements (Klontz et al. 2011). In the precontemplation stage, problems that the client does recognize are seen to be caused by something or someone else.

Stage 2: Contemplation

In the contemplation stage, clients are aware that they have a problem. They can identify negative consequences of their behaviors, and acknowledge they bear some responsibility. Contemplative clients initiate serious thought about the nature of their problems and challenges, and may gather information to understand the causes and consequences of the behavior. At this stage, clients can be ambivalent about change, being not yet convinced that making significant changes are worth the time or effort. Clients are in the contemplation phase when they recognize they have a problem and are considering making a change within the next 12 months.

Stage 3: Preparation

In the preparation stage, clients begin making commitments to change and place a high level of importance on dealing with financial problems. Addressing their financial problems becomes a priority. Information gathering now focuses on solutions to the problems. In the preparation phase, there is a shift in focus towards the desired future state. This is the stage when creating plans of action is appropriate.

> A client in the preparation stage is anticipating making a change in the next one to three months.

Stage 4: Action

Clients in the action stage begin to put their plans into place. In the action stage, clients are able to implement behavioral change. This is where the advice of a therapist or financial planner is desired and where the client may be most willing to accept the advice. In this stage, a directive approach, the sharing of opinions, and providing specific advice are less likely to be rejected. Most traditional therapy techniques are designed to assist clients in the action phase. However, based on the research of Prochaska et al. (1994), at any given time around any given issue, only 20% of our clients are in the action phase. As such, 80% of the time traditional methods of facilitating change are inappropriate (e.g., providing more information, arguing with logic, encouraging immediate action). For clients in an earlier stage of change, these techniques will make it less likely they will act on advice from a financial therapist.

Stage 5: Maintenance

In the maintenance stage, the client has lived with the changes for at least several months and can look back on their previous behaviors with some insight. Acknowledging and reinforcing the client's success to date based on their action efforts is important. It can also helpful to quantify the positive changes that have been accomplished, through reviewing the increased savings accounts or lower credit card balances, and how these outcomes link to their desired financial goals. In this stage, clients will assimilate their changed behavior into a lifestyle routine. Relapses to problem behaviors are a normal occurrence in this stage. As such, it can be helpful to normalize relapses and setbacks during this time.

> …three conditions… must be met before a client will be motivated to make changes in his or her financial life. These conditions include: (a) the perceived importance of change, (b) the client's perceived confidence in his or her ability to change, and (c) the client's readiness to change.

Stage 6: Termination

In the termination stage, new behavior is fully integrated, a self-image of financial health is established, and little if any temptation exists to revert back to problem behaviors. Often, therapy is terminated at this point or reduced to monthly or quarterly check-ins to reinforce and support treatment gains.

The Precursors to Change

Establishing Trust

To set the foundation for facilitating a client's move through the stages of change, several important relational elements need to be in place. To be most effective, there is a need to (a) establish credibility and the "right" to intervene on client financial behaviors, (b) earn the client's trust, and (c) display a willingness to be persistent in your efforts to help your client (Kahler et al. 2007). The works of Miller and Rollnick (2002) and Kahler et al. (2007) described three conditions that must be met before a client will be motivated to make changes in his or her financial life. These conditions include: (a) the perceived importance of change, (b) the client's perceived confidence in his or her ability to change, and (c) the client's readiness to change. The perceived need to change can be established through a review of the

client's situation, consequences of no change, and benefits of change. The ability to change can also be established through encouragement and by reviewing past examples of when the client has made successful change. Readiness to change is often harder to achieve and takes patience and persistence. Miller and Rollnick (2002) suggested that therapists can use a "ruler" to assess these three precursors for change. This can be done by simply asking clients to rate themselves on a scale from 1 to 10 on their perceived importance, confidence, and readiness for change.

Avoiding Questions

Reflective listening is a powerful technique Miller and Rollnick (2002) described for overcoming ambivalence and building motivation for change, and also a challenging technique to master (Klontz et al. 2008). Reflective listening involves a concerted effort to discover what someone is trying to say, even though he or she may not be articulating it fully or effectively. The skilled reflective listener will interpret and summarize what the listener is trying to say, then reflect it back in the form of a statement (Klontz et al. 2008; Miller and Rollnick 2002). The specific application of reflections will be explored below. Well-formed reflective statements are less likely to elicit resistance from a client and are preferable to reflective questions (Miller and Rollnick 2002). To illustrate the difference between a reflective statement and a reflective question, read the following examples while paying close attention to your emotional response:

QUESTION: "You're having difficulty saving?"
STATEMENT: "You're having difficulty saving."

While the words are identical, the sentences differ by inflection at the end of the sentence. A reflective response ends in a lower tone, while questions tend to be raised at the end (Miller and Rollnick 2002). Clients can respond dramatically different to questions as opposed to statements. Reflective questions can remind a client of being called on to answer a question in a middle school math class, where there is a right and wrong answer, or being questioned by a judgmental parent or boss.

> Questions are often experienced as confrontational and are more likely to elicit feelings of anxiety and defensiveness.

A skilled reflective response lets clients know you understand what they are saying, and does not create roadblocks to change (Klontz et al. 2008). Sometimes, a question or improper response can lead to resistance in the form of an argument or elicit a client to delve deeper into an emotional roadblock (Miller and Rollnick 2002). Questions are often experienced as confrontational and create negative emotional experiences that impede change. In contrast, reflective statements serve

as acknowledgments of the client concerns. Because the content of the reflection comes from the client's own words and ideas, reflections are more likely to result in a positive emotional experience. A well-framed reflection statement lets clients know you understand what they are trying to express and invites the conversation forward (Klontz et al. 2008; Miller and Rollnick 2002). Another benefit of proper reflective listening is that it helps the client feel heard and understood (Klontz et al. 2008). Regardless of content, these types of conversations become positive experiences for clients.

Change Talk

Change talk is an important concept in motivational interviewing (Miller and Rollnick 2002). Change talk helps intensify and resolve ambivalence by highlighting the differences between the current condition and the desired future state. In essence, change talk is talk in favor of change. Typically, when a therapist runs into client resistance, in an effort to help, the therapist will engage in the change talk. In response to therapist change talk, clients engage in status quo talk, rehearsing the reasons why they should not change, and making it less likely they will change. Miller and Rollnick (2002) identified four categories of change talk: (a) disadvantages of the status quo, (b) advantages of change, (c) optimism for change, and (d) intention to change. Disadvantages of the status quo statements acknowledge there is a problem and reason for concern. With this form of change talk, there may not be a verbal recognition of the problem, but merely the recognition of the undesirable elements of the current state of behavior. The advantages of change statements include helping the client recognize the desirable elements of the future state and helping bring out the positive results gained through change. The optimism for change statements are formed to help the client verbalize their confidence and ability to make the desired change. Lastly, the intention to change statements by the client is where the desired future state and how his or her life will be improved take shape. Here are some examples of the different forms of change talk related to financial therapy clients:

- Disadvantages of the status quo:
  - "Tell me the reasons you have decided to meet with me today."
  - "Tell me which financial challenge worries you the most."
- Advantages of change:
  - "Tell me how you would feel if you were able to save more."
  - "Tell me how paying off your credit cards might improve your lifestyle."
- Optimism for change:
  - "Share with me the personal strengths you think it will take to make this change happen."
  - "Tell me about a time when you were able to make a similar change."

- Intention to change:
  - "Tell me how making this change in your life might help you accomplish your goals."
  - "Give me an idea of what you would you be willing to try/change to achieve your retirement goals."

To be most effective, the client needs to be the primary source of arguments in favor of change.

Resistance to change is a normal part of the change process.

In change talk, clients are led to establish the value of change and create motivation through statements of importance and confidence. This goes against a therapist's "righting reflex" (Miller and Rollnick 2002), believing that they need to establish value and motivation to get the client to take action. With client change talk, the client articulates the future state and why it is desirable. Sharpening the contrast of the present state to the future state serves as a form of intrinsic motivation, which intensifies the discrepancy to overcome ambivalence and create motivation for change (Miller and Rollnick 2002).

Understanding Resistance to Change

Resistance to change is a normal part of the change process. A primary goal in financial therapy is to help a client engage in healthier financial behaviors. It is inevitable that financial therapists will make recommendations that a client may not be ready to act upon. Resistance responses have been compared to traffic signals, asking you to slow down or stop, since the client is not following or agreeing with your line of discussion (Miller and Rollnick 2002). A red or yellow light during a change discussion is not a problem, as long as the therapist recognizes it, stops what he or she is doing, and works to move the signal back to green so the change process can move forward. A persistent red or yellow signal, which intensifies during the interaction, is a signal that the therapist is off track. In motivational interviewing, persistent resistance responses by clients are considered to be the result of an unskilled approach. Resistance is a sign that the therapist is either moving too quickly or in a direction the client is not ready to go. While resistance as mentioned here can result in negative outcomes, the reality is that change is more likely to happen if a client is challenged. The role of the therapist is to "lean" into the client, stretching him or her towards change and when resistance is encountered to back off, slow down, and

move on to another topic. Motivational interviewing is based on the premise that the client wants to change in positive directions and can be counted on to move in that direction. The therapist's role is to be with a client in such a way that the client discovers their own motivation, strength, and wisdom. Increasing client resistance is sometimes caused by the therapist's use of improper techniques. Changing styles to help decrease resistance is important, since this has been associated with long-term change (Miller and Rollnick 2002). Motivational interviewing highlights the importance for therapists to notice client resistance when it is happening, to stop what they are doing, and to respond to client resistance in an effective manner.

Dealing with Client Resistance to Change Through Motivational Interviewing

Motivational interviewing offers evidence-based methods for facilitating change, including specific techniques for change inspiring dialogue (Miller and Rollnick 2002). These methods focus on acknowledging and resolving a client's ambivalence to change and building the client's motivation to change. A client's ambivalence and lack of motivation serve as the basis for many objections encountered (Miller and Rollnick 2002). A review of several evidence-based techniques will be explored along with examples of dialogue to illustrate appropriate application. Through practice, the use of research-based techniques for overcoming ambivalence and motivating clients to make meaningful change can be accomplished.

Miller and Rollnick (2002) described the following eight techniques therapists can use when meeting with client resistance. After a description of each technique, a sample client–financial therapist dialogue is presented for illustrative purposes. This is followed by a case study where motivational interviewing was used as the primary financial therapy intervention with a client.

Simple Reflection Even if a reflective response does not accurately mirror a client's intention, the client correcting the therapist helps the client clarify his or her thoughts and feelings to move the conversation forward (Resnicow and McMaster 2012). Simple reflections allow clients to: (a) feel understood, (b) gain insight into the discrepancy between their behaviors and goals, and (c) become better aware of the consequences of not changing (Klontz et al. 2008). The therapist has the choice to reflect back the *content* of what the client is saying or the *emotion* the client is feeling:

CLIENT: I don't have time to set up a budget.
THERAPIST (content reflection): Budgeting is not a top priority for you at this time.
CLIENT: I can't believe that my husband bought that motorcycle without talking to me first.
THERAPIST (reflecting the feeling): You feel angry and betrayed.

A simple reflection is perhaps the most powerful change technique and is often sufficient to support a client's movement in the direction of change.

Amplified Reflection Another useful reflective technique is amplified reflection, which is an exaggerated reflective response. This can be a challenging technique to master and should be used with empathy and genuineness. The danger is that a client could experience a poorly delivered amplified reflection as sarcasm or as disrespectful (Klontz et al. 2008). Amplified reflections can get the client to retreat from their argument against change. Clients will often correct the therapist in the direction of change and the therapist can follow up with an invitation for the client to clarify, resulting in client change talk.

CLIENT: I know I should reduce our spending but I just haven't been able to do it.
THERAPIST: So reducing your spending in any area is out of the question right now.
CLIENT: Well, I am not saying it's impossible.
THERAPIST: Tell me what you mean.

Double-Sided Reflection The double-sided reflection reflects back both sides of a client's ambivalence. It invites a client to more deeply explore the pros and cons of change. With this technique, you use the client's statement and add the other side of the issue to complete the reflection.

CLIENT: I know I need to talk with my daughter about her spending habits.
THERAPIST: So on the one hand you recognize that this is a conversation you need to have, and on the other hand, you are worried that she may get angry with you.

Shifting Focus Away from the Impasse Shifting focus entails changing the focus of the conversation to go around an impasse. When a client is showing resistance around a particular topic, the therapist shifts focus away from the impasse towards a less contentious area to keep the dialogue moving forward.

CLIENT: I am not addicted to gambling and I am tired of people suggesting that I am.
THERAPIST: Okay, so your gambling isn't really a problem for you and you are tired of having to defend yourself. Let's talk instead about your financial goals.

Reframing Reframing involves providing new information to clients to cast their circumstances into a new light. The therapist acknowledges the validity of clients' point of view, while offering a different frame of reference. Viewing a problem in a different frame can help redefine the problem and discover new solutions.

CLIENT: I get really depressed when I think about budgeting.
THERAPIST: Budgeting can be tough. Let's develop a spending plan instead. Let's start with deciding where, what, and whom you want to spend your money on.

Viewing a problem in a different frame can help redefine the problem and discover new solutions.

Agreeing with a Twist This technique involves agreement with the client's statement followed by shift in direction. Agreeing with a twist combines a simple reflection, which helps the client feel understood and supported, and a reframe, which offers the client a new perspective. Agreeing with the client first increases the likelihood that he or she will accept the subsequent change in perspective. What follows is an example of shifting a client's perspective from blaming his wife for their overspending to an awareness of their relationship dynamics.

CLIENT: My wife and I keep having the same fight over and over. She always wants to spend and doesn't seem to care at all about our retirement.

THERAPIST: It is frustrating to feel like she doesn't care about your financial future. It seems like the more you push to save for the future the more she digs her heels in, wanting you both to enjoy spending now.

Emphasizing Personal Choice and Control When clients feel like their freedom of choice is under threat, they may respond with attempts to assert their liberty (Miller and Rollnick 2002). A useful technique when encountering resistance is to emphasize an individual's right to freedom and self-determination.

CLIENT: I have no desire to go to Debtor's Anonymous. I would be way too embarrassed to talk to other people about my spending and it wouldn't help at all.

THERAPIST: And it is of course entirely your decision. No one can tell you what to do and I absolutely respect your right to decide for yourself.

Coming Alongside In coming alongside, the therapist sides with the client's argument against change. This technique can be used when the client is meeting almost all of the therapist's efforts with opposition and is delivered in a calm, matter-of-fact manner (Miller and Rollnick 2002). Coming alongside is best used when the therapist is willing to support the client's decision to not change even if the status quo is not in the client's best interests (Klontz et al. 2008).

CLIENT: I don't think that financial therapy is going to help with my spending. I have been in therapy before and it didn't work.

THERAPIST: I am glad you said that. Financial therapy takes a lot of time and effort and without a belief in the possibility of success it is doubtful we would succeed anyway.

Case Study

Background Information

Joann is a 52-year-old, Caucasian, upper class, divorced female with an adolescent daughter. She is an entertainer who is a recovering substance abuser. She has maintained her sobriety for 20 years with no relapses. Joann is an only child whose parents divorced when she was in middle school. Her parents were substance abusers who were in and out of jail. Joann was primarily raised by her grandparents in a blue collar neighborhood. She became very self-sufficient as a teenager, began alcohol and drug use in her mid-teens, played music, wrote songs, and hung around with much older kids. She was married in her mid-30s and divorced in her early 40s.

Joann is intelligent, street smart, a self-starter, creative, accomplished, caring, introspective, honest, self-aware, independent, strong, and motivated. She received treatment for substance abuse at age 31, and has been treated for depression with various medications for the past 14 years. Joann has seen a variety of mental health professionals, but none have engaged her relative to her overspending. She has had a professional relationship with three financial management groups over the past 35 years. She reported that all had been concerned about her spending and one fired her as a client because of her overspending.

Presenting Issue

Joann's financial manager called in a financial therapist to a meeting they were having to go over yearly financials and asked for help in addressing a chronic overspending problem. Joann reported that she believed she was "addicted" to spending just like she used to be addicted to alcohol and other drugs. She said that all of the addictive thinking patterns, including rationalizations, and behaviors were the same around money as they had been around drinking and drugging. She reported that she needed outside help because she had been trying to change such behaviors for years without success.

She reported her spending problems manifested themselves primarily by compulsive shopping while traveling and online at night when home alone. She reported buying things she did not need, primarily clothing and jewelry. She said quitting this "will be the hardest thing I have ever tried to do. Quitting my alcohol and drug use was easy compared to this." As an aging female performing artist she had been told by her agents over the past few years that her career had peaked, she was in less demand, and she could not count on making as much money as she had in the past. She recently had the realization that if she did not change her spending behaviors she might lose her home; one of the most important things in her life and the one thing that she wanted to pass on to her daughter. She reported that she had finally realized, through no fault of her advisor, that she had been subsidizing her yearly

lifestyle expenses by continually drawing down her savings which had declined from about $ 1,500,000 to less than $ 400,000 and that if she paid off all her current debt, including the mortgage on her house, she would be broke.

Joann reported a significant degree of fear and anxiety over running out of money. The previous 12 months she had spent $ 216,000 on lifestyle, while being able to afford $ 72,000. The difference was drawn from her retirement savings. She was very aware that if she did not change her behaviors, she would have spent her entire retirement savings in about three more years. Joann admitted to experiencing a lot of shame and guilt about her behaviors and hopelessness about being able to change them.

Case Conceptualization

It was clear that Joann was an overspender. She was experiencing confusion, denial, a lack of awareness, naiveté, and secret keeping in terms of her spending issues. Motivation for change appeared high at first glance per Joann's report. The actual intrinsic motivation to live within her means and save money for her and her daughter's future was actually quite low. The primary motivating factors seemed to be external, in the form of fear, created by talking to her advisor. While stating a desire to spend less, she was clearly ambivalent about taking the necessary steps to do so.

Intervention

Motivational interviewing uses a self-rating scale from 1 to 10 to have clients report the degree to which they feel a change is important, confidence in their ability to make the change, and their readiness to change. Joann rated the importance of accomplishing her goal of reducing her spending a 7 or 8 on a scale of 1–10. Joann rated her level of confidence that she could accomplish her goal at a 3 on a scale of 1–10. When asked how ready she was to begin making changes, she rated herself a 10 on a scale of 1–10. Joann said that if she did not change she would lose her house and not be able to support her daughter. She suggested that she had no personal interest in accumulating wealth, and in fact, did not want to be seen by others that way. That said, she was committed to making sure to take care of herself well enough financially so that her daughter never had to take care of her financially, and she wanted to leave something (her house) for her daughter to give her a "head start." These values and goals were something to utilize in therapy when her motivation begin to wane.

When clients rate themselves low on an aspect of the change ruler, motivational interviewing does not ask them why they do not rate themselves higher. Such a question would elicit status quo talk and is counterproductive. To encourage change talk, Joann was asked to talk about why she rated her confidence score at a 3 rather than at a 0. She responded that she had made difficult changes in the past, so she had

some confidence in her ability to change, but that she needed a lot of help. Joann indicated that she had tried to cut back on her spending a dozen times over the past 10 years or so and had been consistently unsuccessful. She said that it felt like an "addiction," even more powerful than the alcohol/drug addiction that she has been in recovery from for about 20 years, the difference being she had to deal with money every day and, unlike alcohol and other drugs, just could not put it away and never have to deal with it.

To address the low confidence score, Joann was asked tell the story of how she was able to change her alcohol/drug addictions. She was asked to talk about the resources she used (systemic, interpersonal, and intrapersonal) to accomplish this goal and to identify how she might use those resources to tackle this challenge. The primary tool she attributed to her success was peer support and mentoring. She went on to say "I know how I can fix this. I could start going to Debtors Anonymous. But I am not going to do that." She elaborated on this statement for a while, and the financial therapist decided to change focus away from this impasse and agreed that if an easier and less intrusive approach would work, it should be tried first.

During sessions over the coming weeks, when Joann would become discouraged and speak of her lack of faith that she could be successful in addressing her overspending, the therapist made reference to the resources she had mentioned which were instrumental in changing her behaviors with alcohol and other drugs.

To help her manage her lack of confidence, relapse to previous behavior and momentary failure was framed as a normal part of the change process and that the goal was gradual change over time, rather than immediate, and perfectly linear change. She was reminded that those moments simply meant that we had forgotten something that we needed to implement. This concept was introduced only after she failed to be "perfect" in following her plan.

A great deal of time was spent, using a variety of strategies, attempting to ameliorate her powerful self-loathing, shame (her primary objection to Debtors Anonymous was letting other people know she had a problem), feelings of hopelessness, and critical self-talk when she did not perform her financial management tasks as well as she wanted. Though Joann acknowledged that her overspending may have been an attempt to meet unmet emotional needs, she wanted the financial therapy to be focused on external strategies to see if some simple money management techniques and willpower would be sufficient to facilitate change. The client was asked to begin recording all expenditures on a daily basis. She found a software application for her smart phone that facilitated this process and she reported feeling a sense of enjoyment in recording her expenditures in this way. The following additional strategies were developed and used:

- Obtaining and reviewing with the financial therapist a detailed schedule of monthly/annual expenses. The current crisis involved overspending her monthly budget by a ratio of 3:1. Her monthly budget was established at $ 4000 per month, which would be a reduction of $ 8000 per month.
- Reducing discretionary spending (e.g., cable TV, eating out, daughter's allowance).

- Paying off $ 60,000 in credit card debt from savings.
- Canceling all personal credit cards, leaving only one business credit card, which remained in the possession of her manager.
- Disclosing her spending problem to her performance road manager who traveled with her.
- Asking for her manager's assistance and support in cities she was visiting, to plan alternatives to the usual shopping sprees. Joann's work took her on a relatively regular rotation of performance venues and cities. She had developed personal relationships with the owners of boutique clothing and jewelry stores near the hotels where she regularly stayed, who were in the habit of buying things especially for her, notifying her that the next time she was in town she should stop buy. Joann felt obligated to purchase these items.
- Putting a picture of her house and daughter on her electronic tablet as her screen saver to serve as a visual reminder of why she was making changes.
- Leaving her electronic tablet out of her bedroom (most of her online buying occurred late at night, from her bed, as she surfed the Internet). Joann had admitted to feeling lonely at night and would buy things to assuage that loneliness.
- Developing a spending plan with spending limits (cash only) for her fun trips.
- Refinancing her home saving 2 % APR.
- Becoming more willing to work more to increase income.
- Setting aside 25 % of what remained to a recreational travel savings account, 25 % to her monthly spending allowance, and 50 % to long-term savings.

Course of Treatment

Financial therapy primarily took place by phone or Internet conferencing for approximately 1 h weekly for 40 weeks. During those sessions, the previous week's spending was reviewed, and significant time and energy was spent deconstructing spending decisions and incorporating lessons learned into new strategies. The session was always ended with a comparison of last year's rate of spending with the current rate, which was always favorable. One phone call a month was dedicated to looking at the previous month's financial report. Joann gained increasing success with several relapses, which became less and less frequent. After her final relapse, she agreed to get involved with Debtors Anonymous. She got a sponsor, formed a "pressure relief" group, and began attending regular meetings.

Outcomes

Joann was able to reduce her spending by 60 % and increase her income by 15 % over the course of 12 months. Her financial advisor reported that this was the first year in the past 11 years that Joann spent less than she earned. Joann reports that she is now "solvent," and that her goal is to remain that way. She reports feeling

great satisfaction in her accomplishment. At last report, 2 years after termination of financial therapy, she remained "solvent."

Three key components in her change were the following: (a) having an accountability partner that she checked in with at least once a week, (b) her diligent daily focus on keeping track of her spending, and (c) regularly meeting with others, either in person, by phone, or electronically, who were engaged in the same effort. As long as she continues these behaviors her prognosis is excellent. There is, however, a significant risk that she will revert back to her old behaviors. Her impulsive spending was apparently used, in part, in an attempt to manage feelings of loneliness, depression, anger, and fear. Though experiential financial therapy (discussed in detail in Chapter 7) was recommended to address these deeper issues, Joann was not willing or able to commit to addressing them in a direct way. As such, she runs the risk of relapse if those issues become prominent.

Ethical Considerations

With a firm grasp of the concepts of stages of change, ambivalence towards change, change talk versus status talk, and reflective listening, financial planners without training in advanced motivational interviewing techniques and/or psychotherapy can use stages of change theory and motivational interviewing to help clients make positive financial decisions. For example, if a client is ambivalent about, or resistant to, getting a will, establishing a trust, or saving for retirement, these techniques can be applied to great effect. However, the financial planner may be in an excellent position to use these techniques to help encourage a client to seek appropriate treatment from a qualified professional.

> If financial therapy is aimed at the treatment of a money disorder … it would be inappropriate for a non-mental health trained financial therapist to attempt to provide treatment.

Future Directions

To be most effective in helping move clients through change, it is critical to recognize in what stage of change they reside. The therapist's ability to identify the proper stage and tailor the approach will greatly improve success in facilitating change. Though general in tone and approach for all the stages of change, very specific therapeutic strategies for each stage have been developed and should be practiced. As noted, around any given issue at any given time it is more probable that a client is not ready to change. It is critical that financial therapists recognize client resistance, stop what they are doing, slow down and, if necessary, shift

their focus. If resistance is not handled appropriately, clients will be less likely to change than if they had never met with a therapist. Motivational interviewing's use of reflective statements, encouraging client change talk, and utilizing techniques to address resistance can be highly successful when used alone or integrated with other financial therapy approaches. Research has shown that the use of motivational interviewing techniques is associated with significantly improved retention of the behavior change (Goldberg and Kiernan 2005). However, science has not verified the effectiveness of the stages of change model and motivational interviewing in the realm of financial therapy, which is an exciting frontier for future outcome research.

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