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Journal of Financial Therapy

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Table of Contents

Editorial	i-vii
<i>Kristy L. Archuleta</i>	
2013 Membership Profile of the Financial Therapy Association: A Strategic Planning Report	1-21
<i>Sarah Asebedo, Megan A. McCoy, & Kristy L. Archuleta</i>	
Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory	22-42
<i>Megan A. McCoy, D. Bruce Ross, & Joseph Goetz</i>	
Hoarding Disorder: It's More Than Just an Obsession – Implications for Financial Therapists and Planners	43-63
<i>Anthony Canale & Bradley T. Klontz</i>	
Researcher Profile: An Interview with Dr. Russell James	64-66
<i>Russell James</i>	
Practitioner Profile: An Interview with Amanda Clayman	67-71
<i>Amanda Clayman</i>	
A Review of “How to Give Financial Advice to Couples: Essential Skills for Balancing High-Net-Worth Clients’ Needs”	72-74
<i>Alycia DeGraff & D. Bruce Ross</i>	

Editorial

Kristy L. Archuleta, Ph.D.

Welcome to the second issue of the *Journal of Financial Therapy's* fourth volume! In this issue we are featuring three unique papers, a practitioner profile and an academic profile, and one book review. We lead this issue of the *JFT* with the latest Financial Therapy Association's membership profile, a descriptive analysis of current characteristics of those who are involved in financial therapy. This second profile of the FTA membership was led by Sarah Asebedo, Megan McCoy, and Kristy Archuleta as part of the FTA Board of Director's Strategic Planning Committee's initiative to assess the development of financial therapy. As a follow up to the initial profile published in *JFT* in 2011, the second profile followed the recommendations outlined in Jerry Gale, Joseph Goetz, and Sonya Britt's "Ten Considerations in the Development of the Financial Therapy Profession" published in 2012 in *JFT*. More in-depth data is planned to be collected at the next annual FTA conference.

The second paper by Megan McCoy, D. Bruce Ross, and Joseph Goetz is a theoretically-informed approach to integrate financial planning with narrative therapy and cognitive behavioral interventions. The journal welcomes well-developed theoretically informed models of financial therapy. These types of papers can be used to help train new financial therapists as well as be replicated in empirical research, both of which help inform and validate the emerging area of financial therapy. The third paper by Anthony Canale and Brad Klontz thoughtfully and thoroughly reviews the literature on the financial aspects of Hoarding Disorder and offers implications for financial therapists, especially financial planners. The journal also encourages refined literature reviews that can add to the body of knowledge in a particular area related to financial therapy. For a literature review submission to be successfully accepted and published in *JFT*, it must synthesize the body of knowledge in a way that provides new information in a particular area. As with any submission, it will be peer reviewed and must be well written, follow the *Publication Manual of the American Psychological Association, 6th Edition*, and meet the other guidelines of *JFT*. These guidelines can be accessed by visiting www.jftonline.org and clicking on the "Policies" tab.

This issue's professional profiles feature Russell James from Texas Tech University as the academic profile and Amanda Clayman from the Financial Wellness Program at the Actors Fund as the practitioner profile. Both of these professionals are impacting financial therapy in their unique ways. Dr. James is the Director of Graduate Studies in Charitable Financial Planning. His research focuses on financial decision-making, primarily in the area of charitable decision-making, and publishes scholarly research in a variety of fields,

including economics, psychology, marketing, and sociology. Dr. James has also published research on the topic of financial ratios and household financial satisfaction with co-author, Scott Garrett, in *JFT*. Amanda Clayman is a Certified Financial Social Worker who helps individuals, couples, and families through a national non-profit human services agency in New York City. Amanda writes a blog titled, "The Good, the Bad, and the Money," and her work has been featured in the New York Times, the Wall Street Journal, and SELF magazine, just to name a few.

The issue concludes with one book review written by Alycia DeGraff and D. Bruce Ross of the University of Georgia. They gave a positive review for Kathleen Kingsbury's *How to Give Financial Advice to Couples: Essential Skills for Balancing High-Net-Worth Clients' Needs*. If you know of a book that should be considered for review, or you would like to write a review of a book, please email kristy@ksu.edu. I will pass along the information to our incoming Profiles and Book Review Associate (PBR) Editor, Dr. Martie Gillen, from the University of Florida. We are excited to have her on board in 2014!

In regards to other *JFT* activities, *JFT* transitioned to a new online platform with bePress in November, as announced in Issue 1 of this volume. Although the migration has slowed the actual publishing of this particular issue, we believe the experience for authors, reviewers, and readers will be positive and we are excited for the change. As a result of this transition, you will need to create a new login ID and password for our new system. If you had a login for the old system, it will no longer function.

I would like to thank Dr. John Grable who filled in for me this fall while I was away for maternity leave. As former co-editor of the *JFT*, he was able to easily reprise his role for a couple of months, helping to make sure that submitted manuscripts continued through the review process without delay. I also need to thank Megan Ford, *JFT*'s copyeditor, and the 2013 PBR Associate Editor, Emily Burr. I have enjoyed working with these two women; we have made a great team!

As always, we continue to solicit quality papers that feature financial therapy practices, experiments, and other research related to financial therapy. We are also looking for individuals who are willing to review manuscripts submitted to the *JFT*. Please join us as an author or reviewer in our efforts to communicate across disciplines with both practitioners and academics!

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Sarah Asebedo, M.S. is a shareholder and director at Accredited Investors Inc. She is pursuing a doctorate in Personal Financial Planning and a certificate in Conflict Resolution through Kansas State University. She serves on the Board of Directors for the Financial Therapy Association and is a member of FPA.

Anthony Canale, M.B.A. is a doctoral student at Kansas State University in the Personal Financial Planning program, a Certified Financial Planner™ practitioner in private practice, and a teacher at St. John's University in New York.

Alycia DeGraff, M.S. is a doctorate student in Human Development and Family Science with an emphasis in Marriage and Family Therapy at the University of Georgia. She earned her Master's degree in Marriage and Family Therapy at Texas Tech University. Alycia works as a therapist and financial counselor at the ASPIRE Clinic. She is a member of the American Association for Marriage and Family Therapy and the Financial Therapy Association. Her special interests include addictive disorders and recovery studies, military family finances, and financial therapy.

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 currently serves as the Past-President of the Financial Therapy Association and 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 from the University of Georgia. He received his bachelor's degree from the University of Missouri-Columbia, and completed three graduate degrees in the areas of financial planning, psychology, and consumer economics at Texas Tech University.

Bradley T. Klontz, Psy.D. is an Associate Research Professor of Personal Financial Planning at Kansas State University and Director of Research at H&R Block Dollars & Sense, a program that since 2009 has donated nearly 3 million dollars in personal finance curriculums to high schools across the United States to help create a financially fit nation.

Dr. Klontz is an internationally recognized expert in financial psychology research and practice. With his father, Dr. Ted Klontz, he has co-authored four books on the psychology of money: *Mind Over Money (Broadway Business, 2009)*, *Wired for Wealth (HCI, 2008)*, *The Financial Wisdom of Ebenezer Scrooge (HCI, 2005, 2008)*, and *Facilitating Financial Health (NUCO, 2008)*.

Megan A. McCoy, M.S. is a Marriage and Family Therapy doctoral student at the University of Georgia. While working on her Ph.D., she works at the ASPIRE Clinic practicing both traditional therapy, as well as financial therapy. In 2008, she earned her Master's degree in Marriage and Family Therapy at Drexel University. Since then, Megan has worked as a therapist in Pennsylvania, North Carolina, and Georgia. She is a member of the American Association for Marriage and Family Therapy and is currently serving on the Financial Therapy Board of Directors as the student representative.

D. Bruce Ross III, M.S. is a Marriage and Family Therapist working on his doctorate in Human Development and Family Science, with an emphasis in Marriage and Family Therapy at the University of Georgia. He earned a Master's degree in Marriage and Family Therapy at the University of Maryland. While working towards his Ph.D., he works as a traditional therapist, as well as a financial practitioner at the ASPIRE Clinic. Bruce is a member of the American Association for Marriage and Family Therapy and the Financial Therapy Association. His special interests include premarital therapy, issues of divorce, and financial therapy.

Financial Therapy Network

The following individuals have identified themselves as providing services that promote a vision of financial therapy. The Financial Therapy Association cannot guarantee the services of those listed in the FTA Network. For more information and to view these professionals' profiles, visit <http://www.financialtherapyassociation.org>.

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2013 Membership Profile of the Financial Therapy Association: A Strategic Planning Report

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Megan A. McCoy, M.S.
University of Georgia

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Kansas State University

A second profile of the Financial Therapy Association (FTA) membership was conducted to continue the development of financial therapy as a new area of practice and study. The FTA was established in 2010 as an effort to bring together practitioners and researchers from diverse disciplines to share in a common vision of financial therapy. This profile report depicts the demographic profile (e.g., age, education, gender, occupation, income) and perspectives of members who participated in the survey commissioned by the FTA Strategic Planning Committee in 2013. The results of the membership profile survey highlight the future directions of and the challenges facing the FTA and the emerging area of financial therapy.

REPORT

Financial therapy is a growing area of interest among practitioners and scholars and has been conceptualized as the integration of “cognitive, emotional, behavioral, relational, and economic aspects that promote financial health” (Financial Therapy Association, 2013). In an effort to bring together practitioners and researchers from diverse disciplines to share in a common vision of financial therapy, the Financial Therapy Association (FTA) was established in 2010. Since its inception, the FTA has become a thriving organization, establishing a board of directors, creating both a consumer referral program and a website, and joining social media (e.g., LinkedIn, Facebook, Twitter). The FTA organizes and holds an annual conference in addition to sponsoring a peer-reviewed scholarly journal (*The*

Journal of Financial Therapy). In an ongoing effort to continue the development of financial therapy as a new area of practice and study, Archuleta et al. (2011) suggested that a profile of the membership should be conducted regularly. Like most young and growing associations, differing and evolving opinions and ideas among an association's members are inherent. Archuleta et al. (2012) interviewed FTA members and found that there is not yet a consensus on what financial therapy is or what it actually entails. Not only were the differing opinions influenced by various members' disciplines, but they were also driven by the experience of working with clients. For example, some practitioners that were interviewed believed financial therapy occurs when a mental health and financial planner work collaboratively with a client(s) to address the aforementioned goals, while others believed one practitioner trained in both mental health and financial areas can provide financial therapy.

Capturing the diversity of members' perspectives, ideas, and experiences in relation to financial therapy is an important aspect of developing a strategic plan to build a common vision and mission of financial therapy. Gale, Goetz, and Britt (2012) recommended, "regularly checking in and assessing membership views and feelings can be helpful" for the FTA to avoid making "decisions that can have unforeseen implications" (p. 4). In order to carefully approach the future development of financial therapy, the FTA Board of Directors took steps in 2013 to establish the strategic planning committee whose sole goal was to address the future development and direction of the association. Following the recommendations of Archuleta et al. (2011) and Gale et al., the FTA strategic planning committee's first step was to commission a second survey of its members to ensure that the FTA was moving forward in alignment with their membership. This report serves as the summary of the results of the second survey, which was based on the ten considerations proposed for FTA by Gale et al.'s review of interdisciplinary associations' pitfalls and successes. These considerations were:

1. Defining financial therapy and successful outcomes of financial therapy services.
2. Developing theoretical model(s) to explain and predict how people change behavior, cognition, and relationships within the context of financial therapy.
3. Identifying the unit of service or treatment in financial therapy.
4. Defining relationship dynamics and boundaries between professionals from different professions of practice, and between the professional and client when providing financial therapy services.
5. Developing a set of skills required to provide financial therapy services.
6. Developing assessment tools to determine when good work is achieved.
7. Ensuring knowledge and expertise required to provide financial therapy services.
8. Acknowledging the responsibilities of the professional and client and developing a sensitivity to power dynamics.
9. Addressing cultural and spiritual diversity.
10. Adhering to a code of ethical behavior, professional standards, and best practices.

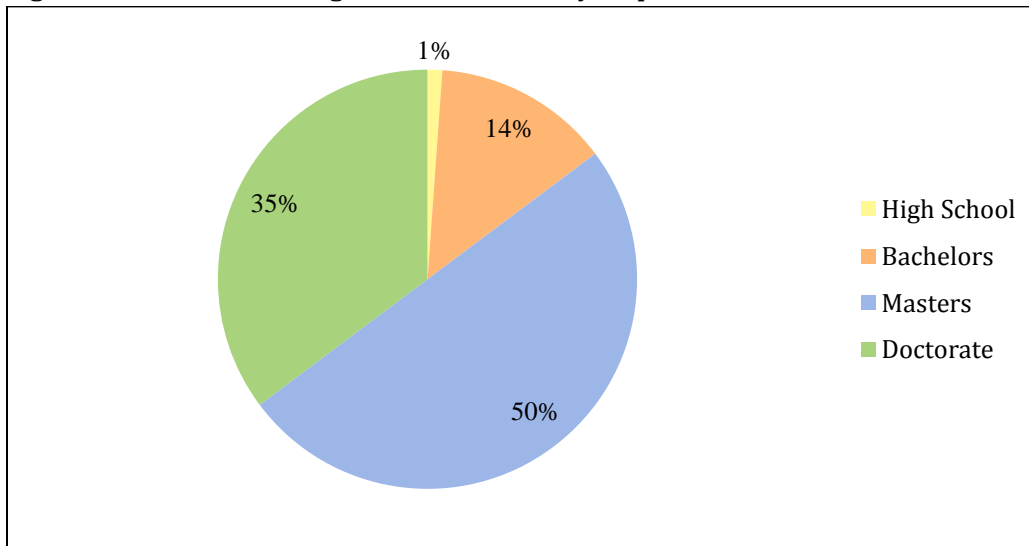
METHODS

The intention of this profile is to build upon existing data (Archuleta, 2011) around perspectives and trends of practice, education, and research associated with financial therapy. As outlined above, this profile addressed the 10 Considerations (Gale et al., 2012), with the exception of Considerations 8 and 9, which were deemed to be better addressed through qualitative methods. The electronic survey was emailed to all FTA members on July 24th, 2013 (N = 140). Overall, there were 88 respondents, yielding a 62% response rate. The number of respondents varied per question and, therefore, the number of persons (*n*) who responded to each question is included for ease of interpretation.

Demographic Profile of the FTA Membership

Before moving into the ten considerations, it is important to explore the demographics of the respondents. Therefore, questions were asked to elicit this information. The demographics of the 2013 survey respondents were similar to the initial membership profile conducted in 2011 (see Archuleta et al., 2012). In 2013, FTA members (*n*=83) ranged in age from 24 to 78 years, with an average age of 50.22 years (*SD* = 13.69). In regards to gender (*n*=88), 41% were male. In general, the membership sample (*n*=88) was well educated, with the majority (85%) reported having a Master's or Doctorate degree. Figure 1 illustrates the educational backgrounds of the FTA membership sample in 2013.

Figure 1. Educational background of FTA survey respondents



Source: Financial Therapy Association 2013 Member Survey
n=88

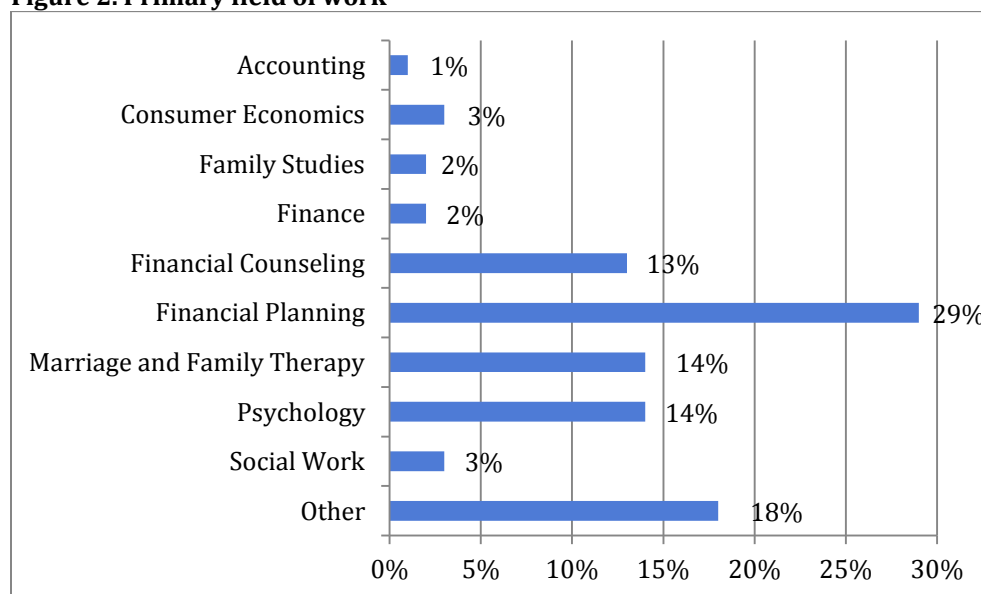
Respondents (*n*=84) were asked the field of study in which they attained their highest educational degree. Mental health fields (e.g., marriage and family therapy, psychology, social work, and counseling) were the largest group, accounting for 42%,

followed by financial professionals (e.g., financial planning, finance, financial counseling, consumer economics, and accounting), who were 31%. The remaining fields included human development, family studies, education, and business. Only 2.4% reported a finance and mental health degree combination.

Primary Field of Work among FTA Members

Survey participants ($n=87$) were asked to report their primary field(s) of practice or study. Approximately 44% chose financial planning, financial counseling, or finance. Marriage and family therapy, psychology, and social work comprised 31% of the sample. Figure 2 represents the primary fields reported, as well as “other.” Examples of “other” fields listed included: (a) research, (b) coaching, (c) mental health counseling, (d) psychotherapy, and (e) family therapy.

Figure 2. Primary field of work



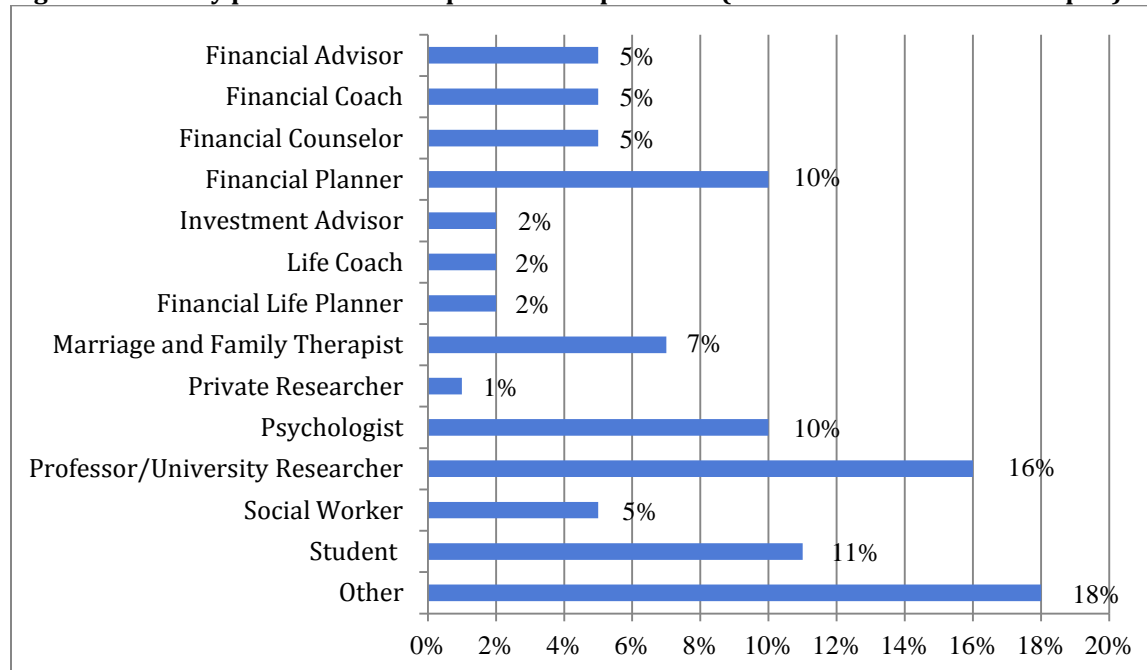
Source: Financial Therapy Association 2013 Member Survey
 $n=87$

Primary Occupations among FTA Members

Respondents ($n=87$) were asked to report their primary occupation other than a financial therapist. Primary occupation differs from primary field of practice, in which primary occupation refers to what professionals generally call themselves, whereas primary field of practice implies a broader area of study and practice. The field may be influenced by the professional’s formal training and background. For example, a professional may call him/herself a financial advisor, but is in the finance field of study. Another professional calling him/herself a financial advisor may consider financial planning as the primary field of study. Approximately 29% chose the primary occupation of financial advisor, financial coach, financial counselor, financial planner, or investment

advisor. Twenty-two percent chose professor/university researcher, student, and private researcher as a primary occupation. Marriage and family therapist, psychologist, and social worker accounted for 22% of the sample. Figure 3 represents the occupations reported, as well as the “other” category, which included: (a) psychotherapist, (b) business coach, (c) mental health counselor, (d) wealth counselor, and (e) speaker.

Figure 3. Primary professional occupation of respondents (other than a financial therapist)

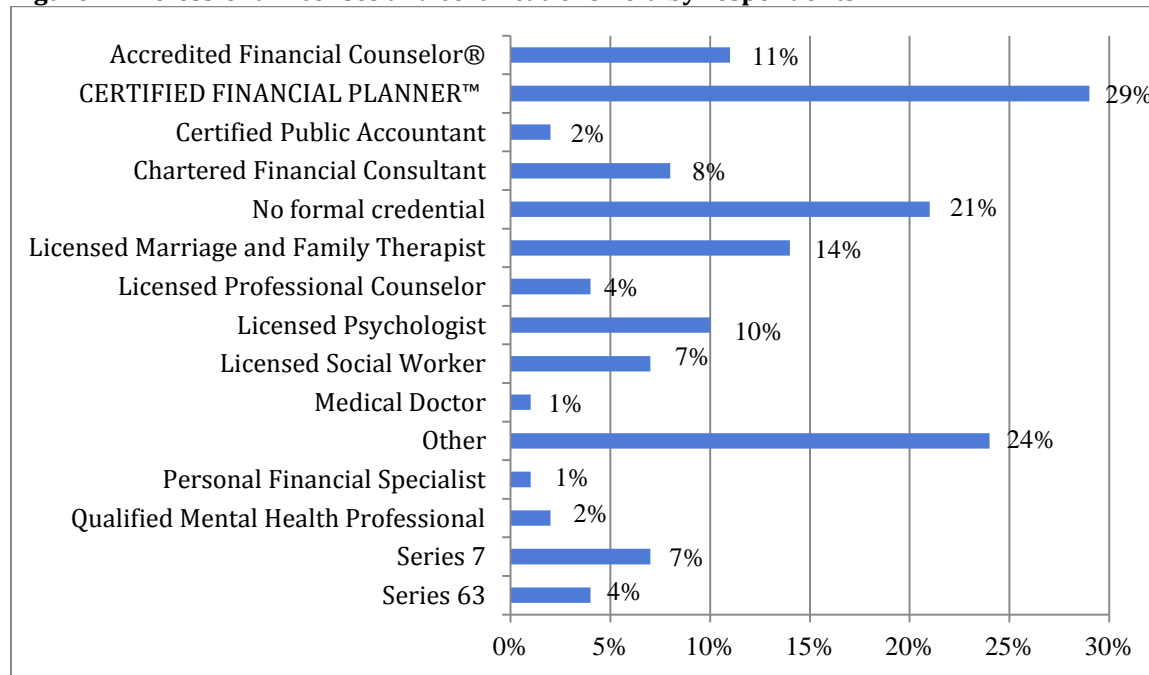


Source: Financial Therapy Association 2013 Member Survey
n=87

Professional Credentials Held among the FTA Membership

Respondents were asked to report the type of license or certification currently held. Multiple responses were permitted in order to capture professionals who hold more than one credential. As illustrated in Figure 4, respondents ($n=84$) indicated FTA members hold a wide variety of licenses and credentials.

Figure 4. Professional licenses and certifications held by respondents

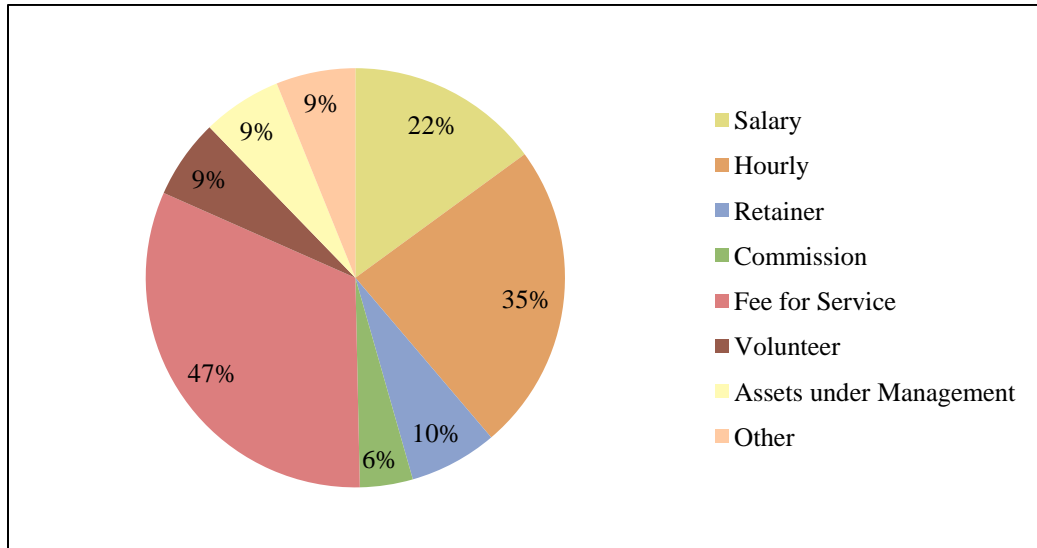


Source: Financial Therapy Association 2013 Member Survey
 Multiple responses permitted; n=84

Compensation Issues

The primary compensation models for financial therapy consist of hourly, salary, or fee arrangements. Those responding to this survey question (n=68) were able to select multiple methods of compensation. Figure 5 summarizes the various compensation models for financial therapy-related work reported by the survey respondents.

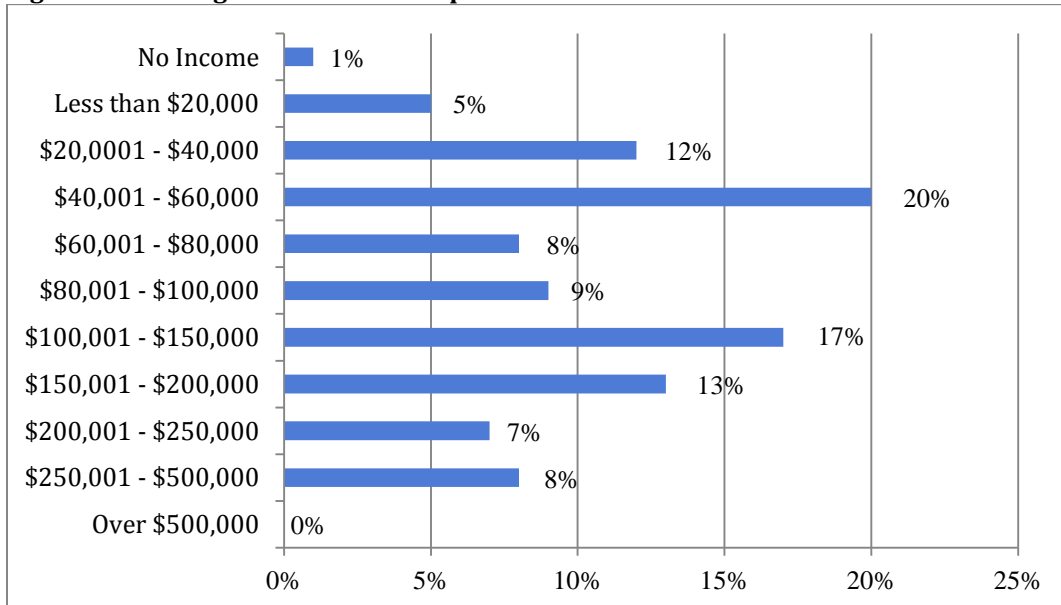
Figure 5. Compensation models for financial therapy work



Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; n=68

Survey respondents reported their annual gross income, ranging from no income to between \$240,001 and \$500,000 (n=76). Annual income included income from all services the professional provided, not just financial therapy-related services. Annual gross income results are illustrated in Figure 6.

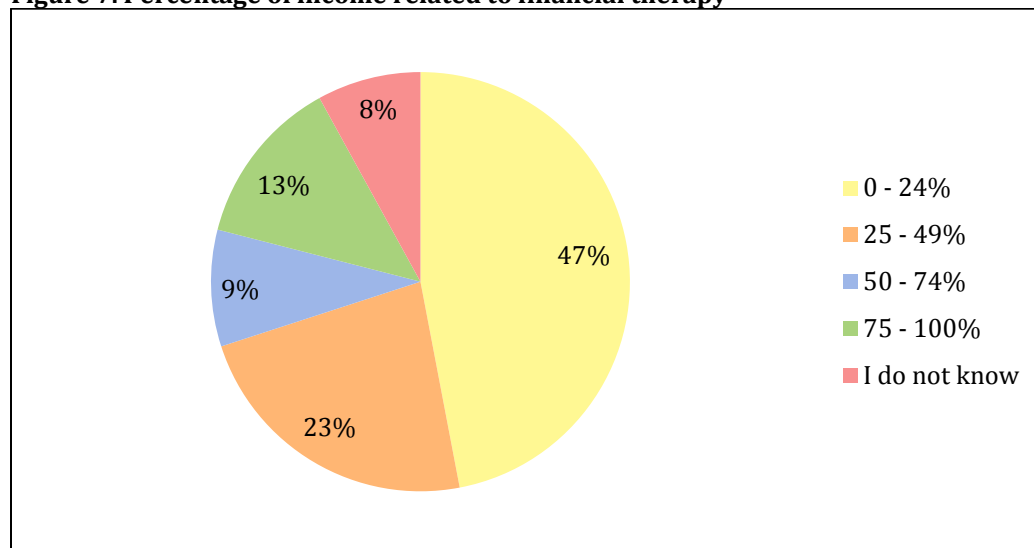
Figure 6. Annual gross income of respondents



Source: Financial Therapy Association 2013 Member Survey
n=76

Respondents were also asked to report the percentage of their total income that was derived from financial therapy services, as depicted in Figure 7. Forty-five percent of respondents reported that over 25% of their total income was derived from financial therapy work.

Figure 7. Percentage of income related to financial therapy



Source: Financial Therapy Association 2013 Member Survey
n=64

Finally, respondents were asked how long they have been doing work related to financial therapy as described by the Financial Therapy Association (i.e., “integration of cognitive, emotional, behavioral, relational, and economic aspects that promote financial health”). Although the answers varied greatly, ranging from 0 to 40 years. On average, respondents had almost nine years ($M=8.8$; $SD=8$) of work experience in the area of financial therapy.

MEMBERSHIP PERSPECTIVES IN RELATION TO 10 CONSIDERATIONS OF FINANCIAL THERAPY

In regards to the aforementioned ten considerations proposed by Gale et al. (2012), several survey questions were asked in order to assess respondents’ perspectives on 8 of the 10 considerations (excluding Considerations 8 and 9). The following results section describes the participants’ views of these areas.

Consideration #1 – Definition and Outcomes

What is financial therapy? Respondents were asked three separate questions related to the term *financial therapy*, which are:

1. To what extent do you agree that the FTA's definition of financial therapy (i.e., the integration of cognitive, emotional, behavioral, relational, and economic aspects that promote financial health) accurately describes your work/research?
2. To what extent do you agree with the FTA's definition of financial therapy?
3. To what extent do you agree the term *financial therapy* is related to your work/research?

Respondents were asked to rate their responses to each question on a scale from 1 (*strongly disagree*) to 10 (*strongly agree*). On average, participants were likely to agree with the definition ($M=8.17$; $SD=1.77$) and that the definition accurately reflected the work they do ($M=7.78$; $SD=2.09$). Participants were in moderate agreement that the term financial therapy was related to their work ($M=6.78$; $SD=2.76$). As a follow-up for those who disagreed with these items, respondents were asked to explain why they disagreed. Those who disagreed with the definition felt that the definition was too broad, that financial therapy only occurs when a therapist and planner work conjointly, that the word "economic" is not a strong enough word to describe the depth of the financial plan developed in the process, that the focus on financial health is too limiting, and that the definition is too complex for the average consumer.

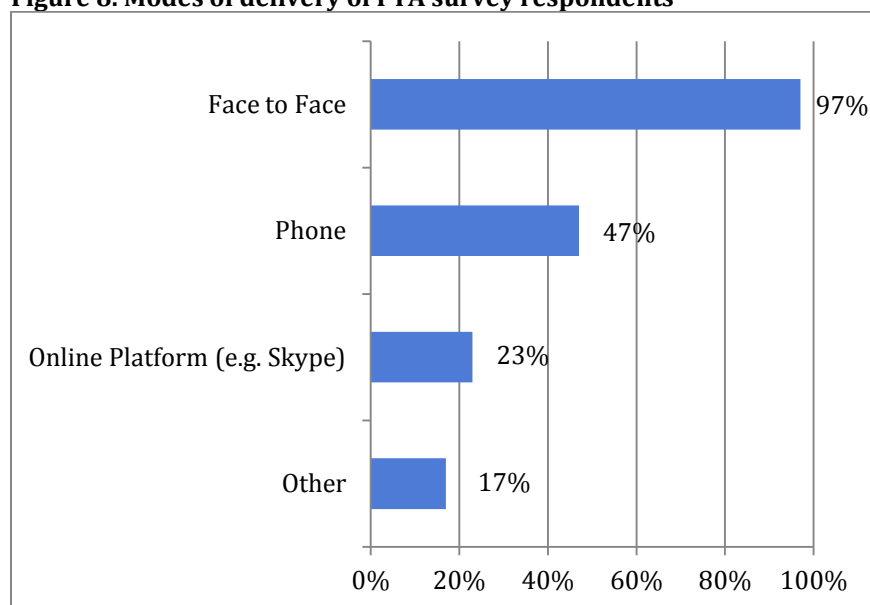
Despite participants being in moderate agreement that their work was related to financial therapy ($n=79$), only 18% of respondents called themselves "financial therapists." Those who reported that they did not call themselves financial therapists were requested to explain why. Themes developed from these responses included that the term "therapist" does not describe their work, lack of training, not actively providing services, other terms better describe work, need to learn more about the term "financial therapist," and regulatory concerns. Most of the themes presented reflect the fact that there are no formal educational requirements or credentials associated with being a financial therapist.

What are the desired outcomes? Gaining a consensus about what financial therapy actually is will help us better define the desired results of this intervention. Gale et al. (2012) pointed out varying professions may emphasize differently the aspects of financial therapy. For instance, financial planners may emphasize the financial side more than mental health professionals. To address this point, respondents were asked an open-ended question: "How would you describe the primary goal or outcome of financial therapy services?" Responses ($n=51$) varied, resulting in themes related to financial health, financial success, financial independence, financial literacy, well-being, enlightenment, and behavior change. In addition, respondents were asked if there was a point where financial therapy services end because financial therapy goals are met. Of the respondents ($n=74$), 36% felt there was a stopping point, but only 4% did not. The majority of respondents answered that they were either not sure (22%) or felt the question was not applicable to their practice (38%).

What does financial therapy look like? The practice of financial therapy looks different for the various existing professions (e.g., financial planner, marriage and family

therapist, money coach) represented within FTA. To understand what financial therapy looks like, respondents who were actively engaged in working with clients were asked to answer questions addressing the number of times the practitioner meets with a client(s), duration of the client-professional relationship, frequency of client meetings, length of each client meeting, and how practitioners meet with clients (i.e., face-to-face, phone, online platform, or other). Active practitioners reported that they see their clients for as little as one visit or for many years, and the duration of the relationship ranged from one session to lifetime. Frequency of client meetings was reported to occur as often as weekly, to as little as annually. Length of client meetings was reported to last for 30 minutes, or as long as 3 hours. Not all practitioners see their clients in person. In this sample, 3% do not see their clients in person. In addition, 47% of respondents also indicated they use the phone, and 23% use an online platform to deliver financial therapy to their clients in lieu of meeting in person. Figure 8 provides a summary of these responses.

Figure 8. Modes of delivery of FTA survey respondents



Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; n=60

Consideration #2 – Theoretical Application and Development

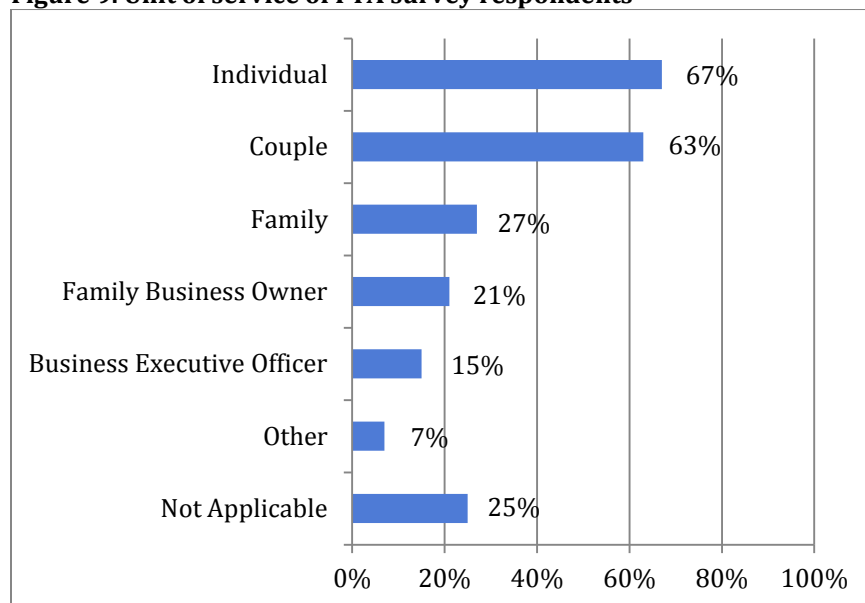
Gale and his colleagues (2012) highlighted the importance of using models and theories to “inform our professional decisions, undergird the research process in order to access effectiveness, and provide criteria for professional and ethical standards” (p. 8). As an interdisciplinary organization, the membership can consider using theories or models from either mental health or financial disciplines. Eventually, it would be beneficial to create a financial therapy theory or model to explain, predict, and test the practice of financial therapy (Gale et al., 2012). Participants were asked to list the theoretical approach/model or integration of models utilized in their client work. Responses (n=36) included: (a) Family Systems, (b) Neuroscience, (c) Bowenian, (c) Solution Focused Therapy, (d) Motivational Interviewing, (e) Behavior Economics, (f) Narrative, (g) ACT, (h)

Cognitive Behavioral, (i) Jungian, (j) Psychodynamic, (k) Inner Child Analytical, (l) Collaborative Language Systems, (m) Kolb Teaching Model, (n) Self-Psychology, (o) Neuroeconomics, (p) Experiential, and (q) Imago Couples Therapy.

Consideration #3 - Unit of Service

The unit of service for treatment at first glance appears to be a simple question. Most would consider the individual(s) present in the meeting room as the unit of service for financial therapy. However, Gale and associates (2012) challenged the idea of unit of service to be influenced by how culture, couples, and families impact each others' actions, perceptions, and values. To begin to address this complex point, respondents ($n=75$) addressed to whom (i.e., unit of service or treatment) they primarily provide financial therapy. Respondents were allowed to select multiple responses to this question. The overwhelming majority reported working with individuals (67%) and couples (63%). Figure 9 shows that the family, businesses, and executives were among other units of service assessed.

Figure 9. Unit of service of FTA survey respondents



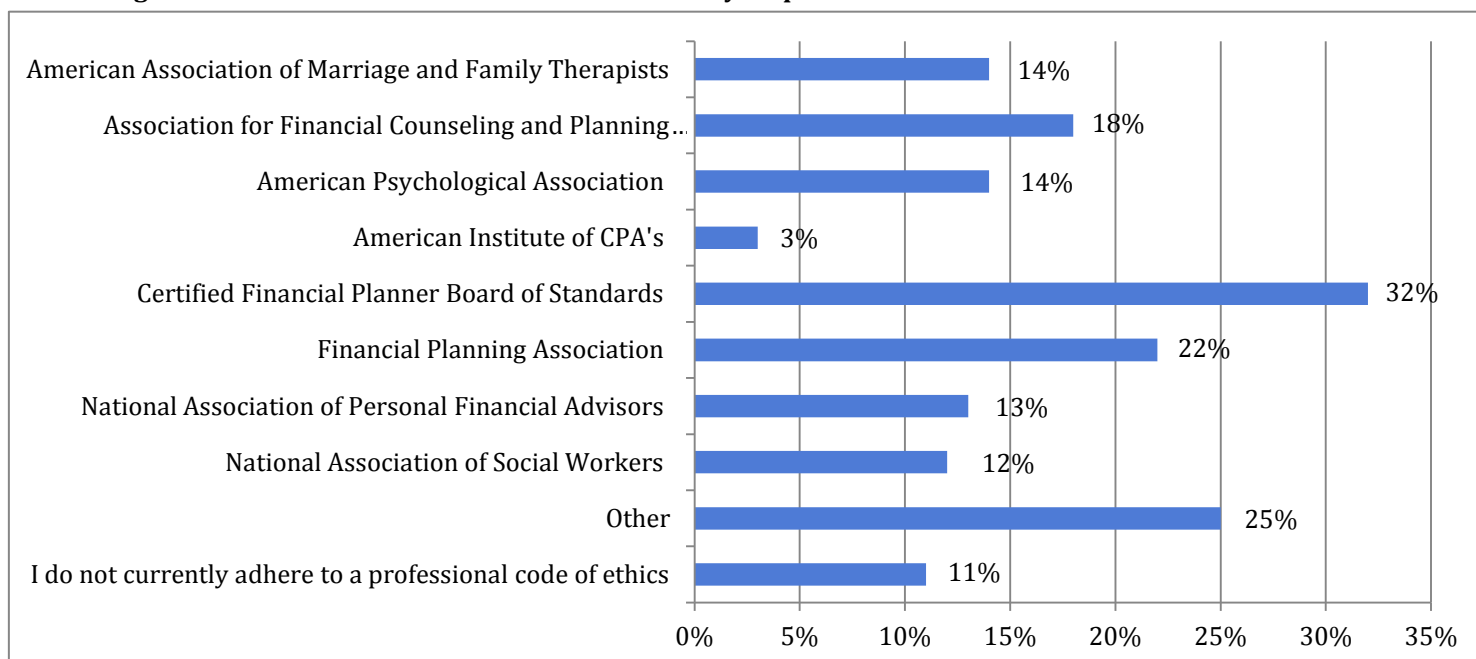
Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; $n=75$

Considerations #4 and 10 - Relationship Dynamics and Professional Boundaries and Ethical Behavior

Considerations 4 and 10 are interconnected, as the boundaries around the relationships in the financial therapy room will have clear implications on what should be considered as ethical behaviors in practice. Issues facing professionals from diverse backgrounds can be complicated. Here, the results regarding the practitioner-client relationship and ethical codes of conduct are reported.

Practitioner/client relationship dynamics and professional boundaries. The relationship between a mental health professional and a client is different than the relationship between a financial professional and a client. For example, mental health professionals must adhere to explicit rules related to the avoidance of personal relationships with clients outside of the professional setting. In addition, mental health professionals are mandatory reporters of abuse and threats to safety. However, these rules are not applicable to most financial planners. An understanding of the ethical guidelines being utilized in the practice of financial therapy is important to developing an understanding of what is acceptable in financial therapy and, more importantly, what *should* be acceptable in practice (Gale et al., 2012). The respondents ($n=76$) of this survey answered whether they adhered to various professional codes of ethics (see Figure 10). The majority of respondents did abide by a code of ethics, namely the ones listed. Examples of “other” code of ethics respondents adhered to included: (a) International Coaching Federation, (b) American Mental Health Counselors Association (AMHCA), (c) California Board of Behavioral Sciences, (d) American Counseling Association (ACA), (e) International Association of Registered Financial Consultants (IARFC), and (f) Institutional Review Board (IRB).

Figure 10. Professional code of ethics of FTA survey respondents



Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; $n=76$

Dual practitioner relationship dynamics and professional boundaries. Ethics around financial therapy are not clear yet, and they become even murkier when practitioners from two fields work together. One of the major discussion topics in financial therapy currently is whether or not the process requires both a mental health professional and a financial professional working conjointly. The alternative is a single professional who has training in both areas. This debate may be influenced by current codes of conduct and

professional training. Currently, 50% of the subsample ($n=30$) of mental health professionals collaborate with a financial professional when working with clients who present financial issues in therapy, while only 26% of financial professionals ($n=27$) collaborate with mental health professionals in their work.

When professionals from two different professions work together, ethical dilemmas can arise. Survey respondents were asked how they address differences in practice standards of client boundaries when working with a professional in a different discipline. When collaborating with a professional from a different field who adheres to a different code of ethics ($n=42$), 52% of respondents reported that they abided by their own code of ethics, and 24% reported that they abided by the most stringent code of ethics. Interestingly, 21% of respondents had not considered how to handle differences in code of ethics. When differences in ethical codes exist ($n=36$), the vast majority of respondents (75%) always or almost always communicate how the differences in professional boundaries will be handled within the engagement. In response to the question of if the Financial Therapy Association should develop a code of ethics, the majority of respondents ($n=74$) responded positively with maybe or yes (88%), with only 12% saying no. Reasons for each response varied. The resulting themes summarizing the responses can be found in Table 1.

Table 1
Development of code of ethics reasons

<i>Yes (62%)</i>	<i>Maybe (26%)</i>	<i>No (12%)</i>
<ul style="list-style-type: none"> • Establish legitimacy as a profession • Clarify boundaries • Protect self & consumers • Basic standard for a professional association • Standardize & integrate practice of financial therapy 	<ul style="list-style-type: none"> • Current code of ethics likely covers • More research needed • If providing certification • Application & training issues • Code of ethic diversity issues 	<ul style="list-style-type: none"> • Duplication issues • Confusion with primary discipline • Too difficult to create • Too many existing codes of ethics to adhere to

*Source: Financial Therapy Association 2013 Member Survey
 $n=74$*

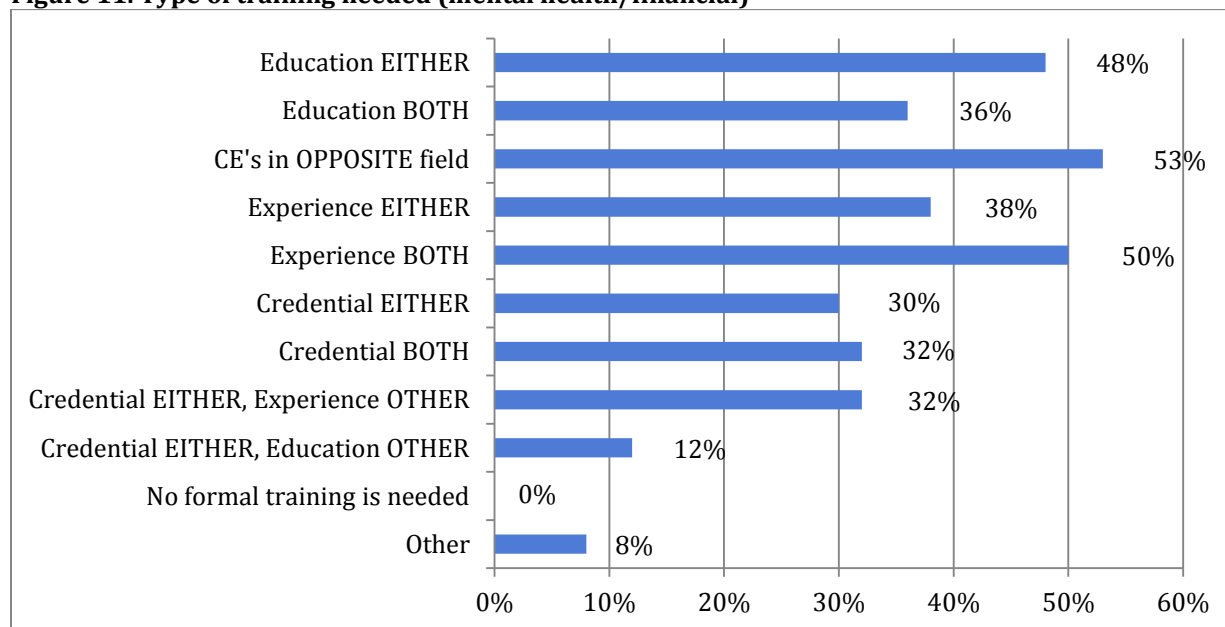
Consideration #5 - Necessary Skill Set

The next consideration refers to the skills needed to be a proficient financial therapist. In other words, what skills are required from the mental health and financial disciplines to provide financial therapy? Recently, an autoethnography was published about a marriage and family therapy doctoral student who took a financial course to develop a skill set (McCoy, Gale, Ford, & McCoy, 2013). She addressed how therapists can learn from the financial discipline and what financial planners can learn from mental health disciplines. From this student's perspective, she argued that therapists and financial planners fare better when they collaborate. Yet, when that is not possible, they do not need

to be completely proficient in both fields. Instead, she suggested that therapists need to learn practical financial skills (e.g., how to create budgets), how to recognize “red flags” of financial distress, and be able to access resources for clients (e.g., credit counseling bureaus). Planners need to learn more about how to manage emotions in session, how to address power dynamics, and learn techniques used to motivate change as well as other interpersonal skills. Similar to McCoy et al.’s (2013) findings, in an open-ended question the respondents of this survey suggested that interpersonal therapeutic skills (e.g., active listening, empathy) and a working knowledge of personal finance are both necessary skills. More specifically, they reported that practitioners need skills in the areas of communication, conflict resolution, relationships, and mental health (e.g., therapy, psychology, coaching).

How a financial therapist develops these skills provides another opportunity for dissension. Most respondents reported that formal education was not needed in both disciplines. However, some respondents did state that a strong mental health background was necessary to use the term “financial therapist.” Figure 11 shows the breakdown of the responses about what type of training is needed to call themselves a financial therapist. Respondents were able to choose multiple responses to this question. Although respondents varied in their opinions, the majority appeared to feel that experience and training (e.g., continuing education) in both fields is needed, but that education is only needed in one.

Figure 11. Type of training needed (mental health/financial)

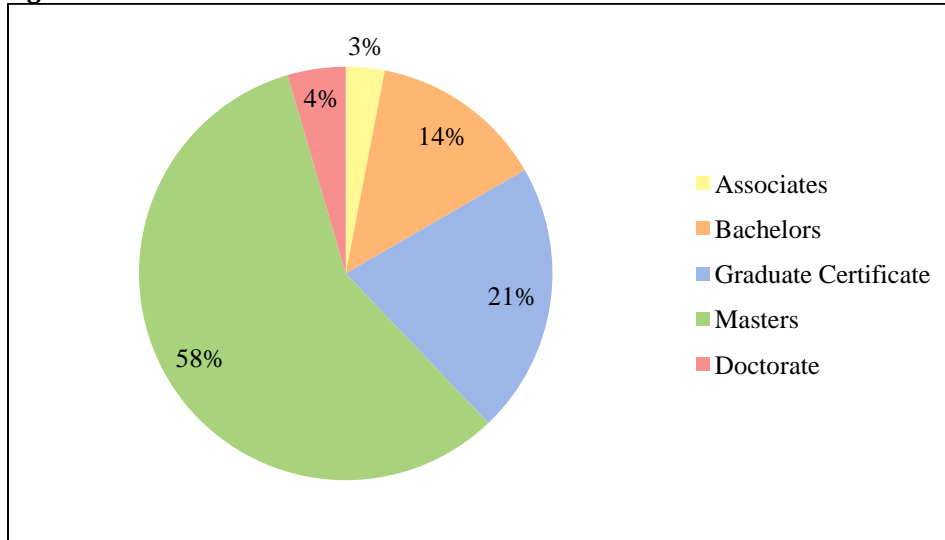


Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; n=66

Respondents (n=66) addressed what level of education was needed to practice financial therapy. The majority of respondents (79%) agreed that at least a graduate

certificate or master's degree was needed. Figure 12 illustrates the level of education respondents believed those practicing financial therapy needed.

Figure 12. Level of education needed



Source: Financial Therapy Association 2013 Member Survey
n=66

Consideration #6 - Assessment Tools

Gale and colleagues (2012) pointed out that the only way to know when good work is being done is through evaluations, such as formal and informal assessments. Unfortunately, only one known study has been published evaluating the effectiveness of financial therapy thus far (Klontz, Bivens, Klontz, Wada, & Kahler, 2008); and no approach has been established as an evidence-based financial therapy model. However, there are numerous formal and informal assessments that can be used from either mental health or financial disciplines. The types of formal and informal assessments used are found in Table 2.

Table 2
Formal & informal assessments

<i>Formal (n=15)</i>	<i>Informal (n=26)</i>
<ul style="list-style-type: none"> • Klontz Money Scripts Inventory • Klontz Money Behaviors Inventory • PhQ-9 • Financial Behavior Assessment • OQ.45 • F.I.R.O. Testing • Willoughby Personality Schedule • Financial Anxiety Scale • Fear Survey Schedule • Motivated Asset Pattern Assessment • MSQ • Collaborative Language Systems • FDAS • GAF/GARF 	<ul style="list-style-type: none"> • Budget questionnaire • Money history • Financial behavior assessment • Family history • Online behavioral survey • Genogram • Spending patterns • Money egg • Money atom • Online behavioral survey • Attitudes toward money surveys • Value inventory • Risk tolerance assessment • Behavioral finance • Assessment of mood • Money quotient • Motivation for change • Improvement in goals

Source: Financial Therapy Association 2013 Member Survey
n=70

Of the 70 professionals who responded to the question about utilizing assessments, only 15% of respondents reported regularly using a formal assessment, and 17% used no assessment at all to monitor their progress. The rest reported *sometimes* using formal or informal assessments in their work.

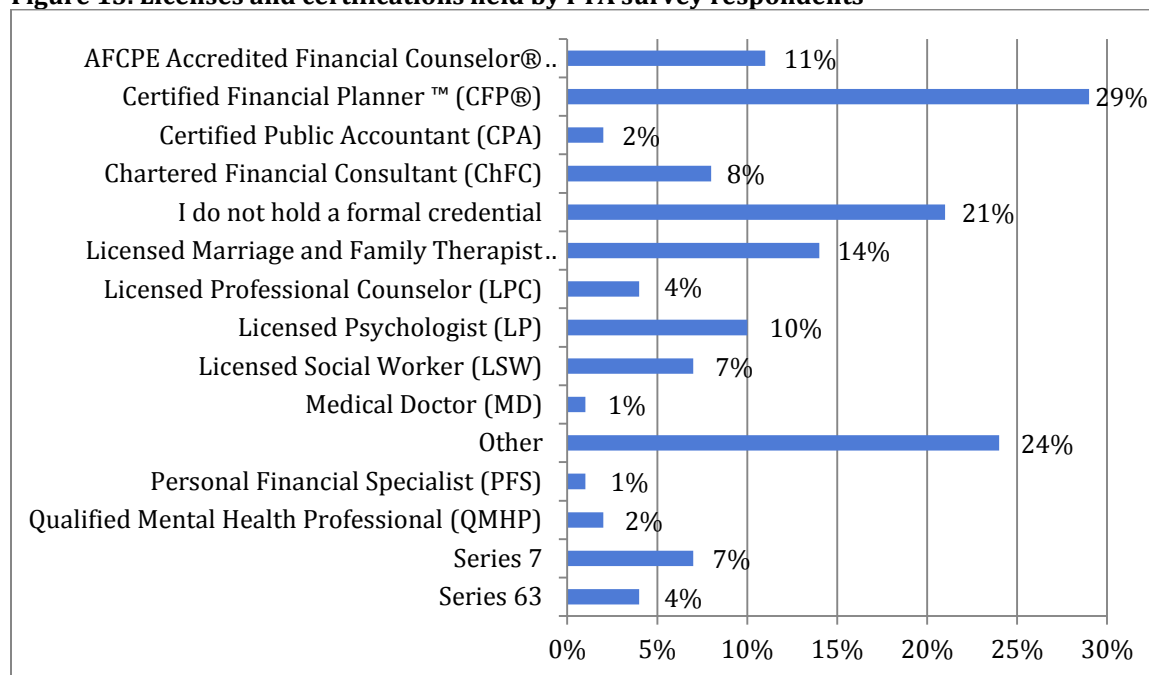
Few financial therapy assessment tools exist. Therefore, to move the field forward, assessment tools need to be created. In light of this observation, participants were asked to identify what type of assessment tools need to be developed to help determine when good financial therapy work is achieved. While 35% (*n=23*) were unsure of what assessments were needed, other suggestions from respondents included assessments of body language, couples relational skill sets, behaviors, conflict styles, health and money relationships, personality, financial progress and subjective well-being, and client’s expressed values and their actions.

Consideration #7 - Ensuring Knowledge Expertise

As the field of financial therapy continues to grow, the FTA will need to decide whether a regulatory body needs to be established to register or certify financial therapists with credentials or designations in order to provide consumer protection (Gale et al., 2012). Currently, most respondents reported holding credentials or designations in their home discipline, meaning that they held credentials in the field in which they received their main training or in which they primarily practiced. In regards to types of licenses or

certifications held, respondents were allowed to indicate multiple credentials. The single largest category was the CFP® designation. Twenty-four percent of respondents reported “other” types of credentials including: (a) Accredited Estate Planner (AEP®), (b) Certified Trust and Financial Advisor (CTFA), (c) Series 65, (d) Professional Certified Coach (PCC), (e) Specialty-Certified New Money Story® Mentor, (f) Enrolled Agent (EA), (g) Certified in Financial Forensics (CFF), (h) Certified Fraud Examiner (CFE), (i) Associate Certified Coach (ACC), (j) Board Certified Coach (BCC), (k) Chartered Retirement Planning Counselor (CRPC), (l) Accredited Asset Management Specialist (AAMS), (m) Chartered Life Underwriter (CLU), (n) Certified Money Coach (CMC), and (o) Registered Financial Associate (RFA). Figure 13 represents the variety of responses.

Figure 13. Licenses and certifications held by FTA survey respondents



Source: Financial Therapy Association 2013 Member Survey
Multiple responses permitted; n=84

Advantages and disadvantages of creating a formal regulation body were identified. When asked if they felt like financial therapists should have credentials or a designation of their own, most (62%) agreed that there should be a credential or designation. Respondents were also asked to provide reasons as to why or why not credentials or designations should be available. In response to a credential or designation in financial therapy being offered, these members felt like a practice standard would be created, would help to distinguish financial therapy from other professions, and would help create visibility and legitimacy of the profession. Major themes among the respondents who felt unsure reflected the field of financial therapy's infancy and having already existing credentials that are adequate. Reasons as to why a credential or designation should not be

available, or why respondents were unsure if one should be offered are summarized in Table 3.

Table 3
Credential/designations

<i>Yes (64%)</i>	<i>Unsure (26%)</i>	<i>No (11%)</i>
<ul style="list-style-type: none"> • Creates a standard • Allows for differentiation • Integrates various professions into one • Legitimizes the profession • Increases visibility 	<ul style="list-style-type: none"> • Financial therapy is too young to establish a designation /credential • There are too many current designations/credentials in general • Primary field designation/credentials likely suffices • Support depends upon requirements of designation/credential 	<ul style="list-style-type: none"> • Credentialing can cause exclusivity • Current designations/credentials are adequate • There are too many current credentials/designations

Source: Financial Therapy Association 2013 Member Survey
n=66

DISCUSSION

This report serves as a follow-up membership profile, completed two years after the initial membership profile in 2011 (Archuleta et al., 2011). At the time the survey was sent out to members, there were 140 members, representing a decrease in membership since 2011, yet the response rate grew from only 28% to 62%. The decline in membership should not be looked upon negatively for a number of reasons. First, FTA membership in 2010 was obtained by donation rather than a standard membership fee that is now in place, which allowed for individuals to become members and browse the benefits of membership without making a financial commitment. Second, because there was not a structure set to automatically identify and renew annual memberships, many memberships were carried over from 2010. The FTA Board spent a considerable amount of time in 2012 and 2013 working on a system to better track and notify current and former members of their membership status. Third, members may be more involved in the association than in 2011 as indicated by an increase in response rate; therefore the decreased membership may represent those who are more committed to FTA and its mission and vision. Finally, attendance at the annual conferences has included at least 70% of the membership, another sign of an active and engaged membership.

In regards to the basic demographics of the association, most statistics remained relatively the same (i.e., age, gender, education attainment, profession, and income), but the percentage of income from financial therapy has grown. Presently, 92% of respondents reported that they received some income from financial therapy, whereas only 72% received income from financial therapy in 2011. The higher financial therapy income is also another sign that current FTA members are more invested in the association simply due to

the type of services they perform. Regardless of why membership may have decreased, continued efforts by existing members and the FTA Board of Directors to recruit new members should be a primary focus moving forward.

One of the largest differences in the 2013 profile is that the survey was framed around the ten considerations for interdisciplinary associations created by Gale et al. (2012). The 2011 profile was not organized in the same manner, but did ask many similar questions. For instance, in both surveys, members were asked their opinion on the definition of financial therapy created by the association. It appeared that a majority of the respondents agreed with the definition of financial therapy and stated that it was related to their work. Despite the high rate of agreement with financial therapy's definition and its applicability to their work, only 29% of respondents in 2011 and 18% of respondents in 2013 identified themselves as a financial therapist. The 2011 survey did not go into any further detail. However, the current survey explored why a disconnect appears to exist between conducting financial therapy and calling oneself a financial therapist. In 2013, participants reported reasons for this discrepancy primarily related to having no formal educational requirements, licensures, or certifications that would signify that they could legally or ethically call themselves a financial therapist. Others stated that conducting financial therapy was only part of what they did rather than their primary occupation. Qualitative methods should be implemented to gain deeper insight into this discrepancy.

The 2013 survey also asked how long the participant had been doing financial therapy, what the desired outcomes of financial therapy were, what financial therapy looks like, and what the necessary skill sets were to practice financial therapy. These questions were not in the 2011 survey, and therefore, no comparison data is available. Future profiles should include similar questions to explore how the membership views are evolving in these areas.

Another core topic of both the 2011 and 2013 survey was the professional practices of the membership in regards to their collaboration across disciplines. In 2013, 50% of mental health professionals reported that they regularly collaborated with a financial professional during financial therapy-related practice, whereas in 2011, only 41% reported collaboration efforts. However, less of the association's financial professionals are collaborating with mental health professionals (45% in 2011 and 26% in 2013). The decrease in collaboration efforts by financial professionals is interesting because they are still active in the financial therapy field. One hypothesis as to why this trend is occurring is that financial professionals may have more access to training on interpersonal and intrapersonal issues, and are therefore implementing this training in their practice without the mental health practitioner in the room. Further research is needed to not only explore this shift further, but to also gain insight into the benefits and challenges of working across disciplines.

Due to the cross-disciplinary nature of financial therapy, ethics was a focus in both profiles. As the FTA continues to mature, creating an overarching framework to provide

insight on how to handle gray areas, like relationship boundaries, confidentiality, and mandated reporting, may be prudent (Gale et al., 2012). In 2011 and 2013, the majority of members (69% and 88%, respectively) asserted that a code of ethics needs to be established for the Financial Therapy Association. Yet, more research is needed to understand what should be included to accommodate the diverse professionals involved.

Another component of ethical work is the use of theory and research in practice. In 2011, 62% of participants reported using a theoretical approach in their practice. Whereas, in the current survey only 41% of participants reported using a theoretical approach. As our field continues to grow, the importance of utilizing theory and evidence-based practices is important to the establishment and credibility of a new field. Utilizing theory and knowing what works in financial therapy (i.e., evidence-based practices) not only creates a common thread and increases quality and effectiveness of services among practitioners, but also helps to provide training to new financial therapy professionals. However, to create evidence-based practices, increased collaboration efforts between researchers and practitioners need to exist. It is essential for practitioners conducting financial therapy-related work to share their methods and have them tested in order to ensure that practice methods are being supported by research. The thought of having researchers evaluate what practitioners are actually doing may be an intimidating notion, but it is necessary to gain credibility and train future financial therapists.

In addition, because research on effective practices is imperative to the growth and quality of financial therapy services, practitioners need to be current on the latest financial therapy-related research. Unfortunately, only 33% of respondents reported that scholarly journals are the most important source of research and resources. Furthermore, many of the respondents did not list *The Journal of Financial Therapy* as a journal they utilize, despite it being the flagship journal of the field. *The Journal of Financial Therapy* is an open access journal (i.e., anyone can access it for free), is sponsored by the FTA, and provides the latest research trends related to financial therapy. FTA members receive a complimentary electronic copy of *JFT*, in which each article published in the issue is combined into one document. To move the emerging field of financial therapy forward, more work is needed to create theory that supports the interdisciplinary nature of financial therapy work, as well as support for evidence-based practice. Publishing this type of research in *JFT* and increased readership by members about this type research is pertinent.

CONCLUSION

Gale and colleagues (2012) encouraged the Financial Therapy Association and its members to explore their own perspectives and values and to engage in dialogues about the ten considerations through online discussions, conference participation, ongoing publications, and letters to the FTA Board, small group discussions with those in your local area, and to even consider serving as FTA Board Members. The goal of this 2013 membership profile is to act as a springboard for this dialogue. In an attempt to continue this exploration and our strategic planning efforts, additional qualitative research is being planned for at the next annual Financial Therapy Association conference. Members and those who are interested in developing financial therapy are strongly encouraged to attend.

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Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

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Narrative financial therapy is one of the first attempts to develop an integrated theoretical approach to financial therapy that can be used by practitioners from multiple disciplines. The presented approach integrates the components of the six-step financial planning process with components of empirically-supported therapeutic methods. This integration provides the foundation for a manualized approach to financial therapy, shaped by the writings of narrative theorists and select cognitive-behavioral interventions that can be used both by mental health and financial professionals.

Keywords: financial therapy; financial psychology; money psychology; marriage and family therapy; financial planning; financial counseling; narrative therapy; cognitive behavioral therapy

INTRODUCTION

Many professionals in the financial and mental health fields have discovered an overlap between their disciplines. Research indicates financial planners spend approximately 25% of their time dealing with non-financial issues, such as marital distress (Dubofsky & Sussman, 2009), and about one-third of couples in marital therapy report financial stress or problems (Aniol & Snyder, 1997; Miller et al., 2003). The development of the Financial Therapy Association (FTA) is, in part, a response to this overlap in practice. FTA's purpose is to create a vision of financial therapy that "integrates the cognitive, emotional, behavioral, relational, and economic aspects that promote financial health" (Financial Therapy Association, 2013). More specifically, financial therapy is a relatively new model of study and intervention that integrates treatment components from the mental health fields with techniques and processes from the financial planning profession (McGill, Grable, & Britt, 2010). The goals of the current financial therapy model include: (a) helping clients

Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

increase couple communication, (b) strengthening relationship stability, (c) decreasing financial distress, (e) increasing financial management skills, (f) creating an economic locus of control, and (g) improving financial and overall well-being (Kim, Gale, Goetz, & Bermudez, 2011).

Recently, Archuleta et al. (2012) interviewed professional members in the Financial Therapy Association and found that there is not yet a consensus on what financial therapy actually entails. Some of the practitioners interviewed as part of the study believe financial therapy occurs when a mental health and financial planner work collaboratively with a client or clients to address the aforementioned goals, while others believe one practitioner trained in both mental health and financial areas may also provide financial therapy. Many professionals are clamoring for the latter (an integrated approach), but past literature primarily references models that either have professionals working collaboratively or just superficially addressing relational or financial needs. Gale, Goetz, and Britt (2012) emphasized the importance of creating theoretical models and applications for the evolving field of financial therapy. In response to this need, this paper presents an integrated theoretical approach to financial therapy that combines components of both mental health and financial planning models and can be used by mental health or financial professionals.

LITERATURE REVIEW

Three integrated financial therapy models are discussed in past literature. The first two models discussed are considered collaborative approaches, involving professionals from the fields of financial planning and mental health. Conversely, the third model is more of an integrated approach which offers some financial counseling techniques, but requires a practitioner with substantial training in a mental health discipline. In the following paragraphs, all three approaches to financial therapy are discussed, as well as the limitations of each of the approaches.

Two studies have applied a collaborative approach to financial therapy. In these approaches, mental health professionals worked alongside financial planners to help families. The first study was conducted by Klontz, Bivens, Klontz, Wada, and Kahler (2008). This team of psychologists and financial planners completed an open clinical trial on individuals experiencing financial strain. The treatment approach integrated psychological and financial concepts to treat unhealthy financial behaviors and related psychological symptomology in a six-day experiential therapy program (Klontz, Kahler, & Klontz, 2006; Zaslou, 2003). An emphasis on shame reduction was an integral part of treatment, attempting to assist participants in making a conceptual distinction between harmful thinking and behaviors around money and one's core self. Financial information and financial exercises were drawn from the work of Klontz et al. (2006) and Kinder (1999). However, the core treatment modality was experiential in nature and was based on the theory and techniques of psychodrama (Dayton, 1994; Moreno & Fox, 1987). Psychodrama is an approach to therapy that has the clients use role playing of past experiences to investigate and gain insight into their lives (Moreno & Fox, 1987). The primary focus was

on exploring the participants' previous financial experiences and resulting beliefs around money that lead to poor financial decisions. Participants reported reductions in psychological distress, anxiety, and worry about money and finance related situations.

The second study was conducted by Kim, Gale, Goetz, and Bermudez (2011). This pilot study looked at the effectiveness of a financial planner and a family therapist working together to provide therapy for 12 couples experiencing concomitant financial and relational distress (Gale, Goetz, & Bermudez, 2009). The researchers utilized a five-session protocol plus a pre-session. In the sessions, the goal was to identify short and long-term goals for both the couple's relationship and financial stability, gaining an understanding of the emotional and psychological aspects of the couples' financial and relational well-being, motivating the couple to practice financial management behaviors that would assist in achieving their goals, and highlighting and celebrating the clients' progress by summarizing their achievements in order to validate their success. Approximately three months after the final session, the couples completed post-treatment interviews. Overwhelmingly, the couples reported fewer relationship problems, less financial strain, and improved financial well-being.

Both studies incorporated mental health and financial interventions without fully explaining why the interventions were chosen. Additionally, both studies required a professional from each field to be present in the sessions. This is not always a viable option in therapists' work due to scheduling or monetary constraints. Many times, a mental health professional and a financial expert work alone with couples who are experiencing both financial and marital stress. Thus, there needs to be an approach that both a mental health professional and a financial professional can individually utilize to resolve inter-related topics in session. In other words, the next step for the field of financial therapy is to create theoretical and evidence-based models and approaches that can be implemented by practitioners from both the mental health and financial fields.

Another attempt at an integrated approach was the Ford Financial Empowerment Model (Ford, Baptist, Archuleta, 2012), which involved a trans-theoretical approach for financial empowerment through integrating aspects of cognitive-behavioral, narrative, and Virginia Satir's experiential therapies, along with some financial counseling techniques. Though this is a step in the right direction, the article presents little integration of financial therapy. The scope of the article discouraged mental health professionals from providing financial planning advice and financial planners from implementing therapeutic interventions if they are not trained in the area. It would be difficult to apply this approach without extensive specialized training in financial planning as well as narrative, cognitive-behavioral, and experiential therapy approaches. The model was skewed for mental health professionals, and therefore would be difficult for most financial planners to integrate into their practice. Consequently, this approach is not a practical option for all practitioners interested in providing financial therapy.

Despite the limitations associated with these approaches, the application of all three models showed positive results. To apply the collaborative approaches described by Kim et al. (2011) and Klontz et al. (2008), two practitioners are needed (i.e., a mental health

Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

professional and a financial professional). Conversely, the Ford Financial Empowerment Model begins integrating the fields using a single practitioner, but there is still a need for substantial training in the therapy approaches described, which excludes most financial planners. To move the financial therapy field forward, there needs to be therapeutic financial approaches that can be implemented independently by either mental health or financial practitioners.

Creating an integrated approach that both practitioners can utilize is a difficult process. Recently Smith, Nelson, Richards, and Shelton (2012) published a book on an integrated approach that is a step in the right direction. However, it still requires substantial knowledge of various therapeutic theories to utilize. Therefore, a goal of the current paper is to develop an integrated, manualized approach for financial therapy that mental health or financial practitioners can use in their practice. A manualized approach means that directives are laid out to guide and explain how to proceed with treatment. For example, guidelines are presented on how a financial or mental health professional can use: (a) narrative questions, (b) cognitive behavioral psychoeducation and interventions, and (c) the six-step financial planning process to help individuals, couples, and families. It is considered a manualized approach because it has six steps with objectives that need to be completed before the practitioner can proceed.

Manualized therapies dominate outcome research and have the empirical support clinicians need to justify practice (Levant, 2005). Manualized approaches provide structure to treatment and a guide that is easier to follow than most therapeutic interventions. Manualized approaches also provide a way to better test the efficacy of treatment by increasing internal validity (Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997). A manualized approach to doing financial therapy is presented to make the approach more accessible to both financial and mental health professionals. It is not a manualized approach for conducting narrative therapy; rather, it is a manualized approach for conducting narrative *financial* therapy. Therefore, this article presents a coherent, integrated, and manualized approach for both mental health and financial planning professionals to conduct financial therapy.

MODEL DESCRIPTION

The proposed model incorporates narrative questions and cognitive behavioral therapy interventions into the well-established six-step financial planning process (CFP Board, 2013). While both narrative therapy and cognitive behavioral therapy have been shown to be effective therapies on their own, the integration of the two can augment the benefits in treatment (Griffin, 2003; Blenkiron, 2005; Blenkiron, 2010; Bertrando, 2011). For example, the integration of narrative and cognitive behavioral therapies have been shown to be effective in addressing numerous mental health issues and facilitating behavior changes in the areas of: (a) trauma (Deblinger et al., 2011; Tuval-Mashiach et al., 2004), (b) mood disorders (Bradfield, 2010), (c) premenstrual symptoms (Ussher, Hunter, & Cariss, 2002), and (d) various forms of psychosis (Rhodes & Simon, 2009). Given the

effectiveness of utilizing an integration of these two models, the current integrative model applies cognitive behavioral interventions to a narrative approach in addressing financial concerns.

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 & 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 co-written by social, cultural, and political contexts (Freedman & 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 about themselves. For example, if a client comes in stating they are depressed, they are creating a thin description of themselves as depressed. It is called a thin description because it does not allow for alternative descriptions (Morgan, 2001). 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 help the client see themselves as a strong, smart, and resourceful person that is fighting against depression during this period in their life. Narrative therapists refer to this as, "thickening" the stories.

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 & Combs, 1996).

Each stage of narrative therapy has types of questions that can help move toward a preferred narrative. In Figure 1, examples of 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. Common financial issues clients

Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

may report include challenges with the following: (a) debt management, (b) budgeting, (c) spending patterns, and (d) financial power differentials. These questions can facilitate a financial therapist to co-write with their clients a thicker story that hopefully shifts the clients' perception of reality away from the internalized problem and the internalized maladaptive discourse and moves toward a new story of possibility (Freedman & Combs, 1996).

It is important to clarify that narrative therapy is based on a nonpathologizing stance; this means that practitioners who utilize 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, 2001). Thus, the focus can shift to the future and client strengths, rather than fixing past problems.

Cognitive Behavioral Theory

While the narrative approach is the primary theory supporting the presented financial therapy model, cognitive and behavioral techniques are also used to enhance the process. Cognitive behavioral therapy (CBT) enhances narrative financial therapy by providing therapeutic interventions financial therapists can use to change and modify maladaptive behaviors and thought processes that create financial challenges for clients, while also strengthening the positive financial characteristics of clients. Historically, CBT was developed through the integration of conditioning principles of behavioral therapies with therapies that addressed strictly cognitive clinical issues, such as obsessive thinking (Dobson, 2010). This integration was created to address issues that manifested from both cognitive and behavioral problems. CBT is included in the proposed model to address the combination of behavioral financial issues (e.g., budgeting and managing spending patterns) and cognitive financial issues (e.g., shame associated with overspending) that financial therapists often see in practice. CBT is also included due to its history and success with reducing client's financial stress. Several studies have described how to apply a cognitive behavioral therapy model to specific financial problems. For example, cognitive and behavioral interventions have been shown to be effective in the treatment of financially-related stressors and behaviors, such as compulsive buying (Dell'Osso et al., 2008; Ertelt et al., 2009; Mitchell et al., 2006), compulsive spending (Mitchell et al., 2006), gambling (Toneatto & Ladouceur, 2003), as well as maladaptive financial beliefs and behaviors (Klontz et al., 2008).

In brief, CBT works to increase desired behaviors and decrease undesired behaviors through a concrete system of exercises and techniques that address specific, measurable goals (Wright, Basco, & Thase, 2006; Nichols, 2010). Cognitive and behavioral interventions and procedures can be numerous and varied, but can be organized through the three categories of cognitive restructuring, coping skills building, and problem-solving (Dobson, 2010). Cognitive restructuring assumes that maladaptive thoughts cause emotional

distress, and thus tries to challenge and then modify thought processes in order to create new, positive thought patterns. Building coping skills focuses on helping the client develop a skill set which assists the client in managing different stressors that arise. Problem-solving revolves around the combination of cognitive restructuring and coping skills building, as well as the creation and development of active, concrete strategies to address and manage problems. In financial therapy, the financial therapist and client are responsible for taking an active role in implementing these procedures through a collaborative effort in planning the treatment program. While the financial therapist helps guide the structure of these procedures through providing initial education, the development, planning, and implementation is co-constructed by the clients and financial therapist so that each have an active role in the positive change process. Common techniques utilized in CBT are assigning homework to do between sessions, providing psychoeducation on the specific issues presented, charting problem behaviors between sessions, disputing and challenging irrational beliefs or cognitive distortions that exacerbate the issues, and building communication skills (Wright, Basco, & Thase, 2006; Beck, 2011). When implemented appropriately, these techniques help to enhance the therapeutic process for clients.

The Six-Step Process of Financial Planning

Incorporated in the proposed model is the six-step financial planning process as outlined by the Certified Financial Planner Board of Standards, Inc. (CFP Board, 2013). The CFP Board is responsible for granting the CFP designation, as well as upholding ethical standards for Certified Financial Planner™ professionals. The six-step process includes the following sequential actions:

1. Establish and define the client-planner relationship.
2. Gather client data and discuss goals.
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 & Epstein, 1990) and selected cognitive behavioral interventions (Beck, Rush, Shaw, & Emery, 1979). 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 & Schweitzer, 2011). A condensed version of the objectives designed for each step of the six-step process is found in Appendix A.

PROTOCOL FOR 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. As previously discussed, financial therapy is a relatively new and unique way of addressing both financial and relational goals. It is important that clients feel safe and understand the unique boundaries around this new style of intervention. Due to the integration of disciplines, each practitioner needs to create appropriate boundaries based on the practitioner's "home" discipline's laws, ethics, and guidelines, as well as with one's own personal and professional standards. Clients need to have a clear understanding of the boundaries and ethics regarding services. For instance, an important ethical consideration is that confidentiality standards may be higher with a therapist at times than a financial planner (e.g., the use of detailed email correspondence with a client is generally used by financial planners, but not most therapists). 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 treatment or services can begin. If financial therapy does not seem like a good fit to either the client or the practitioner, then proper referrals should be made to more appropriate services.

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 & Schweitzer, 2001). There is no assumption that the current behavior of a client is unhealthy or abnormal. Rather, 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. The practitioner should also highlight any strengths and resources the client may possess. Similarly, Tomm (1987a; 1987b; 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. Tomm provided a resource for any practitioner interested in learning more about how to word questions to produce strong therapeutic change and progress. 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 & 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 that help achieve client goals. In cognitive behavioral therapy, the tasks assigned between sessions are called homework and are designed to implement change toward the client's goals (Epstein & Baucom, 2010). The homework assigned may include locating and organizing information related to the client's financial situation in preparation for the following session. This information typically includes their credit report, credit score information, income and expense statement, assets and liabilities statement, bank and credit account statements, recent tax returns, and other financial information pertinent to their current financial position. Clients may also complete a short financial risk inventory, money scripts or attitudes inventory, and other assessments that are designed to assess the client's comfort or preferences around financial risk and one's conscious and unconscious beliefs around money; for a compendium of assessments available, see Grable, Archuleta, and Nazarinia (2011).

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. Normalizing the stress is an important technique used 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. For example, if clients are assigned the task of retrieving their credit report and score, the practitioner should also provide helpful, no-cost, web-based tools, such as annualcreditreport.com to view their credit reports, or creditkarma.com to track the movement of their credit score over time. 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. 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 lives. 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, but rather a result of dominant discourses that their partner has internalized (e.g., "I need to look rich so that people see me as competent;" "I need to be stingy with money to protect our children because as a woman, I am in charge of the family").

Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

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. Deconstructing listening and deconstructing questions are a way 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 & 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. By uncovering these dominant discourses, they can begin to be broken down. In Figure 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.

Figure 1. Examples of narrative questions

	Financial Strain
Deconstructing	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • What name would you give the problematic influence that is currently convincing you that you cannot talk to your partner about money?
Sparkling Events	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • How has your new ability to talk about money together impacted other aspects of your relationship?
Audience	<ul style="list-style-type: none"> • 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?

Figure 1. 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), and Shapiro and Ross (1992). 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.

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 non-pathologized 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 (Morgan, 2001). For instance, practitioners may hear their clients use a statement like "I am just not a money person; I just don't like thinking or talking about it." By locating the problem within themselves, the clients may feel powerless to overcome it or make positive changes in their lives. A practitioner utilizing externalizing language can ask questions, such as "When did *the worry* around money start convincing you that you can't think or talk about it?" Externalizing questions, such as this, help the client begin to acknowledge that they are not helpless in dealing with money, but rather they are capable of combating the externalized problem - the worry.

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 (2011) for ways to understand how to more effectively externalize the problem. Furthermore, examples of externalizing questions around finances can be found in Figure 1. Once externalizing occurs it is easier to move to the final objective of this step - creating goals.

During the course of this step, it is critical for the practitioner to complete the final objective by establishing goals that reflect the attitudes and wishes of the clients. According to Gehart and Tuttle (2003), a cognitive behavioral approach addresses the presenting problems by first defining them 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 is clear to all parties how the goals of therapy are addressed through the course of treatment (Sills, 2006).

Step 3: Analyze Information & 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. In order to analyze the information, the practitioner needs to have a foundation of some financial knowledge. This is the stage of the model that mental health professionals need to evaluate their training and knowledge in order to proceed. It is imperative that neither professional operates outside of their scope of competence. This does not mean that a practitioner needs to be fully licensed in a financial domain to provide education or financial options to his or her clients. However, without appropriate training and licenses, practitioners cannot provide specific investment or legal advice. Instead, 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. For mental health professionals who are interested in incorporating financial therapy into their practice, being familiar with general personal finance content is important to implement this approach. The National Law Center's (2013) *Guide to Surviving Debt* can serve as a resource to gain necessary knowledge before initiating this step in the financial therapy process.

Looking for financial *red flags* is 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 mental health professional 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 because they must provide psychoeducation to the clients about the financial issues being dealt with, as well as be able to apply the appropriate interventions and techniques.

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 helps the client use these examples to transform the story of their life into the preferred story. In other words, consistent with narrative theory, 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 (e.g., therapy, coaching, and financial planning) 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.

At times, the clients may feel discouraged about their ability to implement the plan. In narrative therapy, the practitioner may spend some time focusing on events in the clients' lives that could not have been predicted by the problem story (White & 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 because they may not be able to recall when they were feeling financial health at a time when they feel such financial stress or conflict. It is important to look for glimpses of these sparkling events and ask questions that elicit the client's discovery of them. For example, the practitioner might ask:

- "Was there a time when you went ahead and spoke about money in your relationship in spite of the fear encouraging you to avoid or hold back? How were you able to do this?"
- "Can you think of any times when you told someone about your anxiety around money, even though you felt you might be made fun of because of it?"
- "What does this tell you about yourself that you didn't realize before?"

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 (e.g., what those moments of strength reflects about the person) expands the story, invites forward a description of the preferred self, building more connections to intentional states and values (White & Epston, 1990). Vromans and Schwitzer (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

Narrative Financial Therapy: Integrating a Financial Planning Approach with Therapeutic Theory

possibilities in relation to combating the problem. The practitioner can also focus the conversation on ways in which the client has in the past behaved in a way that will allow them to live out their preferred narrative. That way the client can consider behaving this way in the future. These behaviors should be considered in presenting the plan.

It is also important that during this step practitioners make a concerted effort to continue using the externalizing language developed in the previous steps. 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).

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 co-created plan. At this stage, the practitioner continues to incorporate externalizing language and sparking 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 include scaling questions to show progress. Scaling questions are useful in helping clients to track their own progress by rating their progress toward specific goals on a scale of 0 to 10 (Berg, 1994). Furthermore, the practitioner may want to explain and implement the use of a charting technique or automatic thought record to identify problems or struggles with the plan after its implemented.

Charting is a homework task where clients are asked to keep a written record of how they are addressing the problem between sessions. It is a tool used to monitor progress of the client as well as help identify cognitions or behaviors that may be getting in the way of goals (Gehart & Tuttle, 2003, Beck, 2011). Through the charting process, practitioners may also assign the clients to keep a record of their automatic thoughts. This is simply where clients write down their thoughts as they are addressing their problem or when their problem prohibits them from accomplishing their goal, and then considering explanations for why they are thinking in this way (Sexton, Weeks, & Robbins, 2003; Wright, Basco, & Thase, 2006). After assigning techniques, such as charting and automatic thought records, 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

Few, if any, treatment or financial action plans are perfect and all clients are subject to changing circumstances. 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 using the charting technique 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 Figure 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, Keeling, & Carlson 2009). Depending on how quickly clients come into the therapy room, it could be months or years of living a problem-saturated story. Practitioners need to be aware that they set their clients up for failure if they think their job is done simply because the problem has been named. Amplifying the solution creates the reinforcement needed to help clients fight their old narrative by solidifying their new story over time (Bermudez & 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 process externalization. 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 & 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. For instance, finding a coupon cutting club may reinforce spending habits and provide an alternate behavior to shopping. 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.

CONCLUSION

Whenever professionals apply tools and frameworks from another profession, they should do so with careful ethical considerations. It is vital that practitioners from both disciplines educate themselves on each other's fields and understand the limitations of practicing outside one's expertise. However, professionals from the financial, mental health, and coaching fields can benefit from considering interdisciplinary and integrated approaches to more effectively help their clients.

The goals for this article are twofold. First, since financial planners are regularly confronted with relational and emotional dynamics in client sessions (Dubofsky & Sussman, 2009), they need to be able to attend to these dynamics and understand their impact on financial decisions to be able to optimally serve their client. Second, since financial strain has a profound impact on marital satisfaction (Stanley, Markman, & Whitton, 2002), mental health professionals need to develop specific knowledge and skills around decreasing clients' financial stress and addressing financial concerns. Expanding upon the common six-step financial planning process through the integration of an empirically-supported therapeutic approach provides a method for conducting financial therapy that can be used both by financial and mental health professionals. Although research on the effectiveness of financial therapy interventions has only recently begun, research thus far has shown that attending to finances, emotions, and relationships collectively has positive outcomes (Kim et al., 2011; Klontz et al., 2008; Ford et al., 2012).

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 & Gale, 2014). There is also a strong need to broaden the knowledge of the new field of financial therapy by increasing funding, research, and writing (Gale et al., 2012). One way to do this 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. Narrative financial therapy 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 is needed to support this approach to further justify its implementation.

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APPENDIX A**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 it is 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. Use scaling questions to ensure the action plan is being implemented as expected
- Objective 2. Use charting technique to address problems
- Objective 3. Use automatic thought record to identify cognitions that are hurdles to implementation

Step 6: Monitor the Plan

- Objective 1. Use charting techniques to ensure no new needs have developed
- Objective 2. Amplify the preferred narrative to ensure the client is ready to fight their thin description with their new thickened story
- Objective 3. Begin incorporating audience questions to spread the news of difference

Hoarding Disorder: It's More Than Just an Obsession - Implications for Financial Therapists and Planners

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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 Obsessive Compulsive Disorder (OCD) or Obsessive Compulsive Personality Disorder (OCPD). However, hoarding behavior can be a problem in its own right, without someone meeting the diagnostic criteria for OCD or OCPD. Despite being a mental health disorder that poses a serious public health problem, social costs to the public, and strain on families, there is little empirical work that has examined Hoarding Disorder (HD) from a financial perspective. As with other money disorders, for the compulsive hoarder, financial health and mental health symptoms are intertwined. This paper explores the financial psychology of HD and its implications for financial therapy and personal financial planning.

Keywords: compulsive hoarding; money disorder; hoarding disorder; obsessive-compulsive disorder

INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5™) criteria for obsessive-compulsive personality disorder (OCPD) includes “a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes” (American Psychiatric Association, 2013, p. 679). While this statement connects hoarding and financial behavior, little research exists that explores these concepts. Klontz and Klontz (2009) and Klontz, Britt, Archuleta, and Klontz (2012) identified compulsive hoarding as a money disorder that not only includes the acquisition

Hoarding Disorder: It's More Than Just an Obsession

and retention of objects, but also takes a positive behavior like saving to an unhealthy extreme.

Hoarding behavior poses a serious public health problem, social costs to the public, and strain on families (Frost, Steketee, & Williams, 2000; Tolin, Frost, Steketee, Gray, & Fitch, 2008). Hoarding can have a profound effect on one's own health and safety (Frost, Steketee, & Tolin, 2012). Relatively few studies have examined hoarding despite its prevalence and association with significant distress and functional impairment (Coles, Frost, Heimberg, & Steketee, 2003). This paper explores the hoarding of possessions and the hoarding of money. After a review of the literature on hoarding disorder's onset, diagnostic criteria, and interventions, the financial psychology of hoarding is also explored.

Frost and Gross (1993) referred to hoarding disorder (HD) as the acquisition and failure to discard a large number of possessions. It is argued in this paper that hoarding disorder is not just a mental health disorder of concern to psychologists and psychotherapists. HD is a money disorder that has a direct effect on financial planners, the financial planning process, financial therapy, and the financial health of clients. While there is little research that connects hoarding and financial behaviors, in practice, addressing financial issues, such as risk tolerance, miserliness, or money disagreements among couples and family members can be informed by these connections. Understanding the financial aspects of hoarding can alert financial practitioners to look for symptoms of hoarding behavior and interventions that might be effective for their clients. This paper will explore the connection between the hoarding of possessions and the hoarding of money, offering a theoretical basis for further study of this connection. For the purposes of this paper, and to be consistent with the new release of the DSM-5™, hoarding behaviors that cause clinically significant impairment are referred to as hoarding disorder, unless citing the work of others who have referred to it as hoarding or compulsive hoarding. From the review of the literature, these appellations are used to describe the same condition.

LITERATURE REVIEW

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 point prevalence rate of clinically significant hoarding behaviors is 2% to 6% of the population (American Psychiatric Association, 2013; Iervolino et al., 2009; Mueller, Mitchell, Crosby, Glaesmer, & de Zwaan, 2009; Samuels et al., 2008). This is two to five times the prevalence of obsessive-compulsive disorder (OCD) (American Psychiatric Association, 2013; Samuels et al., 2008). To put that into context, the National Institute of Mental Health (2010) reported prevalence rates in a given year for adults in the United States of 2.6% for Bipolar Disorder, 3.5% for Posttraumatic Stress Disorder, and 6.7% for Major Depressive Disorder. Given the paucity of research in the area of HD, these numbers suggest that HD is a prevalent disorder, but has been relatively ignored by the mental health field.

One reason for the lack of research in this field is that, until recently, compulsive hoarding behavior was not considered a distinct disorder, but rather a diagnostic criterion for OCPD (Frost et al., 2012) and a symptom of OCD (Mataix-Cols et al., 2010). OCD can usually be distinguished from OCPD by the presence of true obsessions or compulsions, such as intrusive anxiety-provoking impulses (obsessive) and urges to perform behavioral or mental acts (compulsive) (Abramowitz, Wheaton, & Storch, 2008). Hoarding had been considered a symptom of OCD, and therefore most of the research has investigated hoarding within the context of OCD rather than as a distinct disorder. Research subjects may have been diagnosed with OCD based on other symptoms and hoarding behaviors could have been absent. Recent studies have shown that many people that hoard have no other symptoms of OCD (Frost et al., 2012). While 75% of individuals who suffer from HD have a co-occurring anxiety or mood disorder, only 20% of individuals who meet the criteria for HD also meet the criteria for OCD (American Psychiatric Association, 2013). As a result, many of the findings around hoarding in OCD populations may not have been representative of people with hoarding behaviors (Frost et al., 2012). Consequently, hoarders have been underrepresented in most cognitive behavioral therapy studies of OCD, limiting the ability to generalize research findings to individuals with hoarding symptoms only (Mataix-Cols, Marks, Griest, Kobak, & Baer, 2002).

Hoarding as a Disorder

The DSM-IV-TR™ was ambiguous about the classification of hoarding because it treated it as both a criterion of OCPD and a symptom of OCD (Mataix-Cols et al., 2010). The recently published DSM-5™ cleared up this confusion by identifying HD as a distinct diagnosis (American Psychiatric Association, 2013). Hoarding as a mental disorder was thought to originate from the concept of the “anal character,” which later became OCPD and the advent for the term “anal-retentive.” Freud (1908) explained that while the money motive starts with coins, its most familiar form, an interest in these must come from displaced interest in feces. According to Freud and other psychoanalysts, problematic money behaviors, ranging from hoarding to being a spendthrift, represents varieties of anal eroticism. Freud posited that the anal triad of orderliness, parsimony, and obstinacy are the precursors to OCD and the anal retentive personality (Frost et al., 2012). Anal-retentive personality traits were represented in the DSM-IV-TR diagnostic criteria for OCPD, which included hoarding (Frost et al., 2012). One of the reasons that hoarding may have become associated with OCD was the inclusion of two hoarding items in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), which became the most widely used rating scale for OCD (Mataix-Cols et al., 2010).

After some debate, and based on a proposal from the Obsessive-Compulsive Spectrum, Post Traumatic, and Dissociative Disorders Work Group (Nordsletten et al., 2013), HD has been placed alongside OCD as obsessive-compulsive and related disorders (OCRDs) in DSM-5™ (American Psychiatric Association, 2013; LeBeau et al., 2013). This is an important revision because it will encourage research on populations that meet the criteria for hoarding symptoms alone, rather than people with OCD who may hoard.

The Etiology of Hoarding

Deficits in cognitive processes, maladaptive beliefs, and maladaptive behavioral patterns are thought to underlie pathological hoarding (Tolin, 2011). Individuals who hoard have abnormalities in the specific brain regions associated with executive functioning, impulse control, and processing of reward value (Tolin, 2011). Familial and environmental vulnerability factors have also been identified in hoarding. Approximately 50% of hoarders can identify a relative who hoards and studies on twins suggest that 50% of the variability to hoarding can be attributed to genetic factors (American Psychiatric Association, 2013).

Studies have shown that hoarding develops as a result of conditional emotional responses to various thoughts and beliefs (Grisham, Frost, Steketee, Kim, & Hood, 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. It has been suggested that several types of deficits are contributors to hoarding; information processing, beliefs about emotional attachment to possessions, emotional distress, and avoidance behaviors (Grisham et al., 2006). Neziroglu, Bublick, and Yaryura-Tobias (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 may be a characterological phenomena, whereby saving becomes part of one's identity. Individuals who hoard tend to be single, often lack a personal connection with other people, and therefore 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., 2006). Hoarding behaviors often first appear in early adolescence and steadily worsen, with clinical impairments seen in an individual's mid-30s (American Psychiatric Association, 2013). Using Charles Dickens' classic tale "A Christmas Carol" as a metaphor, Klontz, Kahler, and Klontz (2008a) described Scrooge as a compulsive money hoarder and suggested that his compulsion was born from a childhood of abuse, poverty, and emotional deprivation. Klontz and Klontz (2009) hypothesized that compulsive hoarding 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.

Familial vulnerability to hoarding can also include modeling. Many hoarding patients reported being taught or observed hoarding behavior in their parents from early in their lives (Tolin, 2011). Large-scale cultural financial traumas, like the Great Depression, can also have a tremendous influence on those who experience them. Cognitive structures that develop to protect oneself from future financial catastrophe can be passed down to children and grandchildren (Klontz & Klontz, 2009). Many survivors of the Great Depression developed hoarding behaviors that persisted long after it was over. Living through periods of extreme scarcity, deprivation, and uncertainty can develop intense and irrational fears of being left with nothing (Klontz & Klontz, 2009). Stuffing money under

mattresses, building up stockpiles of food, and saving things like scrap metal and fuel oil were means of survival and in many cases those habits and fears about not having enough were passed down from generation to generation. Many children of hoarders from the Great Depression became hoarders and underspenders by adopting their parents' money scripts and modeling their parents' behaviors (Klontz & Klontz, 2009). Significant financial losses or periods of economic turmoil, such as the 2008 recession, have been linked to symptoms of posttraumatic stress and changes in beliefs and approaches to investing (Klontz & Britt, 2012a).

Traumatic or stressful events may also play a role in the onset and expression of hoarding (Tolin, 2011). Cromer, Schmidt, and Murphy (2007) found that hoarders were significantly more likely than non-hoarders to report experiencing at least one traumatic life event. They further found that patients who were determined to be hoarders and also had experienced traumatic life events had greater hoarding severity than those who had not experienced trauma (Cromer et al.). Related studies have also shown evidence of problematic food hoarding behaviors among children in foster care (Casey, Cook-Cottone, & Beck-Joslyn, 2012). While more research is needed, evidence supports the notion that whether from direct experience or modeling from caregivers, hoarding behaviors can emerge in response to troublesome life events, poverty, or financial trauma. The resulting fear of not having enough can lead to an irresistible urge to excessively acquire and persistently hold onto resources to protect oneself from a period of future potential lack.

Symptoms of Hoarding Disorder

Frost and Hartl (1996) developed the following diagnostic criteria for HD that have been further refined and widely adopted in the field:

- A. Persistent difficulty parting with personal possessions, even those of limited value regardless of the value to others.
- B. This difficulty is due to strong urges to save items and the stress associated with discarding.
- C. The hoarding symptoms result in a large number of possessions that clutter active living space or workplace where their intended use is no longer possible.
- D. "The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Frost, Steketee, & Tolin, 2012, p. 223).
- E. The symptoms are not due to a general medical condition or brain injury.
- F. The symptoms are not restricted to the indicators of another mental disorder such as OCD, depressive disorder, schizophrenia, dementia, autism, or Prader-Willi syndrome (Frost et al., 2012).

In addition to the diagnostic criteria, the guidelines of DSM-5™ include two specifiers for HD (Frost et al., 2012):

Hoarding Disorder: It's More Than Just an Obsession

1. If symptoms are combined with excessive acquisition in the form of excessive collecting, buying, or stealing of unneeded items for which there is no room, and
2. Hoarding behaviors are characterized by:
 - a. Good or fair insight–recognition that hoarding-related beliefs are problematic.
 - b. Poor insight–lack of belief that hoarding behavior is problematic.
 - c. Absent insight or delusional beliefs–convinced that hoarding behavior is not problematic.

Hoarding symptoms create distress or impairment of important areas of functioning, including maintenance of a safe environment for oneself and others (Frost et al., 2012). Normal activities, such as cooking, cleaning, and personal hygiene, can be impaired while health and safety compromised by unsanitary conditions (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, workplace, or other personal surroundings, preventing normal use of the space (Frost & Hartl, 1996). In a study of compulsive hoarding in the elderly, Steketee, Frost, and Kim (2001) found that 80% had severe inhibitions of movement in their living space due to clutter, 70% were unable to use their furniture, 45% could not use their refrigerators or freezers because of spoiled food or storing non-food items, and 81% faced hoarding-related health risks including risk of falling, fire hazards, and/or unsanitary conditions.

In the development of the Klontz Money Behavior Inventory (K-MBI), Klontz and colleagues (2012) identified the following symptoms in their Compulsive Hoarding scale:

1. I have trouble throwing things away, even if they aren't worth much.
2. My living space is cluttered with things I don't use.
3. Throwing something away makes me feel like I am losing a part of myself.
4. I feel emotionally attached to my possessions.
5. My possessions give me a sense of safety and security.
6. I have trouble using my living space because of clutter.
7. I feel irresponsible if I get rid of an item.
8. I hide my need to hold on to items from others.

These symptoms of compulsive hoarding have been found to be more common in men with lower levels of net worth (Klontz et al.). Money avoidance and money worship beliefs can predict higher scores on the K-MBI Compulsive Hoarding scale (Klontz & Britt, 2012b). Klontz and Britt (2012b) also found compulsive hoarding to be significantly correlated with other disordered money behaviors, including Compulsive Buying Disorder and Pathological Gambling.

As mentioned above, some financial psychologists have identified a miserly relationship with money as being a feature of HD in some individuals. It has been suggested that money hoarders have so much anxiety about not having enough money that they may neglect the most basic self-care activities and have great difficulty enjoying the benefits of

accumulating money (Klontz, Kahler, & Klontz, 2008b; Klontz & Klontz, 2009). Forman (1987) described a financial hoarder as having a fear of losing money, distrust of others around money, and trouble enjoying money. Klontz and Britt (2012b) identified a link between money attitudes and hoarding behaviors. They found that money status scripts and money worship scripts predicted compulsive hoarding behaviors. Specifically, individuals who linked net worth to self-worth and held the belief that the key to happiness and the solution to all of their problems was to have more money were significantly more likely to engage in hoarding behaviors. The DSM-5™ criteria for OCPD also included a miserly spending style and the need to hoard money (American Psychiatric Association, 2013), adding support for the link between hoarding and money.

The Function of Hoarding Behaviors

Hoarders save items for reasons related to sentimental attachment, usefulness, and aesthetic qualities, and possessions become an extension of the self (Belk, 1988). Discarding an item feels 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. The hoarder's identity to an extent is wrapped up in everything they own. This becomes such an issue that there is a tendency to assign human qualities to things they own (Belk, 1988). Hoarders feel exaggerated beliefs about responsibility for their possessions reflected in a need to be prepared for any contingency. They do not want to waste something with a useful life, and feel a sense of guilt in discarding (Belk, 1988). Saving is not restricted to worthless or worn out things and many saved items are new and never used (Frost et al., 2012). People who hoard are also less willing to share possessions. Clinically significant distress or impairment is indicated when living areas or the workplace are in such disorganized clutter that finding important items is difficult (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.

Hoarding is sometimes referred to as compulsive-hoarding. The word compulsive was originally added as a qualifier to hoarding as a way to differentiate normal saving and collecting from excessive or pathological hoarding (Mataix-Cols et al., 2010). More recently it has been used to describe hoarding behavior due to the fear of losing an item that could be valuable because of a strong emotional attachment and to differentiate it from secondary hoarding, which might be due to other psychiatric conditions (Mataix-Cols et al., 2010).

Hoarding and Obsessive-Compulsive Disorder

For some individuals, hoarding symptoms overlap with OCD symptoms (Frost et al., 2012). HD can resemble OCD in a number of ways: (a) the avoidance of discarding items for fear that it may be needed in the future, (b) the avoidance of discarding because of an emotional attachment, and (c) 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).

Hoarding Disorder: It's More Than Just an Obsession

The difficulty in discarding possessions may be an obsession, while the avoidance of discarding is a compulsion. However, unlike obsessions in OCD, thoughts related to hoarding or accumulating are not unwanted (Mataix-Cols et al., 2010). Thoughts about possessions are not unpleasant to the hoarder. The distress they experience is usually due to the consequences of the hoarding (i.e., clutter and 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., 2010). These emotions are not usually part of the OCD experience (Mataix-Cols et al., 2010). OCD behavior is believed to ebb and flow over time, while hoarding begins early in life and exacerbates as time progresses (Tolin et al., 2008). In OCD, excessive acquisition is also not usually a factor unless it is related to a specific obsession (American Psychiatric Association, 2013).

Intervention

Historically, it has been difficult to intervene in hoarding behavior 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. For example, Exposure and Response Therapy (ERP) methods have been found to be less effective in treating OCD when hoarding symptoms are present, affirming the impressions of OCD researchers that hoarding was more difficult to treat than other OCD symptoms (Muroff, Bratnott, & Steketee, 2011).

While HD is challenging to treat, recent studies have shown some promise. The most encouraging data has 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, Kiran-Imran, Hasseim, & Vaughan, 2009). Motivational interviewing is used to address ambivalence and poor insight. Cognitive behavioral therapy (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). 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 garnered some empirical support for its clinical utility (Klontz, Bivens, Klontz, Wada, & Kahler, 2008). Muroff, Steketee, Bratnott, and Ross (2012) also found that weekly group cognitive behavior therapy sessions, along with non-clinician home visits over a 20 week period, showed significant reductions in hoarding symptoms.

An open trial of CBT designed for hoarding with 26 individual sessions and monthly home visits over nine to twelve months revealed decreases in saving behavior and reduced clutter (Tolin, Frost, & Steketee, 2007). Turner, Steketee, and Nauth (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. The treatment approach was primarily home based and lasted approximately 35 sessions, focusing on motivational enhancement, cognitive skills, organizational skills, and decision-making and non-acquiring skills.

Steketee, Frost, Tolin, Rasmussen, and Brown (2010) conducted a waitlist controlled trial of modified CBT hoarding treatment where participants were randomly assigned to immediate treatment or to a 12-week waitlist. After only 12 weeks, improvement for participants in the CBT group was statistically greater than those in waitlist group on most hoarding severity measures. Pekareva-Kochergina and Frost (2009) found that bibliotherapy group intervention conferred considerable benefit over a 13-week group intervention. Because of the lengthy and costly process of CBT, video-enhanced and web based CBT therapy has been an ongoing intervention since 1998 (Muroff, Steketee, Himle, & Frost, 2010). Online-based CBT therapy appears to be promising as an intervention strategy that can extend access to a much broader group.

There is also some evidence to support the effectiveness of Selective Serotonergic Reuptake Inhibitor (SSRI) medications, such as paroxetine, clomipramine, fluoxetine, and sertraline, in improving symptoms of HD (Muroff et al., 2011; Saxena, Brody, Maidment, & Baxter, 2007). The efficacy of a combination of CBT and pharmacotherapy for hoarding requires further research (Muroff et al., 2011).

Tolin (2011) offered practice recommendations for working with hoarding patients, which included motivational leverage from friends and family, compliance with homework assignments, consistent praise over completed assignments, and a focus on harm reduction treatment goals rather than symptom resolution. Tolin also recommended assessment and treatment of comorbid Axis I and Axis II disorders and neuropsychological evaluation if cognitive impairment was suspected.

Hoarding and Money

Parallels have been drawn between money and psychology throughout history. However, money has been argued to be one of the most neglected topics in psychological research and practice (Klontz, Bivens, et al., 2008; Lowrance, 2011; Trachtman, 1999). A *New York Times* article mentioned hoarding as a problem financial behavior identified by psychologists in recent years (Kershaw, 2008), yet very little research specifically related to HD as a money disorder has been conducted. The psychoanalytic notion of money as foul and corrupt may explain why so little research has been devoted to money (Doyle, 1992; Trachtman, 1999). The following section will identify some of the characteristics of money, and the psychology of money from the early writings of Karl Marx, to the exploration of money beliefs that can lead to present day money disorders.

Early Parallels. Early writings hint at the connection between psychology and money going back to Karl Marx in 1867 (Marx, 2010), as cited by Lea and Webley (2006), who believed that tradable economic commodities appear as “independent beings endowed with life” through a process he identified as “commodity fetishism” (Lea & Webley, 2006, p. 167). This seems to be a logical fit with how the hoarder views possessions, not as practical items but as having human qualities, making it even more difficult from which to part. It is not inconceivable for someone with HD to commoditize money and view it as having human like qualities as well. There are impelling reasons for

Hoarding Disorder: It's More Than Just an Obsession

the tendency to hoard, which are both psychological and economic (Somerville, 1933). According to Somerville (1933), it would be senseless to amass surpluses of other use values, but one cannot accumulate too much money, which has permanent and universal exchangeability. This represents a dilemma in the sense that hoarding behavior with money seems to mirror positive financial behavior, such as saving, but taken to an unhealthy extreme (Klontz & Klontz, 2009). As pointed out by Klontz and Klontz, it is good to save but it is also necessary to spend. Someone who hoards money will have difficulty parting with it, not necessarily for fiscal reasons but because of the emotional attachment and the comfort and security it provides. This echoes Somerville's (1933) assertion that whatever economic loss may result from saving without investment, there are intelligent reasons for doing so from the hoarder's perspective.

Adaptive Behavior. The desire for money is related to the desire for the things it can buy, but the two are logically distinct (Lea & Webley, 2006). The psychology of possessions and how it leads to the psychology of money can be traced back for centuries. Humans will use time and effort to acquire artifacts, such as newspapers, radios, and television sets (Lea & Webley, 2006). 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). This behavior is not distinctly human. Animals, birds, and insects hoard food and collect nonfood items for storage and courtship rituals (Sherry, 1985). This behavior is adaptive and has obvious value for contingencies and emergency situations (Lea & Webley, 2006).

Miserliness. Hoarding as an adaptive behavior could account for the early accumulation of coins as alluded to by Freud (1908). However, the accumulation of coins may not be due to their physical form since coins do not need to be touched to be enjoyed. Misers can go through their fortunes in their own minds (Booth, 2006). Feelings about money activate neural pathways and "provides a starting point for characterizing the cellular expression of genes for the instinctual capacities that develop into accumulation of resources - or junk" (Booth, 2006, p. 181). In the human species with nonmaterial culture and activity, resources hoarded for no extrinsic purpose can include artifacts that are also nonmaterial, such as balances at the bank (Booth, 2006). Then, money can fulfill the hoarding instinct in biosocial cognitive actuality (Booth, 2006). Booth (2006) seems to suggest that money can be viewed as a possession without its physical form, and as such, can be hoarded. In other words, 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 cognitive clutter that leaves little room for other thoughts or pursuits and results in clinically significant consequences.

Slater (1980) considered a case that is specifically relevant to the hoarding of money or miserliness. As Slater reported, hoarding money is distinct from the accumulation of money for precautionary or investment purposes and has historically been a concern for psychoanalysts. Research and clinical observations have offered some support to the Freudian notion that miserliness and hoarding are components of OCD and are associated with negative financial indicators and other disordered money behaviors (Frost et al., 2002; Klontz & Britt, 2012b; Klontz et al., 2012). There seems to be ample anecdotal

support to argue for a deeper exploration of the correlations and distinctions between the hoarding of money and the hoarding of possessions. This connection has been identified in psychology research long ago, which makes it all the more peculiar that hoarding has not been examined in the literature from a financial standpoint.

Possessions. Belk and Wallendorf (1990) wrote that in industrialized societies consumption objects have special meaning that differentiates these objects from other objects. These objects are not considered for their functionality and are treated with reverence. According to Belk and Wallendorf, a sacred object may have potential use value, but that is not the primary reason it is valued. In some cases it is the lack of functionality of certain objects like antiques, souvenirs, and heirlooms that separates them from the profane world of commodities (Belk & Wallendorf). This research seems to have made a connection between purchased possessions and the feelings they generate. This is akin to the feelings experienced by someone with HD who values possessions not for their functionality or intrinsic value but for some emotional attachment they feel to the item.

Fungibility. According to Belk and Wallendorf (1990), a profane commodity, such as money is usually fungible, that is, easily replaceable with other money. Belk and Wallendorf pointed out that while a miser's money is fungible, a coin collector's is not. This creates a distinction between a miser and someone who collects or hoards. A hoarder of money may see their money as nonfungible, and therefore do not view it as having a functional value, but more as a possession. According to Crump (1981), when money is found to be nonfungible, this is a demonstration of the sacredness of money. While this indicates a perception of money that can be idiosyncratic, it also provides a logical connection that when money is viewed as nonfungible it may be associated with underspending. This also might naturally lead to hoarders also having an excessive aversion to risk, which has been hypothesized by Klontz and Klontz (2009).

Money Beliefs. Hoarding behavior may be of no surprise since people have gotten contradictory messaging about money throughout time. The Protestant Ethic associated the hoarding of money and the attitude that time is money, as a way of promoting a strong work ethic (Tang, 1992). The Protestant Ethic is a belief system that there is a world to come where the rewards and punishments of the next life will be based on the effort and industriousness exerted during the current life (Neustadt, 2011). The Protestant Ethic, which encourages hard work, thrift, and the earning of money as a sign of God's blessings, also proscribes the enjoyment of money that was earned as a result of the hard work that was exerted (Belk & Wallendorf, 1990). Judeo-Christianity extols the virtue of humanistic sacrifice, while people are exposed to the individualistic, acquisitional nature of capitalism in the economic system. Money is esteemed, yet demonized, and both sacred and profane at the same time (Belk & Wallendorf, 1990). According to Karl Marx, "Money is not only *an* object of the passion for riches; it is *the* object of that passion" (Somerville, 1933, p. 335). The Christian Bible described the love of money as being the root of everything evil and warns that it is difficult for a rich man to enter heaven. There is some empirical evidence to support this seemingly contradictory simultaneous vilification and worship of money in hoarders. Klontz and Britt (2012b) found that hoarding symptoms are associated with

Hoarding Disorder: It's More Than Just an Obsession

money worship scripts, which is the belief that money is the key to happiness and the solution to life's problems, which in turn, is associated with money avoidance scripts (i.e., the belief that money is bad and people of wealth are greedy and corrupt).

When money is viewed as having only quantitative meaning it fails to identify the more emotional, qualitative meanings of money (Belk & Wallendorf, 1990). In that case, it does not provide an adequate account of the dominance of affect, norms, and values in our dealing with money (Etzioni, 1988). The disciplines of law and economics view money as a profane commodity (Belk & Wallendorf, 1990). However, if money is itself sometimes considered sacred or having qualitative rather than quantitative meaning, its presence may not necessarily corrupt the objects and people it touches (Belk & Wallendorf, 1990). In fact, it may provide feelings of security and comfort similar to feelings experienced by someone with HD. In some cases, the acquisition of money is hoped for because it is seen to promise a ritual transformation of the individual (Belk & Wallendorf, 1990).

Money has at some point been revered, it has been feared, worshipped, and treated with the highest respect. In sociological terms, money is considered sacred (Durkheim, 1915). "There may be some things that money cannot buy, but even their non-purchasability is cast in doubt when life (e.g., children, surrogate motherhood), death (e.g., contract murder, abortion), 'love' (e.g., bridesprice, prostitution), prestige (e.g., publicity, political campaigns), and even immortality (e.g., religious contributions, philanthropy) are all bought and sold with money" (Belk & Wallendorf, 1990, p. 36). This passage is a perfect example of how much power is placed on money and how hoarding it seems to make sense in capturing its power.

Money Disorder. It is no wonder that the hoarding of money seems to be fairly ordinary and mainstream to a point where it is not seen as pathological or even unusual. As such, other than in cautionary tales like "A Christmas Carol," hoarding has not been looked at as a money disorder. In addition to the problems associated with hoarding previously mentioned, the financial ramifications must be considered as well. According to Lea and Webley (2006), much of psychopathology can be related to reactions between aggression impulses and fear impulses that normally maintains us in social hierarchies, including compulsive gambling, hoarding, and other problems. The miser's hoarding and the spendthrift's self-destructive carelessness are both ways of dealing with interpersonal anxieties and are in no short supply in society. These are issues of financial psychology with interconnections between mental disorders and their financial correlates. For example, the concept of money addiction has found little traction in sociology or clinical psychology and has been used as a method to identify some of the eccentric financial behaviors of people (Booth, 2006). Many of the references to money addiction refer to specific addictions like workaholism, compulsive gambling, or compulsive buying (Booth, 2006). Booth pointed out that these all might be a manifestation of a broader money addiction but there is yet no empirical evidence to support that proposition.

Manifestations of Money Hoarding. Many people see money as a source of conflict; they look at it as filthy and corrupt, yet they hate to part with it (Doyle, 1992). Klein (1957) hypothesized that the confidence and anxiety that people feel about their

place in the world is rooted in their early life experiences. Furnham (1984) described the early origins of money as a communion ritual designed to leave communicants with a morsel of food, and then later a medallion signifying the king's protection. Doyle (1992) deduced from this the idea of money as a talisman against the fears of different personality types as described by Merrill and Reid (1981). Several of these personality types have vulnerabilities to hoarding behaviors and are useful constructs to help financial planners and therapists understand a hoarder's psychological motivation, including: (a) drivers, (b) amiables, and (c) analyticals.

Doyle (1992) hypothesized that a driver is someone raised in a family with at least one cold and distant parent who dealt with failure with more coldness and distance. Drivers use achievement to avoid rejection and isolation. The driver uses money as a talisman against the fear of being found incompetent, spends money on things that will prove success (possessions), and engages in behaviors that emphasize independence and enjoyment of the money process (acquiring), and the use of money as competition. Hoarders are typically isolated and may view money and possessions as ways to prove their competence and keep score, which prohibits them from spending and enjoying it.

The amiable likely grew up in a family with at least one extremely dependent parent who was clingy, but displayed little true affection (Doyle, 1992). The amiable uses relationships to counteract isolation, feels unworthy of affection, and suffers anxiety at the thought of loss of relationships. They use money as a talisman against the fear of losing affection, save money to hold on to people, and have low self-esteem. The amiable hoarder may hold onto money to protect him or herself against anticipated future loss of affection, love, or security.

The analytical personality type may be the most vulnerable to hoarding behaviors. The analytical probably grew up in a fearful family that stressed tidiness and avoided unpleasant things like bodily functions and misbehavior (Doyle, 1992). They learned to use order to avoid isolation and have a fear of losing control. They use money as a talisman against the loss of control, save money to avoid unarmed threats, engage in behaviors such as bargain hunting, hoarding, indecisiveness, cautiousness, and have an unusual ability to defer gratification (Doyle, 1992). In the extreme, the analytical displays indifference to social relationships, restricted emotional experience, preference for solitary activities, OCPD, unattainable standards, perfectionism, and exaggerate the risks of doing something routine (Doyle, 1992). Hoarders amass money for fear of losing control, hold irrational fears of not having enough, and exaggerate the risks of reasonable spending or investing as a way of holding on to their money.

These personality types and their relation to money might help financial planners and therapists understand a client's money hoarding impulses. Hoarders may hoard money for fear of not having enough based on the experience of poverty, living through a global or local financial downturn, surviving a personal financial tragedy, or experiencing a non-financially related traumatic experience. They may hoard money because they have adopted the money scripts and financial habits of their caregivers. They may hoard money

Hoarding Disorder: It's More Than Just an Obsession

to keep score against feelings of low self-worth. They may hoard money as a manifestation of a genetic vulnerability. No matter how much money is accumulated the hoarder will think about the future uncertainties and the chance that it will be needed in the near term. The hoarder may also be in debt even though he or she is holding low yielding assets or has sufficient funds stuffed under the mattress or buried in the back yard with which to pay the debt. This behavior manifests itself from a fear that they don't have enough. Hoarders may also feel strongly about their responsibility to future generations and may hoard cash to leave a legacy to their heirs.

IMPLICATIONS FOR FINANCIAL PLANNERS AND THERAPISTS

“Money is a force of life, a symbol of enormous emotional and psychological power” (Lowrance, 2011, p. 4). The increasingly throwaway society in which we live stands in stark contrast to the psychology of someone with HD. Hoarders store items for anticipated shortages and periods of deprivation or lack. As risk minimization theory points out, this is generally due to the uncertainties of the world we live in (McKinnon, Smith, & Hunt, 1985). Like squirrels storing nuts to survive the coming harsh winter, HD can originate as an adaptive response to an anticipated future of want. It can also occur in response to a personal or family history of trauma, poverty, neglect, or financial loss. In an attempt to protect oneself from future loss, deprivation, and uncertainty, the individual hoards. The hoarding of cash is similar to the hoarding of possessions. The hoarder feels a level of comfort and an emotional attachment to the money and will deprive themselves of the necessities of life to maintain it. In reality, however, there will never be enough because it is impossible to accumulate too much money when the hoarder must protect against all of life's future uncertainties. In terms of investments, hoarders often will forgo anything but the safest investment in order to have cash on hand to protect against the “what if” scenario, often falling prey to the insidious effects of inflation. The hoarding of cash for future uncertainty can be seen in corporate cultures as well and is especially relevant in the current U.S. economy. Since 2008 and the great recession, commercial banks have accumulated huge cash reserves reaching \$1.6 trillion as of June 2012. Corporate hoarding has been damaging to the creation of jobs and economic recovery (Pollin, 2012).

As Cromer et al. (2007) reported, hoarders are more likely to have experienced traumatic life events, and as a result may exhibit greater hoarding severity. Studies have also shown evidence of food hoarding among children in foster care because of maltreatment, early attachment difficulties, or reliable access to food (Casey et al., 2012).

The hoarder may feel a responsibility to future generations, the items they possess, and the environment, and while consumer culture identifies with spontaneity, the hoarder's behavior emphasizes the continuity between past and future times (Cherrier & Ponner, 2010). The prevalence is greater in older individuals, and those with limited household income, and these demographic characteristics should be considered in focusing community interventions (Samuels et al., 2008). Hoarders feel a responsibility for future generations, which will motivate them to underspend as they hoard money not for themselves but for their descendants.

The majority of psychotherapists receive no education or training related to financial therapeutic techniques (Klontz, Bivens, et al., 2008; Lowrance, 2011; Trachtman, 1999). As a clinical psychologist, Lowrance (2011) wrote: "In light of the pervasiveness of dysfunctional financial psychology in our culture, every practicing mental health professional needs some basic level of knowledge to enable them to adequately tend to money-related issues when working with clients" (p.18). Lowrance further insisted that the mental health field must encourage mental health professionals to work with financial therapeutic issues. Klontz and colleagues (2008) argued that: "While evidence exists to support the notion that destructive financial behaviors are the manifestation of underlying psychological disturbance, the field of psychology has done little to identify the problems as a focus of treatment or to develop effective treatments aimed at improving financial health" (p. 306). They went on to urge "therapists to consider the potential value of assessing for, and targeting disordered financial beliefs and behaviors in their provision of holistic and effective mental healthcare" (p. 306).

Research that links the world of finance and mental health is a step in the right direction. Now that HD is listed as an Obsessive-Compulsive related-disorder in the DSM-5™, increased attention to populations that exhibit hoarding behaviors can occur.

HD is a psychological disorder, but also a money management disorder. Since hoarders, as suggested, represent two to six percent of the population, the financial therapy and planning community has and will continue to have clients that exhibit HD. This is particularly likely to be the case when the target of hoarding behavior is the acquisition and retention of money, and can create issues with levels of underspending, poor self-care, and excessive risk aversion. It can be very difficult from a financial planning standpoint to properly plan and assume the appropriate level of risk necessary to achieve financial goals when a client is suffering from severe money anxiety. It is not uncommon to encourage clients to save, but for a person with HD the exact opposite intervention might be necessary. This is the reason financial therapists and planners must understand more about HD and its close association with money. Money must be spent in order to live life and those that save money to the point of ignoring leisure, medical care, personal hygiene, or creating dangerous situations from clutter, need to develop a healthy relationship with money and to find ways to use money successfully. Then, and only then, will they be able to achieve financial health and enjoy the resources they do have. While financial practitioners may not have the training or expertise necessary to treat someone with a severe case of HD, financial therapists and planners are often in the position where it would make sense for them to understand the causes, functions, and consequences of hoarding behaviors if they are to adequately serve their clients.

According to Grable (2000), the attainment of financial success appears to be explained in part by personality traits and socioeconomic background. It would be difficult to achieve financial success when one's personality characteristics are distorted by a psychological disorder. This would mean that the client-adviser relationship would be tenuous at best. In addition it is hard to quantify the increased risks associated with HD, making it extremely difficult to prepare clients to manage that risk over the long term.

Hoarding Disorder: It's More Than Just an Obsession

When working with a person with a tendency towards hoarding, it can be helpful to increase awareness of the connection between an earlier experience of deprivation or lack, either personally, culturally, or multigenerationally. It is also important to consider the resulting money scripts, such as “there will never be enough,” hoarding behaviors, and their impact on one’s financial health, relationships, and life satisfaction. While financial planners may not be in a position to treat hoarding behavior, they are certainly in a position to help increase clients’ awareness of the psychotherapeutic aspects of hoarding. They can help expose clients to the anxiety of letting go of possessions or money through recommendations to spend and/or give to charity. They can also help process the experience with clients. In cases of HD, where financial hoarding behavior is having a significant impact on a client’s quality of life, a referral to a psychotherapist would be beneficial.

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Researcher Profile

An Interview with Russell James, JD, Ph.D., CFP®

Russell James is a professor and the CH Foundation Chair in Personal Financial Planning in the Department of Personal Financial Planning at Texas Tech University, where he is also the Director of Graduate Studies in Charitable Financial Planning. His research is focused on encouraging generosity and satisfaction in financial decision-making.

Keywords: James; financial planning; charitable financial planning; financial therapy

Q. Tell us a bit about yourself.

A. I grew up in Kansas City, Missouri and attended the University of Missouri (MU) for undergraduate (B.A., Economics) and graduate school (Ph.D., Consumer & Family Economics). Prior to completing a Ph.D., I attended law school at MU. After law school, I spent several years as a practicing estate planning attorney and six years as the Director of Planned Giving for a small residential college (Central Christian College, Moberly, Missouri). After taking a brief sabbatical to accelerate the completion of my Ph.D., I was asked by the board of Central Christian College to serve as president of the college, which I did for 5 ½ years. Since then, my career has focused on research and academics. Prior to joining the faculty at Texas Tech University where I am currently a professor, I was a faculty member at the University of Georgia.



Q. Define what you do professionally.

A. I am a professor in the Department of Personal Financial Planning at Texas Tech University. I teach courses related to charitable financial planning as well as a course on behavioral finance. My research focuses on financial decision-making, primarily in the area of charitable decision-making. Within this specialty my most common topics relate to charitable bequest decision-making. My primary research methodologies are econometric analysis of large datasets and functional magnetic resonance imaging (fMRI).

Q. What activities encompass your professional responsibilities?

A. Standard professor stuff: teaching, research, service.



Q. How long have you been engaged in your professional activity?

A. I started as an estate planning attorney and director of Planned Giving in 1994. My experience related to my current focus on bequest giving research goes back at least that far.

Q. What led you to your professional calling?

A. My current focus is driven by I Timothy 6:18 “Instruct them to do good, to be rich in good works, to be generous and ready to share.”

Q. How are you compensated?

A. As a salaried professor.

Q. Do you work alone or do you have a team? Please explain.

A. I work with others on specific projects where we have common interests. I have been fortunate to work with talented co-authors and researchers from the U.S., Europe, and Australia.

Q. What theoretical framework guides your work when dealing with clients and/or conducting research (e.g., some practitioners use a solution-focused theoretical framework while others are more eclectic)?

A. Eclectic theory is useful only to the extent that it successfully predicts outcomes (in this case, human behavior), but is often too closely defended for its inherent complexity and beauty. As a researcher who publishes in a wide variety of fields (e.g., economics, psychology, marketing, sociology, public administration, etc.), I have to remain open to those models held dear by various groups.

Q. What needs to happen so that 10 years from now we can say that financial therapy is a respected field of study?

A. More full-time faculty positions with this focus.

Q. What benefits can the Financial Therapy Association provide to others doing work that is similar to your professional activities?

A. The annual conference is a great opportunity to gain exposure to a wide variety of approaches.

Q. If others are interested in finding out more about you personally and professionally, where can they obtain this information?

A. Those who are interested in learning about my work and graduate studies in charitable financial planning can visit: www.EncourageGenerosity.com.

Practitioner Profile

An Interview with Amanda Clayman, LMSW, CFSW

Amanda Clayman, is a Licensed Master of Social Work and a Certified Financial Social Worker who helps individuals, couples, and families bring money into balance. Since 2006, Amanda has led the Financial Wellness Program at The Actors Fund, a national non-profit human services agency that supports professionals in performing arts and entertainment. She maintains a private financial wellness counseling practice in New York City and is a public speaker on life and money topics. Amanda's work has been featured in media outlets, such as the New York Times, the Wall Street Journal, SELF magazine, REAL SIMPLE magazine, Women's Health, Parenting, and Fit Pregnancy. She lives in Brooklyn with her husband and daughters.

Keywords: Clayman; financial counseling; financial therapy; financial social work; social work

Q. Tell us a bit about yourself.

A. I am from southwest Michigan originally, but have lived in New York City for almost twenty years now. I moved to the city right after college with hardly a dime in my pocket, paying the deposit on my first apartment with a credit card check. Thus began a decade of self-destructive, erratic financial management where no matter how much money I made, I never seemed to have enough. The process of addressing my financial attitudes and behaviors led me to realize how many others struggled in a similar way. I left the corporate world for social work, specializing in money issues, and have been happily ensconced in advocacy and agency work for the last ten years.



Q. Define what you do professionally.

A. I lead the Financial Wellness Program at The Actors Fund, a national non-profit human services organization that supports professionals in performing arts and entertainment. There are many inherent challenges (both internal and external) to making a career in the entertainment industry, and Financial Wellness Program (FWP) services are designed to help our members lead engaged, empowered, and stable financial lives. To this end, we provide clinically-grounded financial counseling to individuals and couples, conduct workshops, groups and seminars, and create online tools and content. For the last few years, I have also worked as a consultant to various social service agencies, developing training programs for casework staff to improve their clients' financial stability.

Q. What activities encompass your professional responsibilities?

A. Because I run a small program with a very big scope, I am always thinking in terms of scale and efficiency. In the first session with a new financial counseling client, we create a scope of work so we know exactly what we are seeking to accomplish or address in a target number of sessions. This helps keep the work focused. If I see an issue come up repeatedly



in individual work, I try to develop group programming around it. A good example of this is the challenge of stabilizing cash flow. Many of the people I work with experience episodic work and variable earning, so eight years ago I created our Managing Cash Flow for Artists workshop, which we now offer three times per year. I personally prefer the hands-on work, but I am sensitive to the fact that that will always be limited by time and geography, so I also try to translate

as many of our programs and services as possible into online video tutorials and interactive learning modules. Finally, I consult with and train our agency staff on financial issues that impact our constituents.

Q. How long have you been engaged in your professional activity?

A. I completed my MSW in 2005 and launched the Financial Wellness Program in January of 2006. I started seeing private clients shortly thereafter and added consulting two years ago.

Q. What led you to your professional calling?

A. I spent the first decade of my professional life working in marketing and promotions, all the while sinking deeper and deeper into a pit of credit card debt. I had a terrible relationship with money, but had no idea how to improve it or where to turn for help. The truth came tumbling out one day (an experience I blogged about in a post titled, *The \$19,000 Haircut*). Thus started a journey of personal financial healing that became so exciting to me I decided to change careers in order to help others achieve the same. In the beginning, I wasn't sure at all what that path would look like. I explored the idea of getting a doctorate in social psychology, but ultimately felt that social work was the best fit since I was also passionate about advocacy and social justice.

Q. How are you compensated?

A. In my agency work, I receive a salary, and services are free to our clients. In my private and consulting work, I charge an hourly fee.

Q. Do you work alone or do you have a team? Please explain.

A. A core principle of social work is helping connect clients with resources. I feel this is especially important when doing financial work, as there are many tasks that are either done more effectively by others or are not part of ethical social work practice. At The Actors Fund, for example, we have a stellar employment and training program called The Actors Work Program. For clients who are under-earning or unemployed, this program is a vital resource for job leads, skills development, employment search support, and career counseling. I also maintain a robust network of financial services professionals, such as credit counselors, attorneys, financial planners, and investment advisors with whom I consult or to whom I refer.

Q. What theoretical framework guides your work when dealing with clients and/or conducting research (e.g., some practitioners use a solution-focused theoretical framework while others are more eclectic)?

A. I use an eclectic approach, though I most often employ a Cognitive Behavioral framework. I've also received training as a personal coach. I find coaching methodology a wonderful framework to expand the continuum of financial work from a focus on repairing deficits to more positive change such as goal-setting and improving performance.

Q. What needs to happen so that 10 years from now we can say that financial therapy is a respected field of study?

A. This is an interesting question, in that it asks specifically about financial therapy as a “field of study.” One of the things I love most about attending the FTA Conference is the exposure to the research community. However, I don’t feel like we are effectively capturing the contributions of the practice community in our exchange. As a member of the practice community, I can claim some responsibility for that, as I have been more comfortable to listen than to present at the two conferences I’ve attended. But those who are in the field practicing financial therapy should take a note from the academics, and dedicate time and energy to documenting, analyzing, and publishing our work. We should develop a set of best practices that can be utilized by all the mental health fields, including clinical psychology, MFT, social work, and even coaching. The cross-discipline collaboration is something that makes our niche unique and I feel there is tremendous opportunity there. We should also focus on how financial therapy can be integrated into professional education and clinical training programs.



Q. What benefits can the Financial Therapy Association provide to others doing work that is similar to your professional activities?

A. I find the exposure to others’ work to be extremely inspiring. Sometimes I feel a bit on the margins because our “voice” as a group seems very academic, and I think we’d find broader appeal if we reduced the degree of structure and formality in our literature. Spreading the word about the amazing work that members are doing, sharing tools, and simply being a platform for connection are all great benefits.

Q. If others are interested in finding out more about you personally and professionally, where can they obtain this information?

A. I keep a blog titled “The Good, the Bad, and the Money” at www.amandaclayman.com. You can follow me on Twitter and Tumblr as @mandaclay, or email me at amanda@amandaclayman.com. I am also on LinkedIn as amandaclayman. For more

information on the Financial Social Work Certification program, visit www.financialsocialwork.com.

Book Review

How to Give Financial Advice to Couples: Essential Skills for Balancing High-Net-Worth Clients' Needs

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Kingsbury, K. B. (2014). *How to give financial advice to couples: Essential skills for balancing high-net-worth clients' needs*. McGraw-Hill Education, 271 pp., \$35.00. ISBN: 978-0-07-181911-4

How to Give Financial Advice to Couples is a financial advisor's must-read text. Kingsbury allows the reader to become familiar with the daunting area of couple dynamics in this unintimidating and easy read. The flow of the book leads the reader into exploring his or her own experiences with finances, and then guides the reader into how to use the understanding of those experiences to help financial clients. With the integration of the financial and psychology/mental health fields, this book provides financial advisors vital information around relationships and mental health issues, as well as a unique way of working with clients and their relationships with money. Every professional that works in the financial advising field would find benefit in reading this book. This article reviews the book's readability, organization, content, and usefulness for financial advisors, as well as for the field of financial therapy.

The book consists of two main sections that cover the psychology of couples and essential skills for working with couples. The reader is provided with some psychoeducation around couples work, in addition to guidance on how to implement this knowledge into practice. The first section describes the psychology of couples. Beginning with a description of the financial advisor's dilemma, the troubles around working with both partners in a financial advising setting are highlighted. Next, common myths about

How To Give Financial Advice to Couples: Essential Skills for Balancing High-Net-Worth Clients' Needs

couples and money are discussed, followed by some common relational dynamics of both the couple and the financial advisor. Lastly, modern couples and families across the lifespan are discussed, highlighting the areas of same-sex couples, blended families, and the developmental stages that couples follow.

The second section of the book, “Essential Skills for Working with Couples” covers skills needed for financial advisors. This section builds on the first by elaborating on how to implement the psychology of couples into practice. Important factors in the advisor-client relationship are discussed and include: (a) building a trusting relationship, (b) balancing gender differences, (c) exploring money mindsets, (d) managing conflict, (e) stages of change, (f) raising financially intelligent children, and (g) working with addiction, dementia, mental health issues, and marital discord. Lastly, the book includes twelve pages of resources for financial advisors to refer to if and when they come across a variety of issues.

Throughout both sections of the book, Kingsbury uses unique strategies to emphasize key points. For instance, she uses text boxes to highlight the words of her interviewees that speak to the point she is making. For example, as she discusses teaching children and even young adults in their twenties to be financially intelligent, Kingsbury highlights the words of an aunt that express her concern for her niece and other young people that do not balance their checkbooks. Other text boxes include words of financial professionals, clinical professionals, and couples themselves. Kingsbury also includes creative worksheets, questionnaires, and fill-in-the-blank sentences to help the reader explore what it means to be a couple-friendly advisor. This is an extremely insightful and interactive way to help financial advisors learn about what it means to work with couples.

This book is a very useful tool for professional financial advisors to utilize; however, a future edition of the book could be strengthened by addressing a few limitations. Kingsbury mentions making adequate referrals when necessary, but this advice holds the assumption that the financial advisor adheres to a particular personal and/or professional ethical code of practice. This may not always be the case for some practicing financial advisors, as boundaries between providing financial advice and therapeutic services to couples can become unclear due to differing credentials, professional standards, and training. Furthermore, the boundaries between providing financial advice to couples versus providing couples counseling work are not clearly defined. Future editions of the book would be strengthened for the reader by defining the scope of couples' work practices.

Overall, the strengths of the book are far more beneficial than the slight limitations. Written from a financial advisor's perspective for financial advisors, Kingsbury's *How to Give Financial Advice to Couples* is an insightful crash course on how to work with couples

and families. With a piece of psychoeducation and a piece of how-to, this book does an excellent job of introducing the difficult concepts of working with couples and finances. With detailed descriptions, support from interviewees, and thought-provoking interactive pieces, this book will be invaluable to any professional working with clients and their finances.